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63-1210 FORM INDEX 63-1210

63-1211 ACTIVE STATE FOOD STAMP FORMS 63-1211

Form No.	Title	Current Version	Form Designation*	Form and Instruction Provided	Form Modification Policy Provided
CA-1	Application for Public Assistance	8-78	R-NS	No	No
CA-6	Alien Status Verification	1-82	R-NS	No	No
CA-7	Monthly Eligibility Report	2-84	R-NS	Form Only	Yes
CA-8	Statement of Facts For Additional Persons	2-84	R-NS	Yes	Yes
CA-331/333	Notice of Actions	11-80	R-NS	No	No
DE 8435 FS	Food Stamp Work Registration	3-81	R-NS	No	No
DFA 285-A1	Application for Food Stamps — Part I	11-83	R-NS	Yes	Yes
DFA 285-A2	Application for Food Stamps — Part 2	12-83	R-NS	Yes	Yes
DFA 285-B	Food Stamp Budget Worksheet	12-83	R-SP	Yes	Yes
DFA 285-C	Application for Food Stamps — Special Medical Deductions	11-83	R-NS	Yes	Yes
DFA 285-D	Food Stamp Budget Worksheet — Special Medical/Shelter Deductions	12-83	R-SP	Yes	Yes
DFA 285.1	Income From Farm Operations and Other Self-Employment Sheet	8-73	R-SP	No	No
DFA 286	Household Issuance Record (HIR Card)	4-79	R-SP	No	No
DFA 287	Food Stamp Program Identification Card	4-80	R-SP	Yes	Yes
DFA 288	Notice of Change to Authorization to Participate Master File or Household Issuance Record	5-79	R-SP	No	No

*Form Designation

R-NS Required Form — No Substitutes
R-SP Required Form — Substitutes Permitted
Rec. Recommended Form
+ Designation Pending

63-1211 ACTIVE STATE FOOD STAMP FORMS (Continued) 63-1211

Form No.	Title	Current Version	Form Designation*	Form and Instruction Provided	Form Modification Policy Provided
DFA 289	Food Stamp Program — Receptionist's Daily Tally Sheet	4-79	R-SP	No	No
DFA 290	Food Coupon Book Issuance Register	10-79	Rec.	No	No
DFA 291	Summary of Daily Issuance Office Transactions	5-74	+	No	No
DFA 292	Coupon Book Inventory Record	8-79	R-SP	No	No
DFA 293	Cashier's Daily Report	4-79	+	No	No
DFA 293.1	Summary of Daily Reports	1-75	+	No	No
DFA 299	Authorization to Participate Card	5-79	+	No	No
DFA 300	Mail Issuance Log	1-80	+	No	No
DFA 301	Mail Issuance Request	3-80	+	No	No

*Form Designation

R-NS Required Form — No Substitutes
R-SP Required Form — Substitutes Permitted
Rec. Recommended Form
+ Designation Pending

63-1211 ACTIVE STATE FOOD STAMP FORMS (Continued) 63-1211

Form No.	Title	Current Version	Form Designation*	Form and Instruction Provided	Form Modification Policy Provided
DFA 303	Replacement Affidavit/Authorization	1-83	R-SP	Yes	Yes
DFA 332.1	Verification of Food Stamp ATP Usage	8-79	+	No	No
DFA 377.1	Food Stamp Notice of Action	12-83	R-NS	Yes	Yes
DFA 377.2	Food Stamp Notice of Expiration of Certification	12-83	R-NS	Yes	Yes
DFA 377.4	Food Stamp Notice of Change	12-83	R-NS	Yes	Yes
DFA 377.5	Food Stamp Household Change Report	12-83	R-NS	Yes	Yes
DFA 377.7A	Food Stamp Notice of Administrative Disqualification	3-84	R-NS	Yes	Yes
DFA 377.7B	Food Stamp Repayment Notice	3-84	R-NS	Yes	Yes
DFA 377.7C	Food Stamp Repayment Agreement	3-84	R-NS	Yes	Yes
DFA 377.9	Notice of Restoration of Lost Food Stamp Benefits	3-81	R-SP	Yes	Yes
DFA 385	Application for Emergency Food Stamp Issuance	2-80	+	No	No
DFA 440	Verification of Physical or Mental Incapacity	5-78	+	No	No
DFA 842	Claim Determination Worksheet	6-81	R-SP	Yes	Yes
NA 960X	Notice of Action (CA 7 Not Received — Discontinuance)	1-84	R-NS	Yes	Yes
NA 960Y	Notice of Action (CA 7 Incomplete — Discontinuance/Reminder)	1-84	R-NS	Yes	Yes

*Form Designation

R-NS Required Form — No Substitutes
R-SP Required Form — Substitutes Permitted
Rec. Recommended Form
+ Designation Pending

63-1212 ACTIVE FEDERAL FOOD STAMP FORMS 63-1212

Form No.	Title	Current Version	Form Designation*	Form and Instruction Provided	Form Modification Policy Provided
FNS-46	Food Stamp Program ATP Reconciliation Report	10-80	R-NS	No	No
FNS-135	Affidavit of Return or Exchange of Food Coupons	10-78	R-NS	No	No
FNS-250	Food Coupon Accountability Report	10-78	R-NS	No	No
FNS-259	Food Stamp Mail Issuance Report	12-78	R-NS	No	No
FNS-260	Requisition for Food Coupon Books	7-78	R-NS	No	No
FNS-261	Advice of Shipment (Food Coupons)	11-78	R-NS	No	No
FNS-287	Request for Reimbursement or Notification of Return of Unused Food Coupons for Refund	2-77	R-NS	No	No
FNS-292	Report of Coupon Issuance for Disaster Relief	8-77	R-NS	No	No
FNS-300	Advice of Transfer (Food Coupons)	6-78	R-NS	No	No
FNS-471	Coupon Account and Destruction Record	9-81	R-NS	No	No

*Form Designation

R-NS Required Form — No Substitutes
R-SP Required Form — Substitutes Permitted
Rec. Recommended Form
+ Designation Pending

63-1220 FORMS PROCUREMENT 63-1220

63-1221 STATE FORMS 63-1221

All CA, DFA, and selected DE forms needed for the administration of the Food Stamp Program may be ordered from the Department of Social Services. The Department of Social Services has both forms which are free and forms which are sold to counties. Information concerning ordering procedures and form prices is available in the DSS County Forms Catalog.

63-1222 FEDERAL FORMS 63-1222

The following federal forms are ordered by counties (or their Issuance Agent, if applicable) directly from FNS, U.S. Department of Agriculture, Washington, D.C., 20250, or from FNS, USDA, Western Region, 550 Kearny Street, Room 400, San Francisco 94108 as indicated:

FNS-46 (number of sets) FNS, San Francisco
FNS-135 (number of copies) FNS, San Francisco
FNS-250 (number of sets) FNS, Washington, D.C.
FNS-259 (number of copies) FNS, San Francisco
FNS-260 (number of sets) FNS, San Francisco
FNS-261 (number of sets) FNS, San Francisco
FNS-287 (number of copies) FNS, San Francisco
FNS-292 (number of copies) FNS, San Francisco
FNS-300 (number of sets) FNS, San Francisco

FNS-250 is to be reordered by checking the reorder notification box on the form. For emergency supplies of this form, counties should contact the Western Region FNS Office in San Francisco or the Food Stamp Program Management Branch.

FNS-471 (number of sets) is to be reordered by submitting the Forms Order (GEN 727 B). Send your orders to Department of Social Services, P.O. Box 22429, Sacramento, CA 95822-3799.

63-1230 STATE FORMS & INSTRUCTIONS 63-1230

CA 7 (2/84)

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

MONTHLY ELIGIBILITY REPORT

For Cash Aid and Food Stamps

THIS REPORT IS FOR THE MONTH OF:

Complete, sign, date and return this form AFTER the last day of:

- You must complete this report and return it by the 5th of the month. If this report is not received by the 11th of the month or is incomplete, your Cash Aid, Cash-based Medi-Cal and/or Food Stamps may be delayed, decreased or discontinued.
- If you do not **ATTACH** proof of reported income, your benefits may be discontinued. If you do not **ATTACH** proof of expenses, your benefits may be decreased or discontinued.
- **Call your worker if you need help completing the form.** Attach a separate sheet of paper if needed.

Worker: Phone:

NOTE: If you or your family no longer want Cash Aid, Medi-Cal or Food Stamps check this box ☐, state the reason and type(s) of assistance no longer wanted, complete the signature block and return the form by the due date.

Reason and Type(s) of assistance:

If you receive cash aid or food stamps, answer ① through ⑨. Answer for everyone in your household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in your home.

① **Did anyone receive income, money, or benefits in the month,** such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment/disability insurance, interest, worker's compensation, SSI/SSP (gold checks), child/spousal support, loans, grants, tax refund, cash, gifts, free housing/utilities, etc.? ☐ YES ☐ NO

If **YES,** complete section below. **ATTACH PAYSTUBS** or other proof of earnings each month. **ATTACH PROOF** for any other income only when it starts and when it changes. If anyone is self-employed, list business expenses on a separate sheet of paper and **ATTACH PROOF** of income and expenses each month. **(If you receive cash aid and you fail to report or ATTACH PROOF of earned income by the 11th of the month, the standard work expense, dependent care, and when eligible for it, the $30 and 1/3 disregard will not be allowed.)**

Who Received Income, Money or Benefits?	Source (If Earnings, List Name of Employer)	Enter below dollar amounts and actual dates received. If earnings, enter gross amount before deductions.					If Earnings: Number of Days Worked in Month	If Earnings: Number of Hours Worked in Month
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		
Name		Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date	Amount $ / Date		

② **Did anyone pay for the care of a child or disabled adult so that someone in the home could go to work, training or look for a job?** ☐ YES ☐ NO

If **YES,** complete below and **ATTACH** a receipt for each person receiving care.

Who Received Care?	Cost of Care	Who Received Care?	Cost of Care
	$		$
	$		$

		YES	NO
③	**Did anyone move into your home (including a new born), move out, get married, or die?**	☐	☐
④	**Did anyone become disabled or recover from a disability?**	☐	☐
⑤	**Did anyone start, refuse, lose, quit or change a job/training, or go on strike?**	☐	☐
⑥	**Did anyone start, stop or change school or college?**	☐	☐
⑦	**Did anyone receive, buy, sell or give away any property such as a house, land, motor vehicle, camper, boat, etc.?**	☐	☐

If **YES,** to any of the changes, give name of person, date of change and explain the change. If property change, give value of item.

COUNTY USE ONLY **E.W. INITIALS** **DATE:**

CA 7 (2/84) AFDC/FOOD STAMPS *Required Form No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

CA 7 (2/84)

(8) **Did anyone have a checking, savings or credit union account open at the end of the month?** ☐ YES ☐ NO
If YES, complete below

☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month	Whose Account?	☐ Credit Union ☐ Checking ☐ Savings	Balance On Last Day of Report Month	Whose Account?

(9) **Did you move, or do you have a new mailing address or phone number?** ☐ YES ☐ NO
If YES, complete below.

Home Address (Number, Street Name, Avenue Blvd. Etc.)	Apt. No.	City	State	Zip Code	Phone No.

Mailing Address (If Different Than Home Address)	City	State	Zip Code

If you receive food stamps, answer (10) through (13) for everyone in your household. If you do not receive food stamps, go to (14) through (17)

(10) **Did the household have housing costs?** ☐ YES ☐ NO
If YES, enter amount billed.
ATTACH bills only if you moved or the cost changed.

Rent or Mortgage	Property Taxes or Insurance (if not in mortgage)
$	$

(11) **Did the household have utility costs?** ☐ YES ☐ NO
If YES, and you moved or claim actual utility costs, complete below and ATTACH BILLS.

Gas/Fuel	Electricity	Telephone	Utility Installation	Garbage/Trash	Water	Sewage	Other (Specify)
$	$	$	$	$	$	$	$

(12) **Did the household share housing or utilities or did anyone help pay these costs?** ☐ YES ☐ NO
If YES, list each item, amount paid, who paid and ATTACH PROOF.

(13) **Did anyone who is disabled or age 60 or older have any medical expenses in the month?** ☐ YES ☐ NO
If YES, complete below and ATTACH BILLS for each expense.

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense?	Type of Expense	Amount
		$			$

If you receive cash aid, answer (14) through (17) for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home. If you do not receive cash aid go to (17).

(14) **Did you or anyone in your family who received income pay any court ordered support in the month?** ☐ YES ☐ NO
If YES, enter the amount paid and ATTACH RECEIPTS: $

(15) **Did anyone start, stop or change health or hospitalization insurance coverage such as Prudential, Blue Cross, Champus, etc.?** ☐ YES ☐ NO
If YES, give name of person, date and explain change.

(16) **Did anyone become pregnant, have a baby or terminate a pregnancy?** ☐ YES ☐ NO
If YES, give name of person, date and explain change.

If you receive cash aid or food stamps, answer (17). Answer for everyone in the household if you receive food stamps. If you do not receive food stamps, answer for everyone receiving cash aid, the aided children's parents, stepparents, and your spouse if in the home.

(17) **Does anyone in the home have other information to report for this month or next month, such as: recent or expected changes in income, place of employment, number of working hours or days per week, place of residence, property, persons in the household, etc?** ☐ YES ☐ NO
If YES, explain the change, if it is expected to be temporary or permanent and indicate the date of the change.

CERTIFICATION

- *I understand that failing to report information or misrepresentation of facts for Cash Aid programs, Food Stamps or Cash-based Medi-Cal can result in legal prosecution with penalties of a fine, imprisonment or both. In the Food Stamp Program the penalties can result in permanent disqualification from the Program, fines up to $10,000 or imprisonment for up to 5 years.*
- *I understand that I must contact my worker to report any unexpected changes which affect my eligibility for or the amount of my Cash Aid within 5 days of the occurrence or if I have any doubt about needing to report any changes.*
- *I understand that reported information may result in a decrease or discontinuance of benefits.*
- *I understand I have the right to request a state hearing on any proposed action by the county welfare department.*
- ***I declare that the information contained in this report is true and correct and is complete for the entire report month.***

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE
For Cash Aid programs, you and your aided spouse (or the other parent of aided children) living in the home must sign the form. For the Food Stamp Program, the head of household, a household member or the household's authorized representative must sign the form.

Signature of Cash Aid Parent or Caretaker Relative and/or Food Stamp Household Member ▶	Date Signed
Signature of Cash Aided Spouse or Other Parent of Cash Aided Children ▶	Date Signed
Signature of Witness to Mark, Interpreter or Other Person Completing Form ▶	Date Signed

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

CA 8 (2/84)

State of California
Health and Welfare Agency

Department of Social Services

STATEMENT OF FACTS FOR ADDITIONAL PERSONS

(Supplemental Application for Food Stamps and Request for Cash Aid)

INSTRUCTIONS: Use this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper.

If you receive Cash Aid, and you want aid for the new person, this form must be completed by the adult caretaker relative who is now receiving aid. The new person may complete the form unless it is a child.

For Food Stamp households, which do not receive Cash Aid or do not want Cash Aid for the new person this form may be completed by a household member, an authorized representative or the new person.

If you receive Food Stamps, answer questions (1) through (18).

If you receive Cash Aid and you want Cash Aid for the new person, answer questions (1) through (14) and (19) through (28).

If you receive Food Stamps and Cash Aid, and you want Cash Aid for the new person, answer all the questions.

PLEASE PRINT IN INK

(1) Name of Person Completing Form (First, Middle, Last)

(2) List all new persons in the home, including a newborn.

Person 1 First Name Middle Last

Social Security Number* | Birthdate | Sex (Circle) M F

Person 2 First Name Middle Last

Social Security Number* | Birthdate | Sex (Circle) M F

Answer the following questions for each new person.

(3) Has he/she applied for or received benefits in the past, such as: AFDC, Food Stamps, Medi-Cal, Refugee/Entrant Assistance, Emergency Assistance, etc.? ☐ Yes ☐ No

If YES, complete section below:

	Date Applied	Date Last Received	Where (County and State)	Type of Benefits
Person 1				
Person 2				

(4) Is Person 1 a U.S. citizen? ☐ Yes ☐ No
Is Person 2 a U.S. citizen? ☐ Yes ☐ No
If NO, complete section below and attach proof of alien status.

	Date Person Entered U.S.	Does Person Have an Individual Sponsor?	If YES, Name of Sponsor
Person 1		☐ Yes ☐ No	
Person 2		☐ Yes ☐ No	

(5) Is he/she related to anyone in the home?
Person 1: ☐ Yes ☐ No If YES, explain relationship(s):
Person 2: ☐ Yes ☐ No If YES, explain relationship(s):

(6) Is he/she a veteran, the child of a veteran or the surviving spouse or surviving child of a veteran? ☐ Yes ☐ No

If YES, check ALL the boxes which apply:

Person 1: ☐ Veteran ☐ Child of a Veteran ☐ Surviving Spouse ☐ Surviving Child ☐ Disabled
Person 2: ☐ Veteran ☐ Child of a Veteran ☐ Surviving Spouse ☐ Surviving Child ☐ Disabled

(7) Is he/she attending school or a training program? ☐ Yes ☐ No
If YES, complete section below:

	Name of School or Training Program	Attending Full-Time?	Expected Date of Graduation
Person 1		☐ Yes ☐ No	
Person 2		☐ Yes ☐ No	

(8) Is he/she participating in a labor strike? ☐ Yes ☐ No
If YES, complete section below:

	Date Person Went on Strike	Gross Monthly Income Earned From This Job Before the Strike
Person 1		$
Person 2		$

COUNTY USE ONLY

CASE NUMBER

DATE RECEIVED

Food Stamps		Food Stamps and Cash Aid							Cash Aid
Nonhousehold Member (Enter Code)	Specify in Box if Elderly or Disabled	Gen 827, MA5-95 or DE 8435 FS (specify form and date completed)	WIN/ES or FS Work Registration Exemption (Enter Code)	Specify type of verification and date viewed: Identity	SSN	Citizenship/ Alien Status	Age		FFP Status (Enter Federal, Non-Federal, Essential Person)

☐ DFA 285-C

CA 6 Other proof (specify): CA 22
1. ☐ ☐ ☐
2. ☐ ☐ ☐

1. ☐ Stepparent ☐ CA 71 (UAM)
2. ☐ Stepparent ☐ CA 71 (UAM)

CA 5 Date Initiated
1. ☐ Yes ☐ No
2. ☐ Yes ☐ No

Eligible Student: School Attendance Verified:
1. ☐ FS ☐ Cash Aid ☐ Yes ☐ No
2. ☐ FS ☐ Cash Aid ☐ Yes ☐ No

*A Social Security Number (SSN) is required by Section 402(a)(25) of the Social Security Act for Cash Aid recipients and by the Food Stamp Act of 1977, as amended by Public Law 97-98, for each food stamp household member. These SSNs are required to ensure the accurate issuance of Cash Aid and Food Stamp benefits to eligible individuals. SSNs are used in computer matching to prevent duplicate participation, to check the identity of individuals, to make changes and for program reviews and audits. Refusal to provide an SSN will result in program ineligibility for the individual for whom the SSN is not provided.

CA 8 (2/84) AFDC RCA ECA Food Stamps *Required Form - No Substitutes Permitted* Page 1 of 3

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

CA 8 (2/84)

(9) Does he/she own or is he/she buying any real property, such as: a house, land, buildings, etc.? ☐ Yes ☐ No
If YES, complete section below

	Type of Property	Address/Location	How Used? (Home, Rent, etc.)	Balance Owed	Value	Name of Mortgage Company	Check if Exempt
Person 1				$	$		
Person 2				$	$		

COUNTY USE ONLY

(10) Does he/she have any of the following resources? Check each item. If YES, explain below.

Resource	Person 1	Person 2	Resource	Person 1	Person 2
Checks or Money (at home or elsewhere)	☐Yes ☐No	☐Yes ☐No	Trust Funds	☐Yes ☐No	☐Yes ☐No
Checking/Savings/Credit Union Account	☐Yes ☐No	☐Yes ☐No	Stocks, Bonds, Certificates	☐Yes ☐No	☐Yes ☐No
Notes, Mortgages, Trust Deeds, Sales Contracts	☐Yes ☐No	☐Yes ☐No	Other (specify below)	☐Yes ☐No	☐Yes ☐No

Type of Resource	Owner	Current Value	Location (Home, Bank Address, Etc.)	Account Number	Check if Exempt
		$			
		$			
		$			

Date Registration and Records Viewed
1. _____
2. _____

(11) Does he/she own or use or is he/she buying any motor vehicles, such as: a car, truck, boat, trailer, van, camper, motorcycle, etc.? ☐ Yes ☐ No
If YES, complete section below:

	Owner	Year, Make, Model	License Number and State of Registration	Amount of Last License Fee	Balance Owed	Check if Exempt
Person 1				$	$	
Person 2				$	$	

Vehicle Valuation
1. $_____
2. $_____

(12) Is he/she employed? ☐ Yes ☐ No
If YES, complete section below. Attach paystubs or other proof of earnings. If he/she is self-employed list business expenses on a separate sheet of paper and attach proof of income and expenses.

	Name of Employer	Gross Pay (before deductions)	How Often Paid (Weekly, Monthly, Etc.)	Number of Days Worked in Month	Number of Hours Worked in Month	Check if Exempt	Enter Date Viewed: Pay Stubs	Enter Date Viewed: Other
Person 1		$						
Person 2		$						

(13) Does he/she receive or expect to receive any other income, such as: Social Security, Unemployment/Disability Insurance, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, Etc.? ☐ Yes ☐ No
If YES, complete section below and attach proof of the income.

	Type of Income	Amount	How Often Received (Weekly, Monthly, Etc.)	Date Last Received	Date Expected to Begin	Check if Exempt
Person 1		$				
Person 2		$				

Specify Verification and Date Viewed:

(14) Does he/she pay someone to care for a child or disabled adult so he/she can go to work or training or look for work? ☐ Yes ☐ No
If YES, complete section below and attach receipts.

	Who Received Care?	Who Provided Care?	Amount	How Often Paid (Weekly, Monthly, Etc.)	Date Receipts Viewed
Person 1			$		
Person 2			$		

Answer questions (15) through (18) only if you receive food stamps.

(15) Does he/she receive food from a Food Distribution Program operated by an Indian Reservation?
Person 1 ☐ Yes ☐ No If YES, which reservation?
Person 2 ☐ Yes ☐ No If YES, which reservation?

(16) Does he/she purchase or prepare meals separately from others in the home?
Person 1 ☐ Yes ☐ No
Person 2 ☐ Yes ☐ No

(17) Is he/she age 60 or older and unable to purchase and prepare meals separately because of a disability?
Person 1 ☐ Yes ☐ No If YES, does he/she want to be a separate food stamp household? ☐ Yes ☐ No
Person 2 ☐ Yes ☐ No If YES, does he/she want to be a separate food stamp household? ☐ Yes ☐ No

(18) Does he/she pay you for meals and/or a room? ☐ Yes ☐ No
If YES, complete section below:

		How Much?	How Often?	No. of Meals Per Day	Household Elects: Boarder	HH Member	Roomer
Person 1	☐ Meals ☐ Room ☐ Both	$					
Person 2	☐ Meals ☐ Room ☐ Both	$					

Answer question (19) if you receive Cash Aid. If you do not receive Cash Aid, skip questions (19) through (28) and complete the certification section.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

CA 8 (2/84)

(19) Does he/she want to receive Cash Aid?
Person 1: ☐ Yes ☐ No
Person 2: ☐ Yes ☐ No
If either person answers YES, complete questions (20) through (28). If both answer NO, skip questions (20) through (28) and complete the certification section.

(20) If he/she is a child under age 19, complete section below:

	Mother's Name	Father's Name	Child Needs Aid Due to Parent's: (Check all boxes which apply)
Person 1			☐ Absence ☐ Incapacity ☐ Unemployment ☐ Death
Person 2			☐ Absence ☐ Incapacity ☐ Unemployment ☐ Death

(21) Does he/she presently live in California and intend to continue living here?
Person 1 ☐ Yes ☐ No
Person 2 ☐ Yes ☐ No

(22) Does she wish to receive aid because of pregnancy? ☐ Yes ☐ No
If YES, complete section below:

	Expected Date of Birth	Father's Name	Unborn Child's Father Is: (Check all boxes which apply)
Person 1			☐ Absent ☐ Incapacitated ☐ Unemployed ☐ Deceased
Person 2			☐ Absent ☐ Incapacitated ☐ Unemployed ☐ Deceased

(23) Has he/she quit or refused a job or training in the last 30 days? ☐ Yes ☐ No
If YES, complete section below:

	Amount of Last Pay Check	Last Day of Job/Training	Hours Worked/ Training in Last 30 Days	Name and Address of Employer/ Training Program	Reason for Leaving or Refusal
Person 1	$				
Person 2	$				

(24) Does he/she own or use personal property which cost at least $100 for each item or are now worth at least $100 each, such as: jewelry, equipment, instruments, livestock, etc.? ☐ Yes ☐ No
Do not list clothing, wedding rings, rugs, furniture, appliances, other household furnishings.
If YES, complete section below:

	Name of Item	Date of Purchase	Purchase Price	Amount Owed
Person 1			$	$
Person 2			$	$

(25) Has he/she sold, transferred or given away any real or personal property within the last 2 years? ☐ Yes ☐ No
If YES, complete section below:

	Name of Item	Date Sold, Transferred or Given Away	Amount Received
Person 1			$
Person 2			$

(26) Does he/she have any of the following insurance coverages: life, burial, disability or mortgage? ☐ Yes ☐ No
If YES, complete section below:

	Name of Insurance Company	Policy Number	Persons Covered (Names)	Premium Paid by (Name)	Amount Paid
Person 1					$
Person 2					$

(27) Does he/she have health or hospitalization insurance, including insurance paid for by an employer or absent parent, such as: Blue Cross, Kaiser, Champus, etc.? Person 1 ☐ Yes ☐ No Person 2 ☐ Yes ☐ No

Complete question (28) in the presence of your eligibility worker.

(28) A. Does he/she want information about the Child Health Disability Prevention Program (CHDP), Family Planning, Alcohol or Drug Abuse Counseling, past medical expenses and other special needs? ☐ Yes ☐ No
B. Does he/she want CHDP Medical or Dental Services? ☐ Yes ☐ No
C. Does he/she want Family Planning Services? ☐ Yes ☐ No

COUNTY USE ONLY

Deprivation Verification
1. _____
2. _____

Pregnancy Verification:
1. _____
2. _____

Determination of Good Cause Required:
1. ☐ Yes ☐ No
2. ☐ Yes ☐ No

Net Market Value:
1. $ _____
2. $ _____

Total CSV
1. $ _____
2. $ _____

OHC Code Entered: Date:
1. ☐ _____
2. ☐ _____

☐ CHDP brochure and explanation given
☐ Referred
☐ Date:
☐ Other services referral
☐ Family Planning info given
☐ Date referred:

CERTIFICATION

- ***I understand that failing to report information or misrepresentation of facts for Cash Aid programs or Food Stamps can result in legal prosecution with penalties of a fine, imprisonment or both. In the Food Stamp Program the penalties can result in permanent disqualification from the Program, fines up to $10,000 or imprisonment for up to 5 years.***
- *I understand that the information I have provided will be verified by local, state and federal personnel.*
- *I understand that my case may be selected for an additional review to ensure that my eligibility was determined correctly.*
- *I declare under penalty of perjury that the above statements are true and correct.*

For Cash Aid programs, you and your aided spouse or the other parent of aided child(ren) living in the home must sign the form. For the Food Stamp Program, the head of household, a household member or the household's authorized representative must sign the form.

Signature of Cash Aid Recipient or Caretaker Relative and/or Food Stamp Household Member ▶	County Where Signed	Date Signed
Signature of Cash Aided Spouse or Other Parent of Cash Aided Children ▶	County Where Signed	Date Signed
Signature of Witness to Mark, Interpreter, or Other Person Completing Form ▶	County Where Signed	Date Signed

Page 3 of 3

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

CA 8 (2/84)

Form Instructions
(For the Eligibility Worker)

STATEMENT OF FACTS FOR ADDITIONAL PERSONS
(Supplemental Application for Food Stamps and Request for Cash Aid)

Purpose:

The CA 8 is one of several methods of collecting information needed to add a new person(s) to the food stamp household and/or the cash assistance unit.

When there is a new person in a food stamp home, the worker may provide the household with a CA 8 or update the most recent DFA 285-A2. Regardless of the method used to collect the information, the household is required to provide information on any new person in the home so it can be determined if the person should be added to the household, or if the person's resources and income should be considered in the computation of the household's benefits.

The county has 30 days from the date the arrival of the new person is reported on the CA 7 or otherwise, to determine the effect of this new person on the food stamp household.

When there is a request to add a new person to the cash assistance unit the worker may provide the recipient with a CA 8 or a new CA 2. The CA 8 has not been designed to collect unemployed parent work history. Therefore, the CA 2 must be used where deprivation is based on the unemployment of a parent.

The county should act on any request to add a new person by determining promptly their eligibility for cash aid.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

Preparation:

Question	Information Requested	Food Stamp Manual Section	EAS Manual Section	Food Stamp Action	Cash Aid Action
County Use Only	N/A	63-300.5 63-402.1 63-402.2 63-407	N/A	Complete requested information. The county-use section of Item 2 is to be used as a summary of food stamp household composition and other food stamp eligibility factors. In the space provided, enter the appropriate code, date, or other information for all persons listed in 2. If the new person is not exempt from work registration, note the appropriate work registration form and the date completed. If the new person is exempt from work registration, enter the work exemption code. For persons excluded from the household, enter the non-household member code (see the DFA 285-A2 for reasons for exclusions).	The CWD is encouraged to use the county-use section to summarize and to document the verification of eligibility factors.
1.	Person Completing Form	63-300.3	40-117 40-121 40-128	Check that the form was completed by an appropriate person.	
2.	New Person(s)	63-402.2 63-402.7 63-404 63-503.442	40-105.2	**SSN** - Do not add to the household any person refusing to comply with the Social Security Number requirements. Count as available to the household the resources and a pro rata share of of the income of any person who refuses.	**SSN** - Each AFDC-FG and U applicant or recipient member of the assistance unit must as a condition of eligibility furnish his/her SSN or if he/she cannot furnish one, cooperate in securing an SSN.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

Question	Information Requested	Food Stamp Manual Section	EAS Manual Section	Food Stamp Action	Cash Aid Action
2.	New Person(s) (Continued)	63-102(i) 63-409.112 63-502.3 63-503.3	N/A	**Elderly/Disabled** - Note if any household member is age 60 or older, or will become age 60 in the month of application, or is receiving disability or blindness payments under Title II of the Social Security Act, and document that a DFA 285-C was given to the household. Allow excess shelter costs and medical deductions, and use the net income eligibility test for any household with such a member.	N/A
3.	Previous Participation	63-102(jjj)(3) 63-503.3	40-131 40-157 40-159	Determine if any person is participating in an existing certified household.	Determine if and when the new person was previously aided in the same assistance unit.
4.	Citizenship/ Alien Status	63-300.512 63-300.532 63-403 63-503.442	40-181.25 42-205 42-433.22 43-119 44-133 44-353	Note if the person is an alien and document the type of verification provided to determine the alien's eligible status. Do not add to the household/assistance unit any person who is unable to provide acceptable documentation of alien status. Note if a CA 6 was completed by the alien and sent to INS. If the person being added is an alien, determine if he/she has an individual sponsor. If there is an individual sponsor, the applicant/recipient must provide additional information. Note if a CA 22 was provided to the alien. Do not add to the household any person whose U.S. citizenship is questionable and verification is not provided.	All citizens are eligible without documentation for a limited period.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

Question	Information Requested	Food Stamp Manual Section	EAS Manual Section	Food Stamp Action	Cash Aid Action
4.	Citizenship/ Alien Status (Continued)			Count as available to the household the resources and a pro rata share of the income of an ineligible alien or questionable citizen.	An illegal or undocumented alien parent is treated as an excluded parent when considering property or income.
5.	Relationship	63-402.1	40-117	Determine if the relationship of the new person to others in the home affects household composition.	Self-explanatory.
6.	Veterans/ Spouses/ Children	63-102(i) 63-409.112 63-502.3 63-503.3	40-131(n)	If checked yes, determine if the person meets definition of "disabled" person and document that a DFA 285-C was given to the household. Allow excess shelter costs and medical expenses and use the net income eligibility test for any household with such a member.	An applicant/recipient must apply for and take all appropriate steps to obtain specific benefits for which he/she appears to be potentially eligible. Note if a CA 5 was initiated and the date.
7.	Students	63-406	42-101.1 42-101.2 42-630	If checked yes, apply student eligibility criteria to determine eligibility as a household member. Check applicable box in county-use section.	A child meets the age requirement for AFDC eligibility under his/her 18th birthday. A child 18 years of age may be eligible if the requirements in 42-101.2 are met. For children 16 and 17 years of age, see Section 42-630 for WIN requirements.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

CA 8 (2/84)

Question	Information Requested	Food Stamp Manual Section	EAS Manual Section	Food Stamp Action	Cash Aid Action
8.	Strikers	63-402.9	41-440 44-206.1	If the person meets the definition of a striker, the greater of either the income that the striker earned before the strike or the strike benefits now being received is counted.	A new person who is on strike is treated the same as other strikers.
9.	Real Property	63-501.1 63-501.2 63-501.3 63-501.4 63-501.7 63-503.44	42-200 44-113.1	For nonassistance households, document resources, making appropriate exclusions. Check if exempt, in the box provided. For PAFS households, see Cash Aid Action.	Determine if the individual has property, the type, assessed value, and if not living in it, determine utilization. The home or other dwelling owned and used as a home is exempt.
10.	Liquid Resources	63-501.1 63-501.2 63-501.3 63-501.4 63-501.7 63-503.44	42-200	For nonassistance households, document resources, making appropriate exclusions. Check, if exempt, in the box provided. For PAFS households, see Cash Aid Action.	Determine value of all property. The combined net market value of real and personal property may not exceed $1,000.
11.	Motor Vehicles	63-501.51	42-211.22 44-213.22	For nonassistance households, evaluate vehicles for resource exclusions. On the budget worksheet compute any countable resource value. For PAFS households, see Cash Aid Action.	Count the net market value of all motor vehicles not exempt from evaluation as personal property.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

Question	Information Requested	Food Stamp Manual Section	EAS Manual Section	Food Stamp Action	Cash Aid Action
12.	Wages/ Self-Employment	63-300.511 63-402.92 63-502.1 63-502.2 63-503.212 63-503.22 63-503.23 63-503.24 63-503.4 63-503.41	44-101 44-113	For each source of earned income, check if exempt in the box provided. Also for each source, note the date and amount of pay stubs or other documentation viewed. Document in the county-use section whether or not income is considered anticipated or from a terminated source, or for Cash Aid only, income of a non-continuous nature for purposes of the budget calculation.	
13.	Other Income	63-300.511 63-502.1 63-502.2 63-503.212 63-503.22 63-503.23 63-503.24 63-503.4	44-113	For all yes answers, check that all other information is provided. In the space provided, check any income amount which is exempt. Document verification of gross non-exempt income. Document whether or not income is considered anticipated or from a terminated source, or for Cash Aid only, income of a non-continuous nature for purposes of the budget calculation. Compute earned income from self-employment using cost and income information provided by the new person(s).	
14.	Dependent Care	63-300.52 63-502.34 63-403.25	44-113.215	If checked yes, consider for a dependent care income deduction.	
15.	Food Distribution Program	63-402.8	N/A	If checked yes, verify that participation in the Food Distribution Program has been terminated.	N/A
16.	Purchase or Prepare Separately	63-300.531 63-402.27	N/A	If checked yes, determine if the person should be added to the household. Document accordingly in the county-use section.	N/A

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

CA 8 (2/84)

Question	Information Requested	Food Stamp Manual Section	EAS Manual Section	Food Stamp Action	Cash Aid Action
17.	Separate Household Status	63-102(i) 63-300.531 64-402.15	N/A	If separate household status is requested by an elderly **and** disabled person and his/her spouse because of the person's inability to purchase and prepare separately, determine if it should be granted.	N/A
18.	Roomers and Boarders	63-402.1 63-402.2 63-402.3	N/A	If checked yes, determine if any person meets the definition of a roomer, boarder, or household member. Boarders are ineligible to participate as separate households and may participate as a household member only if requested by the household. Roomers must be separate households. Document status in the county-use section.	N/A
19.	Request for Public Assistance	N/A	40-117.2	N/A	The request for public assistance should be recorded by the CWD and appropriate action taken as soon as possible.
20.	Child Under Age 19	N/A	41-400 42-101	N/A	The CWD must establish the basis for deprivation for the child for whom aid is requested.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

Question	Information Requested	Food Stamp Manual Section	EAS Manual Section	Food Stamp Action	Cash Aid Action
21.	Residence Declaration	N/A	42-400 42-403	N/A	There are no county residence requirements. A person, must, however, reside in California and intend to continue residing in California.
22.	Pregnancy	N/A	44-203 44-205	N/A	Self-explanatory.
23.	Voluntary Quit	N/A	41-400	N/A	Self-explanatory.
24.	Personal Property	N/A	42-200	N/A	Self-explanatory.
25.	Transfer of Resources	N/A	42-221	N/A	Self-explanatory.
26.	Insurance (Resources)	N/A	42-200	N/A	Self-explanatory.
27.	Health Insurance	N/A		N/A	Self-explanatory.
28.	Social Services	N/A	40-131	N/A	Self-explanatory.
Certification		63-300.3	20-006	Check that the form contains all required signatures and dates.	

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A1 (11/83)

State of California
Health and Welfare Agency

Department of Social Services

APPLICATION FOR FOOD STAMPS
PART 1

COUNTY USE ONLY
CASE NUMBER
DATE RECEIVED

Please complete all questions in ink.

Step 1. Complete Part 1.

To begin to apply for food stamps, complete this page and give it to us. If you are not receiving food stamps or if you did not reapply on time, we are required to take action on your application within 30 days from the date you give us this page. The sooner you give us this page, the sooner you will know if you will receive food stamps. Now go to Step 2.

Step 2. Complete Part 2.

Part 2 must be completed before we can see if you are eligible for food stamps. You can return Part 2 to us along with this page or at the time of your interview. Try to fill out as much as possible before you give it to us. Your worker will help you with the rest during your interview.

NAME: LAST FIRST MIDDLE INITIAL TELEPHONE NUMBER

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

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

SIGNATURE (HEAD OF HOUSEHOLD, HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE) ▶ DATE

ANSWER THE FOLLOWING QUESTIONS IF YOUR HOUSEHOLD HAS LITTLE OR NO INCOME AND NEEDS FOOD STAMPS IMMEDIATELY.

If your household (you and the people who live and eat with you) has little or no money right now, you may be able to receive food stamps within five calendar days.

1. How much do you and the members of your household have in liquid resources, such as: cash, money in checking accounts, savings accounts, or savings certificates; trust deeds, notes receivable, stocks or bonds? (Give your best estimate of the total)

   $

2. How many people living in your home eat with you? (Including yourself)

3. Has anyone in your household received any income so far this month?

   ☐ Yes ☐ No If YES, how much? $

4. Does anyone in your household expect to receive income later this month?

   ☐ Yes ☐ No ☐ Don't Know If YES, how much? $ When?

5. Is anyone in your household a migrant or seasonal farmworker?

   ☐ Yes ☐ No If YES, who?

6. Has your household's only income stopped?

   ☐ Yes ☐ No

COUNTY USE ONLY

DFA 285-A1 (11/83) *Required Form · No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-A1 (11/83)

Form Instructions
(for the Eligibility Worker)

APPLICATION FOR FOOD STAMPS — Part 1

Purpose:

The DFA 285-A1 is Part 1 of the food stamp application form completed by all households when first applying for food stamps. The DFA 285-A1 is also completed by nonmonthly reporting households at recertification. Part 1 is used to initiate the application process and to identify households requiring expedited service. To complete the application process, the household must also complete a DFA 285-A2.

Preparation:

1st Section (Applicant Identification)

Manual Sections: 63-300.3, 63-301.1

An application is considered to be filed when it is received with the following information by the appropriate CWD office:

1. Applicant's name.
2. Applicant's address.
3. Household member or authorized representative signature.

When an application with the above information is received, enter the date of receipt in the space provided. This date begins the 30-calendar-day period during which an eligible household must be given the opportunity to participate, unless a CA-1 was completed before this date. In this case the date of the CA-1 begins the 30-calendar-day period.

2nd Section (Expedited Service)

Manual Sections: 63-301.5, 63-503.4

If the applicant completes this section, review the responses in accordance with the following Expedited Service Eligibility Review table to determine whether the applicant should be referred for expedited service. The questions must be reviewed in the order prescribed by the table or an inaccurate determination may be made.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A1 (11/83)

Expedited Service Eligibility Review

Review Step	Question	Applicant's Answer	CWD Action
1	1	More than $100	Refer for normal processing
	1	$100 or less	Go to Step 2
2	2 and 3	Income exceeds income standard for household size	Refer for normal processing
	2 and 3	Income does not exceed income standard for household size	Go to Step 3
3	3 and 4	No and No or Don't Know	Refer for expedited service
	3 and 4	Any combination of Yes, No or Don't Know and amounts totaling less than $150	Refer for expedited service
	3 and 4	Any combination of Yes, No or Don't Know and amounts totaling $150 or more	Go to Step 4
4	5	No	Refer for normal processing
	5	Yes	Go to Step 5
5	6	Yes	Refer for expedited processing
	6	No	Go to Step 6

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-A1 (11/83)

Review Step	Question	Applicant's Answer	CWD Action
6	4	Yes and income of more than $25 will be received within next 10 calendar days	Refer for normal processing
	4	No or Don't Know, or Yes and income will not be received within next 10 calendar days	Refer for expedited processing
	4	Yes and income of $25 or less will be received within next 10 calendar days	Refer for expedited processing

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

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) Has anyone living in the home received food stamps this month or the previous month? ☐ Yes ☐ No
If YES, where?

(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.

				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
A. Under 18/60 or older
B. Mentally/physically disabled
C. Cares for child under 12 or incapacitated person
D. Cares for child under 18 and HH member reg/emp
E. Registered/Cash Aid
F. UIB registered
G. Participant in drug/alcohol program
H. 30 hour week/min x 30
I. Meets eligible student criteria
☐ DFA 285-C

Non-Household Member Codes
1. Ineligible alien
2. Ineligible student
3. SSI/SSP recipient
4. Disqualified/SSN or fraud
5. Live-in attendant
6. Roomer } Must also be listed in 12
7. Excluded boarder }
8. Separate household (purchase/prepare)
9. Separate household (elderly/disabled)
10. Questionable citizenship

(4) Is anyone currently on strike? ☐ Yes ☐ No
If YES, who?

Date household member went on strike: _____

(5) Has anyone become unemployed in the last 60 days? ☐ Yes ☐ No
If YES, who? When?

Vol. Quit: ☐ Yes ☐ No

(6) Is anyone participating in a Food Distribution Program operated by an Indian reservation? ☐ Yes ☐ No
If YES, who?

(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: _____

*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, AFDC or Medi-Cal. Fraudulent participation in the Food Stamp Program may result in criminal or civil action or administrative claims. Refusal to provide an SSN will result in disqualification of the individual for whom it is not provided.

DFA 285-A2 (12/83) *Required Form - No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

(8) Is anyone a disabled veteran, or a disabled spouse or child of a deceased veteran? ☐ Yes ☐ No
If YES, who?

(9) Does anyone purchase or prepare meals separately from others in the home? ☐ 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
Federally subsidized housing for the elderly ☐ Yes ☐ No
Licensed group home for the disabled/blind ☐ Yes ☐ No
Shelter for battered women ☐ Yes ☐ No
Other ☐ Yes ☐ No

If YES, to any of the above, give name of home/center:

(14) 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? 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 - VEHICLES

(A)	
Home, income producing or handicap?	
Under $4500 per table?	
Exempt? For H.H. use? Work, seek work, school, training?	

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

(B) Values ( ) ( )

FMV		
Minus $4500		
Excess Value		
FMV		
Minus Encumbrance		
Equity Value		

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

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

(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

Complete this section for each person with a full or part-time job. Complete even if the job has recently stopped or if a new job was recently started and wages have not yet been received. If a member has more than one job, list each job separately. Include members who receive income from work study, CETA, WIN or any other training program. For your interview, please bring pay stubs or other proof of wages.

NAME OF WAGE EARNER	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 anyone 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	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

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

(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**

Check the box for each utility cost you pay and list the amount you are billed and how often you are billed. You may request that the state standard utility allowance be used to compute your benefits. If your utility bills are higher than the state standard utility allowance, 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. Water	☐	☐	$	
D. Sewage	☐	☐	$	
E. Garbage or Trash	☐	☐	$	
F. Telephone (basic rate)	☐	☐	$	
G. Gas or Electricity or Other Fuel (for cooking)	☐	☐	$	
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

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
A1	F		
5	7		

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

(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

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63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

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 the Department of Social Services, 744 P Street, Sacramento, CA 95814 or by calling toll free 1-800-952-5253. The toll free number for the deaf (TDD) is 1-800-952-8349.

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. IF YOU OR ANY MEMBER OF YOUR HOUSEHOLD BREAKS ANY OF THESE RULES ON PURPOSE YOU MAY BE PERMANENTLY DISQUALIFIED FROM THE FOOD STAMP PROGRAM. IN ADDITION, YOU MAY BE FINED UP TO $10,000 AND/OR IMPRISONED FOR UP TO 5 YEARS.

- Do not give false information or withhold information to get or continue to get food stamps.
- Do not trade or sell food stamps or 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 (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 if any of this information is found to be incorrect, I may be disqualified from the Program and subject to criminal prosecution for knowingly providing 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

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63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

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 the Department of Social Services, 744 P Street, Sacramento, CA 95814 or by calling toll free 1-800-952-5253. The toll free number for the deaf (TDD) is 1-800-952-8349.

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. IF YOU OR ANY MEMBER OF YOUR HOUSEHOLD BREAKS ANY OF THESE RULES ON PURPOSE YOU MAY BE PERMANENTLY DISQUALIFIED FROM THE FOOD STAMP PROGRAM. IN ADDITION, YOU MAY BE FINED UP TO $10,000 AND/OR IMPRISONED FOR UP TO 5 YEARS.

- Do not give false information or withhold information to get or continue to get food stamps.
- Do not trade or sell food stamps or 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 (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 if any of this information is found to be incorrect, I may be disqualified from the Program and subject to criminal prosecution for knowingly providing 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

Page 5 of 5

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-A2 (12/83)

Form Instructions
(For the Eligibility Worker)

APPLICATION FOR FOOD STAMPS — PART 2

Purpose:

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, and a notice of penalty for the fraudulent receipt or use of coupons or for knowingly providing incorrect information.

Preparation:

Question	Manual Section	Information Requested	EW Action
County Use Only	63-300.5 63-402.1 63-402.2 63-407	N/A	Complete requested information. Date received is the date Part 2 is received. Check box if application is new or recertification, and check appropriate box if application is for expedited service. Follow applicable verification requirements for the type of application. The county-use section of Item 3 is to be used as a summary of household composition completed at the end of the interview. In the space provided, enter the appropriate code or date for all persons listed in 3. For all household members exempted from work registration, enter the work exemption code. For all other household members, note the date that each member registers for work. For persons excluded from the household, enter the non-household member code (reason for exclusions). Enter number of persons to be included in the household in the space provided.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
1.	63-401	Head of Household's Name and Address	Check that the applicant's residence is in the county.
2.	63-102(jjj)(3) 63-503.3	Previous Participation	Determine if first-month benefits should be prorated and if prospective budgeting is appropriate. Determine if any individual is participating in an existing certified household.
3.	63-402.2 63-402.7 63-404 63-503.442	Household Composition	**SSN** — Delete from the household any individual refusing to comply with the Social Security Number requirements. (Note exception for expedited service.) Count the resources and a prorata share of the income of this individual(s) as available to the household.
	63-102(i) 63-409.112 63-502.3 63-503.3		**Sixty/Disabled** — Note if any household member is age 60 or older, or will become age 60 in the month of application, or is receiving disability or blindness payments under Title II of the Social Security Act, and document that a DFA 285-C was given to the household. Allow excess shelter costs and medical deductions, and use the net income eligibility test for any household with such a member.
	63-300.512 63-300.532 63-403 63-503.442		**Alienage/Citizenship** — Note if any individual is an alien and document the type of verification provided to determine the alien's eligible status. Delete from the household any individual who is unable to provide acceptable documentation of alien status. Note if a CA-6 was completed by the household and sent to INS.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
3. (Cont.)			Delete from the household any individual whose U.S. citizenship is questionable and verification is not provided. Count the resources and a prorata share of the income of an ineligible alien or questionable citizen as available to the household.
	63-402.1		**Relationship** — Identify the ages and relationships of all persons listed in 3 to determine eligibility as a household member. The application provides only a key to the relationships of individuals in the home and the subject should be pursued to the extent necessary in the interview to determine household composition. Note: Information is required on all persons living in the home in order to determine who should be considered a household member and if there are nonhousehold members whose income and resources should be considered available to the household. Once the worker clearly determines that an individual does not fall into either of these categories, collection of information on this individual cannot be further pursued.
4.	63-402.9	Strikers	If checked yes, enter date household member went on strike. Two separate eligibility determinations must be made; one based on circumstances immediately prior to involvement in the strike action, and one based on current circumstances.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
5.	63-408	Voluntary Quit	If checked yes, determine if action meets criteria for voluntary quit. Check applicable box in county-use section. If yes, deny the application and disqualify the household for two months beginning with the month of application.
6.	63-402.8	Food Distribution Program	If checked yes, verify that participation in the Food Distribution Program has been terminated. Note: No household shall be allowed to participate simultaneously in the Food Stamp Program and a Food Distribution Program operated by an Indian reservation.
7.	63-501.6	Transfer of Resources	Check circumstances of any resource transfer to determine if program eligibility is affected. If yes, deny application and disqualify the household for the appropriate number of months.
8.	63-102(i) 63-409.112 63-502.3 63-503.3	Disabled Veterans/ Spouses/ Children	If checked yes, determine if individual meets definition of "disabled" person and document that a DFA 285-C was given to the household. Allow excess shelter costs and medical deductions, and use the net income eligibility test for any household with such a member.
9.	63-300.531 63-402.27	Purchase or Prepare Separately	If checked yes, determine if individual should be excluded from the household. Document accordingly in county-use section.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
10.	63-102(i) 63-300.531 63-402.15	Separate Household Status	If separate household status is requested by an elderly **and** disabled individual and spouse because of the individual's inability to purchase and prepare meals separately, determine if it should be granted. Document request in county-use section by checking appropriate box.
11.	63-406	Students	If checked yes, apply student eligibility criteria to determine eligibility as a household member. Check applicable box in county-use section.
12.	63-402.1 63-402.2 63-402.3	Roomers and Boarders	Check the status of each person listed here to determine if he/she meets the definition of a roomer, boarder, or household member. Boarders are ineligible to participate as separate households and may participate as a household member only if requested by the household. Roomers must be separate households. Document status in county-use section.
13.	63-402.4 63-402.6 63-503.46 63-503.47 63-503.48	Residents of Institutions	Determine if eligible institution. Check applicable box in county-use section.
14.	63-102(zz) 63-102(aaa) 63-300.518 63-403.33 63-503.53	Sponsored Aliens	If checked yes, determine if individual(s) is subject to sponsored alien provisions. Obtain necessary information about sponsor to determine alien's eligibility and benefit level.
15A.	63-501.1 63-501.2 63-501.3 63-501.4 63-501.7 63-503.44	Resources (Nonassistance households only)	Document resources, making appropriate exclusions. Check, if exempt, in the box provided.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
15B.	63-501.51	Motor Vehicles (Nonassistance households only)	Evaluate vehicles for resource exemption. Enter in the space provided the source used for determining vehicle valuation. Document valuation in county-use Section A. For all nonexempt vehicles, compute values in Section B. In the space provided, identify vehicle by entering the appropriate number.
	63-409.21 63-409.22 63-501.3 63-501.8	Resource Eligibility Test (Nonassistance households only)	Enter in the space provided the total resource amount. Determine if resources exceed Maximum Resource Standard. Check applicable box. Households in which all members receive AFDC, are food stamp resource eligible. If resources exceed standard, deny application.
16A.	63-300.511 63-402.92 63-502.1 63-502.2 63-503.212 63-503.22 63-503.23 63-503.24 63-503.4	Wages	For each source of earned income, check if exempt in the box provided. Also for each source, note the date and amount of pay stubs viewed. Document in the county-use section whether or not income is considered anticipated or from a terminated source for purposes of the budget calculation. Note: The greater of either the income that a striking household member would receive if not on strike or the strike benefits currently being received should be included.
16B.	63-300.511 63-502.1 63-502.2 63-503.41	Self-employment	Compute earned income from self-employment using cost and income information provided by the household.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
16C.	63-300.511 63-502.1 63-502.2 63-503.212 63-503.22 63-503.23 63-503.24 63-503.4	Other Income	Check that each income source is checked yes or no. For all yes answers, check that all other information is provided. In the space provided, check any income amount which is exempt. Document verification of gross nonexempt income in the county-use section. Document in the county-use section whether or not income is considered anticipated or from a terminated source for purposes of the budget calculation.
	63-402.15	Separate Household Income Test	Determine if the household with which an elderly and disabled individual lives meets separate household income test entitling the individual and spouse to separate household status. Check appropriate box.
	63-409.11 63-502.1(a) 63-503.212	Gross Income Eligibility Test	If applicable to the household, total all nonexempt income and compare to the current Maximum Gross Monthly Income Eligibility Standards. Check appropriate box. If gross income exceeds standard, deny application.
17.	63-300.52 63-502.34 63-503.25	Dependent Care	If checked yes, consider for a dependent care income deduction.
18.	63-300.516 63-502.35 63-503.25	Housing Costs	If applicable, calculate allowable deductions. Document in county-use section verification of all housing costs. Enter in the space provided total allowable housing costs.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
19.	63-300.516 63-502.353 63-502.36 63-503.25	Utilities	Indicate if the household elects actual or standard allowance for utilities by checking the appropriate box in the county-use section. A household is eligible for the standard utility allowance if it is billed separately for heating and cooling fuel. A household is entitled to the standard telephone deduction if it is billed separately for a telephone and is not entitled to the standard utility allowance. Document in the county-use section verification of client utilities. Enter in the space provided total utility costs to be used in the budget.
20.	63-502.2 63-502.36 63-503.25	Vendor Payments/ Shared Living Expenses	Determine if any such payments should be excluded from the household income. Determine if housing and/or utility costs should be prorated. Check the appropriate box to indicate if the SUA is prorated.
21.	63-102(fff) 63-505.21 63-505.221	Migrant Farmworkers	Determine if household is exempt from retrospective budgeting. Document in county-use section.
22.		Ethnic Origin and Primary Language	Circle appropriate code in the county-use section for ethnic origin and primary language.
23.	63-504.712 63-504.72	Prepared Meals	Determine if any household member is eligible to receive delivered meals or to use a communal dining facility. Mark the household identification card accordingly.
24.	63-402.6 63-504.71 63-504.711	Authorized Representative	Include the name of the authorized representative on the household identification card.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-A2 (12/83)

Question	Manual Section	Information Requested	EW Action
	63-300.41 63-505.1 63-505.2 63-505.3 63-505.4 63-505.5	Certification	Determine if the household will be monthly reporting or nonmonthly reporting and check the box for the reporting responsibilities applicable to the household. Explain the household's rights and responsibilities. Check that both copies of page 5 of the application contain all required signatures and dates. Give the second copy of page 5 to the household.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-B (12/83)

State of California
Health and Welfare Agency

Department of Social Services

FOOD STAMP BUDGET WORKSHEET

CASE NAME	CASE NUMBER	COMPANION CASE REFERENCE	CLASSIFICATION ☐ NA ☐ PA ☐ MIXED
CERTIFICATION PERIOD FROM THROUGH	ISSUANCE MONTH	ISSUANCE MONTH	DOCUMENTATION

PART 1 - GROSS INCOME ELIGIBILITY		
A. NONEXEMPT GROSS EARNED INCOME		
1. Gross Salary, Wages	$	$
2. Self-Employment		
3. Training Allowance		
4. Total Gross Earned Income (A1 + A2 + A3)	$	$
B. NONEXEMPT GROSS UNEARNED INCOME		
1. Cash Aid	$	$
2. Social Security, UIB, DIB, Pensions		
3. Child/Spousal Support		
4. Scholarships, Grants, Loans		
5. Other		
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)	$	$
C. GROSS INCOME TEST		
1. Household Size		
2. Maximum Gross Income Allowed (from Table)	$	$
3. Total Gross Monthly Income (A4 + B6)	$	$
4. Gross Income Eligible? (Is C3 less than or equal to C2?)	☐ Yes ☐ No	☐ Yes ☐ No
PART 2 - NET INCOME ELIGIBILITY	☐ Prospective ☐ Retrospective	☐ Prospective ☐ Retrospective
D. INCOME (For Prospective Budgets Only)		
1. Adjusted Gross Earned Income (82% of A4)	$	$
2. Total Nonexempt Gross Income (B6 + D1)	$	$
E. NONEXEMPT GROSS EARNED INCOME (For Retrospective Budgets Only)		
1. Gross Salary, Wages	$	$
2. Self-Employment		
3. Training Allowance		
4. Total Gross Earned Income (E1 + E2 + E3)	$	$
5. Adjusted Gross Earned Income (82% of E4)	$	$
F. NONEXEMPT GROSS UNEARNED INCOME (For Retrospective Budgets Only)		
1. Cash Aid	$	$
2. Social Security, UIB, DIB, Pensions		
3. Child/Spousal Support		
4. Scholarships, Grants, Loans		
5. Other		
6. Total Gross Unearned Income (F1 + F2 + F3 + F4 + F5)	$	$
7. Total Nonexempt Gross Income (E5 + F6)	$	$
G. STANDARD/DEPENDENT CARE DEDUCTION		
1. Standard Deduction	$	$
2. Dependent Care (Lesser of Actual or Maximum)		
3. Total Deductions (G1 + G2)	$	$
4. Total Adjusted Income (D2 - G3 or F7 - G3)	$	$
H. SHELTER DEDUCTION (If G2 is at Maximum, skip H1 - H8 and enter 0 in H9)		
1. Total Housing Costs	$	$
2. Total Utility Costs (Actual or SUA)		
3. Total Shelter Costs	$	$
4. Allowable Shelter Costs (50% of G4)	$	$
5. Excess Shelter Costs (H3 - H4)	$	$
6. Maximum Allowance for Shelter/Dependent Care		
7. Dependent Care Deduction (from G2)	$	$
8. Maximum Shelter Deduction (H6 - H7)	$	$
9. Allowable Shelter Deduction (Lesser of H5 or H8)	$	$
I. NET MONTHLY INCOME (G4 - H9)	$	$
J. NET INCOME TEST		
1. Household Size		
2. Maximum Net Income Allowed (from Table)	$	$
3. Net Income Eligible? (Is I less than or equal to J2?)	☐ Yes ☐ No	☐ Yes ☐ No

First-Month Benefits Prorated? ☐ Yes ☐ No

PART 3 - BENEFITS	ALLOTMENT	SUPPLEMENT	ALLOTMENT	SUPPLEMENT
E.W. Initials/Date				

DFA 285-B (12/83) *Required Form - Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

DFA 285-B (12/83)

WORKSHEET FOR CHANGES AND OTHER DOCUMENTATION

PART 4 — RESOURCES

K. MOTOR VEHICLES	Vehicle (1)	Vehicle (2)
1. Vehicle Owner		
Year/Class		
Make and Model		
Estimated Value		
Amount Owed		
Licensed?	☐ Yes ☐ No	☐ Yes ☐ No
2. Value		
3. Excluded as home, income producing or transport handicapped?	☐ Yes ☐ No	☐ Yes ☐ No
4. Under $4500 per table?	☐ Yes ☐ No	☐ Yes ☐ No
5. Exempt - For household use?	☐ Yes ☐ No	☐ Yes ☐ No
For work, to seek work, school or training?	☐ Yes ☐ No	☐ Yes ☐ No

If exempt and under $4500 STOP here; do not go to 6.

DOCUMENTATION

6. For licensed vehicles count the greater of the excess or equity value. For unlicensed vehicles count the equity value.

Values	(1)	(2)
FMV		
Minus $4500		
Excess Value		
FMV		
Minus Encumbrance		
Equity Value		

L. RESOURCE ELIGIBILITY (Nonexempt Resources Only)	Issuance Month	Issuance Month
1. Previous Month's Resources	$	$
2. Additional Resources (specify)		
a.		
b.		
c.		
3. Subtotal (L1 + L2a + L2b + L2c)	$	$
4. Resources Sold, Traded or Given Away (specify)		
a.	$	$
b.		
c.		
5. Subtotal (L4a + L4b + L4c)	$	$
6. Current Resources (L3 - L5)	$	$
7. Resource Eligible?	☐ Yes ☐ No	☐ Yes ☐ No

PART 5 — INCOME COMPUTATIONS

M. SELF-EMPLOYMENT	Issuance Month	Issuance Month
1. Gross Income from Self-Employment	$	$
2. Expenses		
3. Total Nonexempt Income from Self-Employment (M1 - M2)	$	$
If averaging self-employment income go to M7. If adjusting a previous average, continue to M4.		
4. Adjustment to Gross Income	$	$
5. Adjustment to Expenses		
6. Adjusted Self-Employment Income (M3 ± M4 ± M5)	$	$
7. Monthly Self-Employment Income (M3 or M6 ÷ number of months income covers)	$	$

N. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS	Issuance Month	Issuance Month
1. Income from Grants, Scholarships or Loans	$	$
2. Tuition and Mandatory Fees		
3. Total Nonexempt Educational Income (N1 - N2)	$	$
4. Monthly Income from Grants, Scholarships or Loans (N3 ÷ number of months income covers)	$	$

PART 6 — REPORTED CHANGES (Other than the CA 7 or DFA 377.5)

Type of Change					
Date Change Occurred					
Date Change Reported					
EW Initials					

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-B (12/83)

Form Instructions
(For the Eligibility Worker)

FOOD STAMP BUDGET WORKSHEET

Purpose:

The DFA 285-B is used in conjunction with the application for food stamps (DFA 285-A2), or a monthly eligibility report (CA 7), or a household change report to compute and document a household's eligibility and benefit level. The budget portion of the worksheet provides spaces for two separate budget computations. The change documentation portion of the worksheet is used for documenting resource changes, ongoing resource eligibility, and income computations resulting from information reported either at the time of application or during the certification period.

NOTE: The DFA 285-D, Food Stamp Budget Worksheet — Special Medical/Shelter Deductions, must be used for any household containing a member who is elderly or disabled.

Preparation:

Enter the following identifying information on the top of the front page of the worksheet:

— Case Name
— Case Number
— Companion Case Reference
— Household Classification

Enter the beginning and ending dates of the certification period; month and year. Enter the issuance month for the budget being computed, and complete the budget.

Part 1 — Gross Income Eligibility

Complete Sections A through C using prospective amounts to determine gross income eligibility.

C. Gross Income Test

If the answer on Line C4 is "No", deny the application, or terminate or suspend eligibility, as appropriate. If the answer on Line C4 is "Yes" continue to Part 2.

Part 2 — Net Income Eligibility

Check the appropriate box for a retrospective or prospective budget computation. When the net monthly income is used to determine net income eligibility, use prospective amounts. When the net monthly income is used to determine benefits, use either retrospective or prospective amounts, as appropriate.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-B (12/83)

For a prospective budget, complete Section D and Sections G through I. For a retrospective budget, complete Sections E through I.

I. Net Monthly Income

After net monthly income has been determined, go to Section J when net income eligibility must also be determined.

If the household's net income eligibility has already been determined, skip Section J and go to Part 3.

J. Net Income Test

If the answer on Line J3 is "No", deny the application, or terminate or suspend eligibility, as appropriate. If the answer on Line J3 is "Yes", continue to Part 3.

Part 3 — Benefits

Allotment

Determine if benefits should be prorated and check the appropriate box (Yes or No) in the documentation section. Use the current Tables of Coupon Issuance, household size and net monthly income to find the allotment. If benefits should not be prorated, enter the amount from the table. If benefits should be prorated, compute the prorated amount using the date of application and the appropriate percentage for the month of application from the Reciprocal Table for Prorating First-Month Benefits. Enter the prorated amount.

Supplement

Complete this section if the budget was calculated because of a change and resulted in a supplemental issuance. Enter the amount of the supplement.

Initials/Date

Enter EW initials and date after any action in Parts 1, 2, or 3 of the budget worksheet.

Subsequent Budgets

If a subsequent budget is calculated, enter the issuance month, and complete as outlined above.

If a subsequent budget is not calculated but the first-month benefits were prorated, and the certification period is longer than one month, enter the amount of the household's full allotment for the second month.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-B (12/83)

Worksheet For Changes and Other Documentation

Part 4 — Resources

Section K and L need not be completed for a household in which all members are receiving AFDC.

K. Motor Vehicles

Use this section to record household motor vehicle changes. Each vehicle must be treated separately to determine its countable resource amount. Thereafter, each amount is added to determine the total vehicle resource amount.

1. Complete the items for each vehicle using information provided by the household. A vehicle is licensed if the motor vehicle registration fees are paid for the current year. If not, skip 3 through 5 and go directly to 6.

2. Enter the value of the vehicle based on the blue book, CPI book, newspapers, etc., and document source used for valuation.

3. Evaluate vehicles for exclusion as a resource.

4. For licensed vehicles which are not excluded and which have a value greater than $4,500, determine the fair market value.

5. Determine if any licensed vehicle is exempt from the equity valuation. Compute the equity value of all nonexempt vehicles.

6. Compute resource value of all nonexempt vehicles.

L. Resource Eligibility

Enter the issuance month for each resource eligibility test.

1. Enter the amount of resources used in the last resource eligibility test.

2. Specify any nonexcluded additions to the household's resources and enter the amount(s).

3. Add Lines L1, L2a, L2b, and L2c and enter the total.

4. Specify any nonexcluded subtractions from the household's resources and enter the amount(s).

5. Add Lines L4a, L4b and L4c and enter the total.

6. Subtract Line L5 from Line L3 and enter the remainder.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-B (12/83)

7. If Line L6 is less than or equal to $1,500, check "Yes". If Line L6 is greater than $1,500, check "No". If the answer on Line L7 is "No", deny the application, or terminate or suspend eligibility, as appropriate.

Part 5 — Income Computations

M. Self-Employment

Enter the issuance month for each self-employment income calculation and complete Lines MI through M3.

If self-employment income is to be averaged, go to Line M7. If previously averaged self-employment income is to be adjusted, complete Lines M4 through M7.

Enter the amount from either Line M3 or Line M7 in the appropriate budget.

N. Educational Grants, Scholarships and Loans

Complete this section if the household has income from educational grants, scholarships, or loans.

Enter the issuance month for each calculation and complete Lines N1 through N4. Enter the amount on Line N4 in the appropriate budget.

Part 6 — Reported Changes

For changes reported outside of the monthly report (CA 7) or the household change report (DFA 377.5), enter the type of change, date the change occurred, date the change was reported, and the EW initials.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-C (11/83)

Form Instructions
(for the Eligibility Worker)

SUPPLEMENTAL APPLICATION FOR FOOD STAMPS — SPECIAL MEDICAL DEDUCTIONS

Purpose:

The DFA 285-C is a supplemental food stamp application form completed by any household member(s) who is (1) age 60 or older; (2) receiving Title II Social Security disability or blindness payments as a disabled person; (3) a disabled veteran; (4) a disabled surviving spouse of a veteran; or, (5) a disabled surviving child of a veteran. The application gathers information required to calculate special medical deductions for these individuals. The form is required only for those households entitled to claim excess medical expense deductions, unless they choose not to.

Preparation:

Question No.	Manual Section	Information Requested	EW Action
County-Use Section	N/A	N/A	Enter case name and case number.
1	63-102(i) 63-502.33	Eligible Household Members	Check that each household member named is at least 60 years of age, or will turn age 60 in the month of application, or meets one of the definitions for a disabled person. Check that any Social Security payment received is for the household member's own disability. Document in the county-use section if the household member has been approved for but is not yet receiving Title II benefits, or is entitled to but is not receiving veterans benefits.
2		Medical Expenses	Determine the allowability of each item of medical expense as follows:
	63-102(i) 63-502.33		1. Check that each household member receiving services is an eligible household member listed in question 1.
	63-502.33 63-503.25		2. Check that each amount shown is for an allowable item of expense.
	63-300.517		3. Verify the amount of any deductible medical expenses and note the specifics of the verification in the county-use section.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-C (11/83)

Question No.	Manual Section	Information Requested	EW Action
2 (Cont.)	63-502.33		4. Identify which items of expense are insured, uninsured, and which items (if any) are hospital bills, and document in the county-use section. Determine the applicable amount for each deduction.
	63-503.25		5. Determine which items of expense are recurring, one-month-only, or should be averaged over the certification period.
		Certification	Check that the application contains all required signatures.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-D (12/83)

State of California
Health and Welfare Agency

Department of Social Services

FOOD STAMP BUDGET WORKSHEET - Special Medical/Shelter Deductions

CASE NAME	CASE NUMBER	COMPANION CASE REFERENCE	CLASSIFICATION ☐ NA ☐ PA ☐ MIXED
CERTIFICATION PERIOD FROM THROUGH	☐ Prospective ☐ Retrospective	☐ Prospective ☐ Retrospective	
PART 1 — NET MONTHLY INCOME	Issuance Month	Issuance Month	**DOCUMENTATION**
A. NONEXEMPT GROSS EARNED INCOME			
1. Gross Salary, Wages	$	$	
2. Self-Employment			
3. Training Allowance			
4. Total Gross Earned Income (A1 + A2 + A3)	$	$	
5. Adjusted Gross Earned Income (82% of A4)	$	$	
B. NONEXEMPT GROSS UNEARNED INCOME			
1. Cash Aid	$	$	
2. Social Security, UIB, DIB, Pensions			
3. Child/Spousal Support			
4. Scholarships, Grants, Loans			
5. Other			
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)	$	$	
C. TOTAL NONEXEMPT GROSS INCOME (A5 + B6)	$	$	
D. EXCESS MEDICAL EXPENSES			
1. Recurring Expenses	$	$	
2. One-Month-Only Expenses			
3. Averaged Expenses			
4. Total Allowable Expenses (D1 + D2 + D3)	$	$	
5. Medical Expense Allowance ($35)	$	$	
6. Excess Medical Expenses (D4 - D5)	$	$	
E. STANDARD/DEPENDENT CARE/MEDICAL DEDUCTIONS			
1. Standard Deduction	$	$	
2. Dependent Care (Lesser of Actual or Maximum)			
3. Excess Medical Expenses (From D6)			
4. Total Deductions (E1 + E2 + E3)	$	$	
5. Total Adjusted Income (C - E4)	$	$	
F. SHELTER DEDUCTION			
1. Total Housing Costs	$	$	
2. Total Utility Costs (Actual or SUA)			
3. Total Shelter Costs	$	$	
4. Allowable Shelter Costs (50% of E5)	$	$	
5. Excess Shelter Costs (F3 - F4)	$	$	
G. NET MONTHLY INCOME (E5 - F5)	$	$	
PART 2 — NET INCOME ELIGIBILITY			
H. NET INCOME TEST			
1. Household Size			
2. Maximum Net Income Allowed (From Table)	$	$	
3. Net Income Eligible? (Is G less than or equal to H2?)	☐ Yes ☐ No	☐ Yes ☐ No	
PART 3 — BENEFITS	ALLOTMENT / SUPPLEMENT	ALLOTMENT / SUPPLEMENT	First-Month Benefits Prorated? ☐ Yes ☐ No
E.W. Initials/Date			

DFA 285-D (12-83) *Required Form - Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-D (12/83)

WORKSHEET FOR CHANGES AND OTHER DOCUMENTATION

PART 4 — RESOURCES

I. MOTOR VEHICLES	Vehicle (1)		Vehicle (2)	
1. Vehicle Owner				
Year/Class				
Make and Model				
Estimated Value				
Amount Owed				
Licensed?	☐ Yes	☐ No	☐ Yes	☐ No
2. Value				
3. Excluded as home, income producing or transport handicapped?	☐ Yes	☐ No	☐ Yes	☐ No
4. Under $4500 per table?	☐ Yes	☐ No	☐ Yes	☐ No
5. Exempt - For household use?	☐ Yes	☐ No	☐ Yes	☐ No
For work, to seek work, school or training?	☐ Yes	☐ No	☐ Yes	☐ No

If exempt and under $4500 STOP here; do not go to 6.

DOCUMENTATION

6. For licensed vehicles count the greater of the excess or equity value. For unlicensed vehicles count the equity value.

Values	(1)	(2)
FMV		
Minus $4500		
Excess Value		
FMV		
Minus Encumbrance		
Equity Value		

J. RESOURCE ELIGIBILITY (Nonexempt Resources Only)	Issuance Month	Issuance Month
1. Previous Month's Resources	$	$
2. Additional Resources (specify)		
a.		
b.		
c.		
3. Subtotal (J1 + J2a + J2b + J2c)	$	$
4. Resources Sold, Traded or Given Away (specify)		
a.	$	$
b.		
c.		
5. Subtotal (J4a + J4b + J4c)	$	$
6. Current Resources (J3 - J5)	$	$
7. Resource Eligible?	☐ Yes ☐ No	☐ Yes ☐ No

PART 5 — INCOME COMPUTATIONS

K. SELF-EMPLOYMENT	Issuance Month	Issuance Month
1. Gross Income from Self-Employment	$	$
2. Expenses		
3. Total Nonexempt Income from Self-Employment (K1 - K2)	$	$
If averaging self-employment income go to K7. If adjusting a previous average, continue to K4.		
4. Adjustment to Gross Income	$	$
5. Adjustment to Expenses		
6. Adjusted Self-Employment Income (K3 ± K4 ± K5)	$	$
7. Monthly Self-Employment Income (K3 or K6 ÷ number of months income covers)	$	$

L. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS	Issuance Month	Issuance Month
1. Income from Grants, Scholarships or Loans	$	$
2. Tuition and Mandatory Fees		
3. Total Nonexempt Educational Income (L1 - L2)	$	$
4. Monthly Income from Grants, Scholarships or Loans (L3 ÷ number of months income covers)	$	$

PART 6 — REPORTED CHANGES (Other than the CA 7 or DFA 377.5)

Type of Change					
Date Change Occurred					
Date Change Reported					
EW Initials					

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-D (12/83)

Form Instructions
(For the Eligibility Worker)

FOOD STAMP BUDGET WORKSHEET — SPECIAL MEDICAL/SHELTER DEDUCTIONS

Purpose:

The DFA 285-D is used in conjunction with the application for food stamps (DFA 285-A2) and the food stamp application for special medical deductions (DFA 285-C), or a monthly eligibility report (CA 7), or a household change report to compute and document the eligibility and benefit level for a household which has a member who is elderly or disabled. The budget portion of the worksheet provides spaces for two separate budget computations. The change documentation portion of the worksheet is used for documenting resource changes, ongoing resource eligibility, and income computations resulting from information reported either at the time of application or during the certification period.

Preparation:

Enter the following identifying information on the top of the front page of the worksheet:

- Case name
- Case number
- Companion Case Reference
- Household Classification

Enter the beginning and ending dates of the certification period; month and year. Enter the issuance month for the budget being computed, check the appropriate box for a retrospective or prospective budget and complete the budget.

Part 1 — Net Monthly Income

Complete Sections A through G to determine the household's net monthly income. When the net monthly income is used to determine net income eligibility, use prospective amounts. When the net monthly income is used to determine benefits, use either prospective or retrospective amounts, as appropriate.

After net monthly income has been determined, go to Part 2 when net income eligibility must also be determined.

If the household's net income eligibility has already been determined, skip Part 2 and go to Part 3.

Part 2 — Net Income Eligibility

H. Net Income Test

If the answer on Line H3 is "No", deny the application or terminate or suspend the household, as appropriate. If the answer on Line H3 is "Yes", go to Part 3.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 285-D (12/83)

Part 3 — Benefits

Allotment

Determine if benefits should be prorated and check the appropriate box (Yes or No) in the documentation section. Use the current Tables of Coupon Issuance, household size and net monthly income to find the allotment. If benefits should not be prorated, enter the amount from the table. If benefits should be prorated, compute the prorated amount using the date of application and the appropriate percentage for the month of application from the Reciprocal Table for Prorating First-Month Benefits. Enter the prorated amount.

Supplement

Complete this section if the budget was calculated because of a change and resulted in a supplemental issuance. Enter the amount of the supplement.

Initials/Date

Enter EW initials and date after any action in Parts 1, 2 or 3 of the budget worksheet.

Subsequent Budgets

If a subsequent budget is calculated, enter the issuance month, check if the budget calculation is retrospective or prospective and complete as outlined above.

If a subsequent budget is not calculated but the first-month benefits were prorated, and the certification period is longer than one month, enter the household's full allotment for the second month.

Worksheet for Changes and Other Documentation

Part 4 — Resources

Sections I and J need not be completed for a household in which all members are receiving AFDC.

I. Motor Vehicles

Use this section to record household motor vehicle changes. Each vehicle must be treated separately to determine its countable resource amount. Thereafter, each amount is added to determine the total vehicle resource amount.

1. Complete the items for each vehicle using information provided by the household. A vehicle is licensed if the motor vehicle registration fees are paid for the current year. If not licensed, skip 3 through 5 and go directly to 6.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-D (12/83)

2. Enter the value of the vehicle based on the blue book, CPI book, newspapers, etc., and document source used for valuation.

3. Evaluate vehicles for exclusion as a resource.

4. For licensed vehicles which are not excluded and which have a value greater than $4,500, determine the fair market value.

5. Determine if any licensed vehicle is exempt from the equity valuation. Compute the equity value of all nonexempt vehicles.

6. Compute resource value of all nonexempt vehicles.

J. Resource Eligibility

Enter the issuance month for each resource eligibility test.

1. Enter the amount of resources used in the last resource eligibility test.

2. Specify any nonexcluded additions to the household's resources and enter the amount(s).

3. Add Lines J1, J2a, J2b, and J2c and enter the total.

4. Specify any nonexcluded subtractions from the household's resources and enter the amount(s).

5. Add Lines J4a, J4b and J4c and enter the total.

6. Subtract Line J5 from Line J3 and enter the remainder.

7. If the household size is one and if Line J6 is less than or equal to $1,500, check "Yes"; if Line J6 is greater than $1,500, check "No". If the household size is more than one and if Line J6 is less than or equal to $3,000, check "Yes"; if Line J6 is greater than $3,000, check "No". If the answer on Line J7 is "No", deny the application, or terminate or suspend eligibility as appropriate.

Part 5 — Income Computations

K. Self-Employment

Enter the issuance month for each self-employment income calculation and complete Lines K1 through K3.

If self-employment income is to be averaged, go to Line K7. If previously averaged self-employment income is to be adjusted, complete Lines K4 through K7.

L. Educational Grants, Scholarships and Loans

Complete this section if the household has income from educational grants, scholarships, or loans.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 285-D (12/83)

Enter the issuance month for each calculation and complete Lines L1 through L4. Enter the amount on Line L4 on Line B4 of the appropriate budget.

Part 6 — Reported Changes

For changes reported outside of the monthly report (CA 7) or the household change report (DFA 377.5), enter the type of change, date the change occurred, date the change was reported, and the EW initials.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 287 (4/80)

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP PROGRAM
IDENTIFICATION CARD

Issued to _____

Issued _____ Case No. _____

_____
SIGNATURE OF HEAD OF HOUSEHOLD

_____
SIGNATURE OF OTHER HOUSEHOLD MEMBER

DFA 287 (4/80)

_____
SIGNATURE OF AUTHORIZED REPRESENTATIVE

_____
SIGNATURE OF EMERGENCY AUTHORIZED REPRESENTATIVE

No. of Persons in Household _____

Household Eligible for Delivered Meals

Yes ☐ No ☐

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 287 (4/80)

Form Instructions
(for CWD Worker)

FOOD STAMP PROGRAM IDENTIFICATION CARD

Purpose:

The DFA 287 is issued to each certified household as proof of program eligibility. It must be presented when the head of household, designated authorized representative, or any responsible household member redeems an Authorization to Participate card (ATP) or, if requested, when food stamps are used to purchase consumable items, or in HIR counties, when the household obtains its coupons.

Preparation:

The CWD prepares one card at the time of initial certification and issues it in the name of the head of household.

NOTE: If the ID card is mailed to the household, it must not be mailed in the same envelope with the ATP or food coupons.

The following identifying information is entered on the card:

- Head of Household
- Date
- Case Number
- Number of Persons in Household

Check applicable box indicating if the household is eligible for delivered meals.

The head of household, designated authorized representative or any responsible household member must then sign the ID card prior to using it. If the household does not name an authorized representative or other household member the CWD must indicate on the ID card that no designation was made. The household may also designate an emergency authorized representative at a later date. At that time, the emergency representative signs the ID card in the space provided.

The ID card may be serially numbered at the CWD's option.

NOTE: If the household is eligible for and interested in delivered meal services, the CWD marks the face of the ID card with the letter "M". If the household is certified for delivered meals for a temporary period, the CWD indicates an expiration date on the ID card. In counties where restaurants are authorized to accept food stamps, and if the household is eligible and interested in using communal dining facilities, the CWD marks the face of the ID card with the letters "CD".

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 303 (1/83)

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY — DEPARTMENT OF SOCIAL SERVICES

REPLACEMENT AFFIDAVIT/AUTHORIZATION

COUNTY USE ONLY

CASE NAME	
CASE NUMBER	WORKER
TYPE OF LOSS ☐ ATP ☐ Food Coupon Book(s) ☐ Food	

PART A - HOUSEHOLD AFFIDAVIT

I, _____, the undersigned, living at _____ (STREET ADDRESS)

_____ (CITY), California, declare that the household named above:

☐ Did not receive in the mail the ATP/Food Coupon Book(s) at _____ (STREET ADDRESS)

_____ (CITY) California, for the period of _____.

☐ Received an ATP for the period of _____, however it was:

☐ Stolen: Date stolen _____

☐ Destoyed: How?_____ Date destroyed _____

☐ Received Food Coupon Book(s) for the period of _____, however, they were destroyed.

How?_____ Date destroyed _____ Amount $_____

☐ Purchased food with Food Coupon Book(s), but the food was destroyed.

How?_____ Date destroyed _____ Amount $_____

I further declare that if at any time I receive the above described ATP/Food Coupon Book(s), it will be returned to:

I declare that the foregoing is true and correct to the best of my knowledge. I also understand that if I intentionally withhold information or give false information I may be denied participation in the Food Stamp Program; fined imprisoned or both.

SIGNATURE OF CLAIMANT ▶	DATE

PART B - VERIFICATION

DATE ATP/COUPONS ISSUED	ATP SERIAL #	VALUE OF ATP/FOOD COUPON ALLOTMENT	DATE REPLACEMENT REQUESTED
		$	

Type of household disaster: Source of verification:

Has household received any replacements during the last five months? ☐ Yes ☐ No If Yes, how many?

Type of replacement(s): 1. 2. 3. 4.

PART C - REPLACEMENT AUTHORIZATION

Request: ☐ Approved ☐ Denied Reason for denial

AMOUNT TO BE REPLACED	NAME OF PERSON AUTHORIZING/DENYING REQUEST	REVIEWED BY	DATE
$			

PART D - HOUSEHOLD ACKNOWLEDGEMENT OF RECEIPT

I acknowledge the receipt of a replacement: *(Check appropriate box)*

☐ ATP Serial Number ☐ Food Coupon Book(s) In the amount of $

REPLACEMENT RECEIVED BY (CLAIMANT'S SIGNATURE) ▶	DATE

DFA 303 (1/83) Required Form — Substitutes Permitted

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 303 (1/83)

Form Instructions
(For CWD)

REPLACEMENT AFFIDAVIT/AUTHORIZATION

Purpose:

The DFA 303 is a form completed by the household or an authorized representative and the county. This form is used to (1) initiate a request for a replacement ATP/food coupon book(s), (2) verify that replacement of an ATP/food coupon book(s) is appropriate, and (3) acknowledge receipt of a replacement ATP/food coupon book(s).

Part A is completed by the household or an authorized representative and is the household's affidavit indicating the reason for the replacement.

Part B is completed by the county and is used to verify that the request for replacement is appropriate. This section also provides identifying information relating to the original ATP/food coupon book(s) that was issued.

Part C is completed by the county and is used to authorize the replacement and the amount to be replaced, or to deny the replacement.

Part D is completed in part by the county and signed by the claimant to acknowledge receipt of the replacement ATP/food coupon book(s) issued to the household.

Preparation:

The household must come into the county office to sign the affidavit, in most instances. However, the affidavit must be mailed to the household if the household is unable to come into the office because of age, handicap or distance from the office and is unable to appoint an authorized representative.

Complete an original and one copy if the individual is requesting the replacement in person. Complete a second copy for pending if the form will be mailed for completion. (Additional copies may be required by the county's internal system.) Enter the following identifying information in the county-use section.

- Case Name
- Case Number
- Worker

Check the applicable box for the type of loss being reported.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 303 (1/83)

Part A — Household Affidavit

Before the household or an authorized representative completes this section, enter the address where the household should return the original ATP/food coupon book(s) should they receive it.

When signed, review this section for completeness, paying particular attention to the following items:

- When a claimant indicates the reason for replacement is a stolen or destroyed ATP or destroyed food coupon book(s) or food, be sure the claimant also indicates the date stolen or destroyed, how destroyed and the amount destroyed.

- Be sure that the claimant signs and dates the affidavit.

NOTE: A request for replacement must be acted upon within ten days of the household's request, either by issuing a replacement, or denying the request.

Part B — Verification

Enter the following information as applicable for the type of request:

- Date the original ATP/food coupon book(s) was issued.
- Serial number of the original ATP.
- Amount of the original ATP/food coupon allotment.
- Date replacement is requested.

NOTE: If the request for replacement is for a destroyed ATP, food coupon book(s) or food, enter the type of household disaster and the source of verification.

As appropriate for each type of replacement be certain to verify that:

a. The ATP/food coupon book(s) to be replaced was actually issued.
b. The ATP/food coupon book(s) to be replaced was not returned as undeliverable.
c. The request for replacement was reported within the time frames provided by regulation.
d. The disaster occurred and meets the definition of a household disaster.
e. The household has not already received the allowable number of replacements during the most recent six-month period, which includes the current month. **There are no limitations on the number of replacements for food destroyed in a household disaster.**
f. The replacement is otherwise appropriate as defined by regulation.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 303 (1/83)

Part C — Replacement Authorization

- Check the applicable box to indicate the disposition of the request.
- If the request is denied, give the reason for denial.

NOTE: If the household's request for replacement is being denied, the household must be provided with a DFA 377.4.

- Enter total amount of ATP/food coupons to be replaced.

- Enter signature of person authorizing or denying request.

- Enter signature of individual reviewing request, if any.

- Enter date request is approved or denied.

Part D — Household Acknowledgement of Receipt

Before this section is signed by the claimant, enter one of the following as applicable to the replacement: (1) the serial number of the replacement ATP, or (2) the amount of the replacement food coupon book(s).

The claimant must check the appropriate box for an ATP or food coupon book(s) and sign and date this section when the replacement is issued. If, however, the claimant refuses to sign this section, the replacement cannot be denied.

If the ATP or food coupon book(s) is to be mailed, the original DFA 303 and one copy should be enclosed with the ATP/food coupon book(s) and a self-addressed envelope for returning after it is signed by the household. The county must retain a copy of the DFA 303 pending the return of the original. The county must establish a system of follow-up to ensure that the original is returned.

Be sure this section is signed and dated, and the appropriate box is checked.

Distribution:

The original is filed in the case file, and one copy is provided to the household.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.1 (12/83)

State of California
Health and Welfare Agency

Department of Social Services

FOOD STAMP NOTICE OF ACTION

If you have any questions or want more information about this action, please contact your worker.

Case Name :
Case Number :
District :
Worker :
Phone :
Date of Notice :

☐ APPROVAL. Your application for food stamps has been approved.

Your food stamp certification covers the period from _____ through _____.

Your benefits have been computed for your certification period based on the information you provided. Unless there are changes, you will receive the following benefits for each month:

$_____ for _____ through _____ ; $_____ for _____ through _____ ;
$_____ for _____ through _____ ; $_____ for _____ through _____ ;
$_____ for _____ through _____ ; $_____ for _____ through _____ .

☐ Your first allotment includes more than one month's benefits because of the date your application was approved.
☐ Your first-month benefits were prorated from the date you filed your application.
☐ Your benefits for _____ have been suspended because:

Even though you will not receive any benefits for this period, you must complete and submit your monthly report (CA 7) so we can determine the correct amount of your benefits for the next month. If you do not submit a complete CA 7 as required, your food stamp participation will be terminated.

☐ Because you needed food stamp benefits right away, we did not require you to give us the following information:

If you do not give us this information by _____ , you will not receive any benefits for _____ and your participation in the Food Stamp Program will be terminated without further notice. If the information requested results in a change in your eligibility or benefits, the change will be made without an additional advance notice.

IF YOU ALSO APPLIED FOR CASH AID, and it has not yet been approved, your food stamp benefits may be reduced or terminated without further notice if your cash aid is approved.

☐ PENDING Your application for food stamps is still being processed.

☐ You have done everything you need to do. We will continue processing your application and you will hear from us soon.
☐ You must do the following before we can finish processing your application:

If you do not do this by _____ , your application will be denied and you will have to reapply if you want to receive food stamp benefits.

☐ DENIAL Your application for food stamps has been denied because

☐ If you do the following by _____ , your application will be reopened

If you do not take the required action by the above date, you will have to reapply if you want to receive food stamp benefits.

☐ Based on the reason your application was denied, your household is also disqualified from participating in the Food Stamp Program until _____ You may reapply for benefits at the end of this disqualification period.

The above action(s) is required by the following Food Stamp Manual Section(s)

You have the right to request a state hearing if you believe this action is wrong. See the back of this notice for a hearing request.

DFA 377.1 (12/83) Reproduced Forms: No Substitutes Permitted

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.1 (12/83)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's:* ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10950

NA Back 3 (Cash Aid/FS)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.1 (12/83)

Form Instructions
(for the Eligibility Worker)

FOOD STAMP NOTICE OF ACTION

Purpose:

The DFA 377.1 is used by the Eligibility Worker to notify a household of the approval, pending or denial status of its food stamp application.

The back of the DFA 377.1 explains the household's right to request a hearing and provides instructions on how to appeal the action.

Preparation:

Complete an original and two copies of the DFA 377.1 entering the following identifying information:

- Head of household's name and mailing address
- Case Name
- Case Number
- District (if applicable)
- Worker
- Phone Number
- Date of Notice

Complete the action portion of the notice by checking the heading box for the Approval, Pending or Denial Sections and entering all other required information.

NOTE: If the date by which the household must take some action falls on a weekend or holiday, enter the date for the business day immediately following the weekend or holiday.

Approval

Check the Approval box when an initial application or application for recertification has been approved. Enter the beginning and ending dates of the household's certification period, the amount of the allotment, the amount and dates of any known changes in the allotment, and any of the following, as applicable.

- If the first allotment contains more than one month's benefits (prorated first-month benefits and second-month benefits issued in the second month), check the box for this message.

- If the first-month benefits were prorated, check the proration box.

- If the household's first-month benefits are suspended, check the suspension box. Enter the month for which benefits have been suspended and enter the reason for the suspension.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.1 (12/83)

- If the household applied after the fifteenth of the month, and if expedited service was provided and verification was postponed, check the box and list the information the household must provide. Enter the date by which the household must provide the information (30 days from the date the application was filed except for migrants who need out-of-state verification and who are allowed 60 days from the date of application), and enter the month for which benefits will not be issued if the verification is not provided.

  If the household does not provide the requested information by the specified date, no further notice is required to terminate the household's participation. If the household provides the information and it results in a change in eligibility or benefits, a notice of change must be issued by no later than the date the benefits are issued or in place of the benefits.

If the household subsequently receives cash aid, and food stamp benefits are reduced or terminated, no additional notice is required.

Pending

Check the Pending box when an initial application or untimely application for recertification has not been processed in accordance with application processing standards as a result of either the county's or the applicant's fault.

If the household must take some action to complete the application process, check the box provided for this purpose, enter the required action and enter the date by which the action must be taken.

If the household fails to provide the requested information by the specified date, no further notice is required to deny the application.

Denial

Check the Denial box when an application has been denied and enter the reason(s) for the denial.

If the county has elected the option of denying all applications not processed at the end of the 30-day application processing period due to the household's fault, the first box in the Denial Section is used for this purpose. In such cases, check the box, enter the date by which action must be taken to reopen the application and enter the action which must be taken.

Check the second box in the Denial Section if the application was denied because the primary wage earner voluntarily quit a job without good cause, the household transferred resources in order to become eligible for food stamp benefits, or a one-person household refused to provide an SSN. Enter the date which is the end of the disqualification period. (For an SSN disqualification, the individual is disqualified until an SSN is provided.)

NOTE: Do not use the DFA 377.1 for households disqualified for refusal to work register. The DFA 377.10 is used for this purpose.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.1 (12/83)

Manual Section(s)

Enter the applicable specific manual section(s) for the action(s).

Distribution:

The original and one copy are provided to the household. The second copy is filed in the case record.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.2 (12/83)

FOOD STAMP NOTICE OF EXPIRATION OF CERTIFICATION

If you have any questions or want more information about this action, please contact your worker.

Case Name
Case Number
District :
Worker :
Phone :
Date of Notice :

1. Your current food stamp certification period will end on _____ .
   - ☐ Your application for recertification is being processed.
   - ☐ Your certification period has been shortened because the following change(s) in circumstances may affect your food stamp eligibility or benefits:

2. If you want to continue receiving food stamps after the end of your current certification period, without a break in benefits, you must
   - ☐ Submit your complete monthly report (CA 7) so it is received by no later than _____ , fill out the attached application and submit it to the county welfare department by no later than your recertification interview (see 3 below).
   - ☐ Submit your complete monthly report (CA 7) so it is received by no later than _____ .
   - ☐ Fill out and submit an application so it is received by the county welfare department by no later than _____

3. To be sure your application for recertification is processed promptly, you must:
   - ☐ Appear for an interview on: _____ at:
     - ☐ You may bring your complete monthly report to your recertification interview if you wish.
   - ☐ Call for an interview appointment.
   - ☐ Mail/bring your application to:
   - ☐ Call for an application.
   - ☐ Do the following so we can finish processing your application:

IF YOU REAPPLY LATER THAN THE DATE SPECIFIED IN NO. 2 ABOVE, YOU MAY HAVE TO WAIT UP TO 30 DAYS BEFORE FINAL ACTION IS TAKEN ON YOUR APPLICATION. IN ADDITION, YOUR BENEFITS MAY BE PRORATED FOR THE FIRST MONTH OF YOUR NEW CERTIFICATION PERIOD.

- ☐ If you have a good reason for not applying on time, you should tell the county welfare department. You may be entitled to have any lost benefits restored if the county welfare department decides you had a good reason.

IF YOU MISS YOUR SCHEDULED INTERVIEW AND YOU HAVE A GOOD REASON, YOU SHOULD TELL THE COUNTY WELFARE DEPARTMENT. IF THE COUNTY WELFARE DEPARTMENT DECIDES THAT CIRCUMSTANCES BEYOND YOUR CONTROL PREVENTED YOU FROM ATTENDING THE INTERVIEW, A SECOND INTERVIEW WILL BE SCHEDULED.

You have the right to request an application from the county welfare department at any time and to have the county welfare department accept your application. If you and/or your authorized representative are unable to reapply in person at the county welfare department and you have a good reason for not being able to do so, you should call the county welfare department at the above number. We can arrange to have a worker interview you or your authorized representative at home or by telephone.

The above action is required by the following Food Stamp Manual Section(s):

You have the right to request a state hearing if you disagree with any of these requirements. See the back of this notice for a hearing request.

DFA 377.2 (12/83) *Required Form - No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.2 (12/83)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10950

NA Back 3 (Cash Aid/FS)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.2 (12/83)

Form Instructions
(for the Eligibility Worker)

FOOD STAMP NOTICE OF EXPIRATION OF CERTIFICATION

Purpose:

The DFA 377.2 is used by the Eligibility Worker to notify a food stamp household of the following information concerning its certification period:

- the regular expiration of a nonassistance (NA) household's certification period; or,
- the regular expiration of a public assistance (PA) household's certification period when recertification was not completed with the PA redetermination in the month prior to the last month of certification; or,
- the shortening of an NA or PA household's certification period; and,
- the requirements for recertification.

The back of the DFA 377.2 explains the household's right to request a hearing and provides instructions on how to appeal the action.

Preparation:

1. For the expiration of a regular certification period, the DFA 377.2 must be completed so it is received by the household not earlier than 15 days prior to, nor later than the first day of, the last month of certification, except as noted in No. 3 below.
2. For the expiration of a shortened certification period, the DFA 377.2 must be completed so it is received by the household no later than the first day of the last month of certification.
3. For a household assigned a certification period which ends in the same month the application is approved, the DFA 377.2 must be completed at certification and provided to the household with the notice of approval (DFA 377.1).

Complete an original and two copies of the DFA 377.2 entering the following identifying information:

- Head of household's name and mailing address
- Case Name
- Case Number
- District (if applicable)
- Worker
- Phone Number
- Date of Notice

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.2 (12/83)

NOTE: If the date by which the household must take some action falls on a weekend or holiday, enter the date for the business day immediately following the weekend or holiday.

Complete the action portion of the form by checking the appropriate box(es) and entering other required information in each of the three sections as follows:

1. Enter the expiration date of the current certification period.

   - Check the first box if a PA household's recertification is not completed along with the PA redetermination in the month prior to the last month of certification.

   - Check the second box if the certification period has been shortened because of a change in circumstances and enter an explanation.

2. Check the applicable box as indicated below and enter the required information.

   - Check the first box for NA monthly reporting households and PA monthly reporting households whose certification periods are not aligned with a PA redetermination.

     Enter the eleventh day of the last month of the household's certification period.

   - Check the second box for PA monthly reporting households whose application for recertification is pending.

     Enter the eleventh day of the last month of the household's certification period.

   - Check the third box for nonmonthly reporting households.

     Enter the fifteenth day of the last month of the household's certification period unless it is a short certification (certification period expires the same month the application is approved). If it is a short certification period, enter the date which is 15 days after the date the household will receive the notice.

3. Check the applicable box and enter the required information.

   - Check the first box if an interview has been scheduled for the household. Enter the date, time and location of the interview. If the interview for a monthly reporting household is scheduled before the eleventh of the last month of the certification period, check the small box in this section.

   - Check the second box if the household must call for an interview appointment. Enter the name and number of the person the household must call for an interview appointment.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.2 (12/83)

- Check the third box to advise the household where to mail or bring its application. Enter the address.

- Check the fourth box if a nonmonthly reporting household must request an application. Enter the name and number of the person the household should call for the application.

- Check the fifth box if a PA household whose application is pending must take some action to complete the recertification process. Enter the action which the household must take.

Check the small box in the explanation section (below the bold line) for all nonmonthly reporting households.

Manual Section(s)

Enter the applicable specific manual section(s) for the action(s).

Distribution:

The original and one copy are provided to the household. The second copy is filed in the case record.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 377.4 (12/83)

State of California
Health and Welfare Agency

Department of Social Services

FOOD STAMP NOTICE OF CHANGE

If you have any questions or want more information about this action, please contact your worker.

Case Name :
Case Number :
District :
Worker :
Phone :
Date of Notice :

☐ CHANGE IN BENEFITS. Effective _____, your food stamp benefits are changed from $ _____ to $ _____ each month because:

☐ SUSPENSION. Effective _____, your food stamp benefits are suspended because:

You will not receive any food stamp benefits for _____. During this period of suspension, you must continue to complete and submit your monthly report (CA 7) so we can determine if you will be eligible for benefits the month after the month of suspension. If you do not submit a complete CA 7 during the month of suspension, your food stamp participation will be terminated.

☐ TERMINATION. Effective _____, your food stamp benefits are terminated because:

☐ Based on the reason your benefits are terminated, your household is also disqualified from participating in the Food Stamp Program until _____. You may reapply for benefits at the end of this disqualification period.

☐ PROPOSED CHANGE IN BENEFITS. Effective _____, your food stamp benefits may be reduced or terminated because information needed to determine your continued eligibility or the correct amount of your benefits was not received with your monthly report (CA 7). We must receive the following information by no later than the first day of next month:

If verification of an expense is requested and you do not provide it, the expense will not be allowed when computing next month's benefits. Also, if you do not provide other requested information, your benefits may be reduced or terminated.

Comments:

The above action(s) is required by the following Food Stamp Manual Section(s):

You have the right to request a state hearing if you believe this action is wrong. See the back for a hearing request.

DFA 377.4 (12/83) *Required Form - No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.4 (12/83)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's:* ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10980

NA Back 3 (Cash Aid/FS)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.4 (12/83)
(Instructions Revised 4/6/84)

Form Instructions
(for the Eligibility Worker)

FOOD STAMP NOTICE OF CHANGE

Purpose:

The DFA 377.4 is used by the Eligibility Worker to notify a household of any of the following actions:

- Changes in food stamp benefits during the certification period;
- One-month suspension of benefits;
- Termination of program participation;
- Possible reduction or termination of benefits because a complete CA 7 is missing verification and/or contains questionable information.

The back of the DFA 377.4 explains the household's right to request a state hearing and provides instructions on how to appeal the action. The back also provides information needed by the household to receive continued benefits pending a hearing if benefits are being reduced, terminated or suspended.

NOTE: If the CA 7 is incomplete for any program in which the household is participating, the NA 960Y, CA 7 Incomplete--Discontinuance/Reminder, must be used instead of the DFA 377.4 as the timely reminder notice.

Preparation:

Complete an original and two copies of the DFA 377.4, entering the following identifying information.

- Head of household's name and mailing address
- Case Name
- Case Number
- District (if applicable)
- Worker
- Phone Number
- Date of Notice

Complete the action portion of the notice by checking the heading box for the Change, Suspension, Termination, or Proposed Change section, and entering all other required information.

When benefits are changed, suspended or terminated as a result of a reported change, and/or the disallowance of a deduction, the reason for the action must include the reported change and/or the disallowed deduction. For example: "... your food stamp benefits are changed ... because your gross monthly income increased from $250 to $350 and your dependent care expenses were not allowed."; or, ". . . your household size decreased from 4 to 2."

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.4 (12/83)

(Instructions Revised 4/6/84)

Change in Benefits

Check the Change box when food stamp benefits are increased or will be decreased. Enter the effective date of the change, the current allotment, the amount of the new allotment, and the reason(s) for the change.

If the household is repaying a claim through allotment reduction (intentional program violation or inadvertent household error) the amount entered should reflect the actual allotment the household will receive. The explanation for the change should include the reasons for the change in benefits as well as the effect on the amount of allotment reduction.

Suspension

Check the Suspension box when information reported by a monthly reporting household on the CA 7 results in ineligibility for a one-month period. Enter the effective date of the suspension, the reason(s) and the month for which no benefits will be issued.

For all suspensions, enter the following statement in the Comments section:

> "If the CA 7 you submit for the month of suspension shows that you are still not eligible for food stamps, your benefits will be terminated effective **(enter appropriate date)**."

Termination

Check the Termination box when food stamp benefits will be terminated. Enter the effective date of the termination and the reason(s).

Check the second box if the household's benefits are terminated because resources have been transferred or because a one-person household failed to provide a Social Security Number within the appropriate time. Enter the date which is the end of the disqualification period. (For an SSN disqualification, the individual is disqualified until an SSN is provided.)

NOTE: Do not use the DFA 377.4 for disqualifications resulting from an intentional program violation or refusal to work register. The DFA 377.7A and the DFA 377.10, respectively, are provided for these types of disqualifications.

Proposed Change in Benefits

Check the Proposed Change box when a monthly reporting household submitted a complete CA 7 which is missing verification/information of a deduction and/or contains questionable information. Enter the proposed effective date of the change and the verification and/or information which the household must provide.

Benefits may not be reduced, suspended or terminated based on this reminder notice. A timely notice of adverse action must be provided to the household before the adverse action is taken. (See the special instructions in the All-County Letter transmitting this material.)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.4 (12/83)
(Instructions Revised 4/6/84)

Comments

Use this section as indicated above for suspensions and to provide the household with any additional information.

This section may also be used to advise a household that its request for a replacement ATP/coupons has been denied and the reason for the denial.

Manual Section(s)

Enter the applicable specific manual section(s) for the action(s).

Distribution:

The original and one copy are provided to the household. The second copy is filed in the case record.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.5 (12/83)

State of California
Health and Welfare Agency

Department of Social Services

FOOD STAMP HOUSEHOLD CHANGE REPORT

INSTRUCTIONS:

You must report changes in your household circumstances within 10 days of the time you learn of any change.
You may use this form to report changes **or** *you may report changes in person* **or** *by calling the number below.*
If you use these forms, you only have to complete the sections that apply to the changes you are reporting.
If you have any questions about your reporting responsibilities or any doubt about needing to report a change, please contact your worker.

Worker: Phone:

(1) INCOME CHANGES

A. Did the total amount of income received by your household increase or decrease by more than $25? If **YES**, complete 1(C) below. ☐ YES

B. Did the source of income received by any household member change or did anyone begin receiving income from a new source? If **YES**, complete (1)C below. ☐ YES

C. If **YES** to (1)A or (1)B above, enter all income received by your household. Attach paystubs or other proof of earnings. For all other income attach proof when a change is reported. If anyone is self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

Name	Source (If Earnings, List Name of Employer)	Amount (Before Deductions)	How Often Received?	Date of Change
1.		$		
2.		$		
3.		$		

(2) HOUSEHOLD COMPOSITION CHANGES

Change	YES	Date of Change	If YES, give name of person and explain change.
A. Did anyone move into your home, including a newborn?			
B. Did anyone move out of your home or die?			
C. Did anyone get married?			
D. Did anyone become disabled or recover from a disability?			
E. Did anyone turn age 60?			
F. Did anyone get a new Social Security Number* If **YES**, attach proof.			

(3) RESOURCE CHANGES

A. Did anyone buy or get a licensed vehicle? If **YES**, complete section below: ☐ YES

Vehicle Owner	Year and Class	Make and Model	Estimated Value	Amount Owed
			$	$

B. Did the total of your household's cash on hand, money in a checking and/or savings account, stocks, bonds, etc. reach or exceed $1500? If **YES**, complete section below: ☐ YES

List Each Item	Amount	Date of Change
1	$	
2	$	
3	$	

(4) MEDICAL EXPENSE CHANGES

Did the total amount of medical expenses for a household member who is disabled or age 60 or older increase or decrease by more than $25? If **YES**, attach receipts and complete section below: ☐ YES

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense?	Type of Expense	Amount
1		$	3		$
2		$	4		$

*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, AFDC or Medi-Cal. Fraudulent participation in the Food Stamp Program may result in criminal or civil action or administrative claims. Refusal to provide an SSN will result in disqualification of the individual for whom it is not provided.

DFA 377.5 (12 83) *Required Form No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 377.5 (12/83)

(5) ADDRESS AND SHELTER COST CHANGES

A Do you have a new mailing address or phone number or do you plan to move? If **YES**, complete (5) C ☐ YES

B Did you move? If **YES**, complete (5) C and (5) D ☐ YES

C Enter your new address and or phone number below and enter the date of the change here:

Home Address (Number, Street Name, Ave., Blvd., Etc.) | Apt. No | City | State | Zip Code

Mailing Address (If different than home address) | Phone No. | City | State | Zip Code

D. Did your housing or utility costs change when you moved? If **YES**, complete 1, 2 and 3 below: ☐ YES

1. Enter the amount of each housing cost you have and attach bills for each cost.

Rent or Mortgage: $ | Property Taxes or Insurance: $ (If not in mortgage)

2. If you claim actual utility costs, enter the amount of each utility cost you have and attach bills for each cost.

If you claim the standard utility allowance, attach bills for gas, electricity or other heating fuel.

Utility	Amount	Utility	Amount
Gas or Fuel	$	Garbage or Trash	$
Electricity	$	Water	$
Telephone	$	Sewage	$
Utility Installation	$	Other (specify)	$

3. Did anyone not part of your food stamp household help you pay any of your housing or utility costs? If **YES**, complete 3a, b and c below. ☐ YES

a. Enter the total housing costs paid by the food stamp household: $ _____

b. Enter the total utility costs paid by the food stamp household: $ _____

c. Give the name of each person who paid any of the costs, and if they paid housing and/or utility costs.

(6) DEPENDENT CARE EXPENSE CHANGES

Did you begin paying or has there been a change in the amount paid for the care of a child or disabled adult so that someone in the home could go to work, training or look for a job? ☐ YES

If **YES**, complete section below and attach a receipt.

Who Received Care?	Cost of Care	Who Received Care?	Cost of Care	Who Received Care?	Cost of Care	Who Received Care?	Cost of Care
1.		2.		3.		4.	

(7) DISQUALIFIED INDIVIDUALS/INELIGIBLE ALIENS

Did any person living in your home who is an ineligible alien or who has been disqualified from the Food Stamp Program have any of the changes in questions (1) through (6)? ☐ YES

If **YES**, give the name of the person and the date of the change, and explain the change below:

(8) OTHER CHANGES

Do you have any other changes to report? If **YES**, explain below. ☐ YES

(9) TEMPORARY CHANGES

Do you expect any of the changes reported on this form to be temporary? If **YES**, explain below. ☐ YES

CERTIFICATION

- **I understand that failing to report information or intentional misrepresentation of facts can result in legal prosecution with penalties of fines up to $10,000 and imprisonment up to 5 years, as well as permanent disqualification from the Food Stamp Program.**
- *I understand that I have only 10 days to notify my worker of changes in my household circumstances.*
- *I understand that the information I have provided will be verified by local, state and federal pesonnel.*
- *I understand that if I fail to report a change and because of this I receive food stamps I am not entitled to, I will have to repay these benefits.*
- *I understand that I have the right to request a state hearing on any action by the County Welfare Department*
- *I declare that the information contained in this report is true and correct.*

Signature (Household Member or Authorized Representative) | Date

Signature (Witness, if You Signed with an X) | Date

COUNTY USE SECTION | **E.W. Initials** | **Date**

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.5 (12/83)

Form Instructions
(For the Eligibility Worker)

FOOD STAMP HOUSEHOLD CHANGE REPORT

Purpose:

The DFA 377.5 is completed by a nonmonthly reporting household and is used to report changes in household circumstances that occur within the certification period. The household completes only the section(s) pertaining to the change(s) it is reporting. It is not mandatory that the household use this form to report a change as changes may also be reported by telephone or personal contact. This form is provided to the household at the time of initial certification, recertification, and also whenever the household submits a completed DFA 377.5 to the CWD. The CWD must pay the postage for the household to mail in the report. The Eligibility Worker uses the reported information to compute any change in the household's eligibility or benefits.

NOTE: Nonmonthly reporting PAFS households meet their food stamp reporting requirements by reporting any changes on the CA 7.

Preparation:

Enter the following information on the top of the front page of the report before providing it to the household:

— Head of household's name and mailing address
— Worker
— Phone Number

Question	Manual Section	Information Requested	EW Action
County-Use Section	63-504.422		Verification must be obtained prior to the issuance of any increase in benefits as a result of the reported change. Document verification of income in the county-use section.
1A	63-300.5 63-504.422(b) 63-505.511	Income Changes	If the household's income changes by more than $25 or the source of income changes, the household completes this section and section 1C. The household's total monthly income (before deductions) is used to compute the change. Be sure that all pay stubs or other income verification are provided.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

DFA 377.5 (12/83)

Question	Manual Section	Information Requested	EW Action
2	63-505.512	Household Composition Changes	If there is a change in the household composition, the household completes this section. For all Yes answers, be sure that all information is provided.
2A	63-402 63-504.422(b)		If someone has moved into the home, the CWD must determine if the person should be added to the household. Either the most recent application must be updated or a CA 8 must be completed by the household.
2B	63-402		If someone moved out of the home or died, adjust the household size and benefit level accordingly.
2C	63-402.1		If someone got married, determine if household composition is affected.
2D	63-102(i) 63-409.112 63-502.3 63-503.3 63-505.251		If someone became disabled or recovered from a disability, determine if household composition, income eligibility and/or medical expense deduction eligibility are affected.
2E	63-102(i) 63-409.112 63-502.3 63-503.3 63-505.521		If someone turned age 60, determine if household composition is affected, provide the household with a DFA 285-C and use the net income eligibility standard.
2F	63-402.2 63-402.7 63-404 63-503.442		If someone got a new Social Security Number, determine if household composition is affected after obtaining appropriate verification.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.5 (12/83)

Question	Manual Section	Information Requested	EW Action
3A	63-501.51 63-505.514	Resource Changes	If anyone in the household got a licensed vehicle, this section is completed. The CWD must determine if the vehicle is resource exempt, and, if not, determine its countable value.
3B	63-501.1 63-501.2 63-501.3 63-501.4 63-501.7 63-501.8 63-503.44 63-505.515		If the household's liquid resources reach or exceed $1,500, this section is completed.
	63-409.21 63-409.22		For Yes answers to either 3A or 3B, complete the resource eligibility test section of the budget worksheet.
4	63-102(i) 63-300.517 63-502.33 63-503.25 63-505.511 63-505.53	Medical Expenses	If there is a change of $25 in the household's medical costs for a household member who is elderly or disabled this section is completed. For Yes answers, be sure that all information is provided. The household must attach bills for any expenses it lists. To be permitted as a deduction, increases in medical expenses must be reported in the month of billing or when the bill becomes due.
5A	63-505.513	Address/Phone Number Change	If the household's mailing address or phone number changed (whether or not the household moved), this section and Section 5C are completed.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.5 (12/83)

Question	Manual Section	Information Requested	EW Action
5B	63-505.513	Address Change (Move)	If the household moved, this section and sections 5C and 5D are completed.
5C	63-401 63-505.513	New Address/ Phone Number	If the household answered Yes to 5A and/or 5B this section is completed. Check that the household's mailing address and/or residence are still in the county.
5D	63-300.514 63-502.2 63-502.35 63-502.353 63-502.36 63-503.25 63-505.513	Shelter Cost Changes	A household which moves must report any resulting changes in shelter costs. For a Yes answer to 5D, any changes should be reported in section 5D1 and/or 5D2. Verification of housing costs must be provided when they change. Verification of actual utility costs must be provided when they change as a result of a change in residence. Verification of entitlement to the standard utility allowance (SUA) is required when a household claiming the SUA moves. For a Yes answer to 5D3 the household must provide actual utility costs **paid** by the food stamp household. The CWD must determine which information should be used for the deduction (SUA, prorated SUA, actual costs billed, actual costs paid) based upon a review of the sharing relationship.
6	63-300.52 63-502.34 63-503.25 63-505.522		A household whose dependent care expenses change will complete this section. For a Yes answer check that all required information and verification is provided.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.5 (12/83)

Question	Manual Section	Information Requested	EW Action
7	63-503.442 63-505.51	Other Changes Disqualified Individuals/ Ineligible Aliens	A household with individuals living in the home who have been disqualified or who are ineligible aliens must report changes for these individuals. The CWD must determine the affect of these changes on the household's eligibility or benefit level.
8	63-504.421	Other Changes	If the household has any other changes to report, this section is completed. For Yes answers, be sure that the changes are explained in the space provided.
9	63-505.531	Temporary Changes	The household should explain any changes which it expects to be temporary.
		Certification	Check that the form contains all necessary signatures and dates.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.6 (2/79) Repealed by Manual Letter 84-13, 2/15/84

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 377.7A (3/84)

State of California — Health and Welfare Agency

Department of Social Services

FOOD STAMP NOTICE OF ADMINISTRATIVE DISQUALIFICATION

Case Name:
Case Number:
District:
Worker:
Phone:
Date of Notice:

DISQUALIFICATION DECISION

☐ You were found guilty of committing an intentional program violation at a hearing held on _____. See the State Department of Social Services hearing decision you received earlier for a complete explanation. This decision does not prevent the state or federal government from prosecuting you in court.

☐ You were found guilty of committing an intentional program violation by a court of law on _____. See the court decision for a complete explanation.

DISQUALIFICATION PENALTY

As a result of the above decision, you have been disqualified from the Food Stamp Program.

☐ Since you are currently otherwise eligible for the Program, you will not receive any food stamps for _____ months, effective _____.

☐ Since you are not currently otherwise eligible for the Program, when you reapply and are determined eligible, you will not receive any food stamps for _____ months.

☐ You have been permanently disqualified from the Program and will never receive food stamps again.

NOTICE TO THE OTHER MEMBERS OF YOUR HOUSEHOLD

Because of the above decision, your food stamp file has been reviewed to see if you will receive food stamps while _____ is disqualified.

☐ Your benefits will change from $ _____ to $ _____ effective _____.

☐ You would have received $ _____ in food stamps, but because you had another change in circumstances you will receive a different amount. See the attached Notice of Change for the amount you will actually receive.

☐ You are no longer eligible for food stamps as a result of excluding the disqualified individual from your benefit computation. You may reapply for food stamps at the end of the disqualification period or if your circumstances change.

☐ Although your certification period is over, you may be eligible for food stamps. To see if you are eligible, you may call, write or visit the county welfare department and request an application.

IF YOU BELIEVE THAT THE AMOUNT OF FOOD STAMPS YOU WILL RECEIVE IS WRONG, YOU MAY REQUEST A STATE HEARING. A REQUEST FOR A STATE HEARING IS ON THE BACK OF THIS NOTICE. IF YOU REQUEST A HEARING, YOUR BENEFITS WILL NOT CONTINUE UNTIL THE HEARING AT THE LEVEL PRIOR TO THE DISQUALIFICATION.

The above action(s) is required by the following Food Stamp Manual Section(s):

If you have any questions, please contact me:	Name	Phone Number

See the back of this notice for a hearing request.

DFA 377.7A (3/84) *Required Form - No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.7A (3/84)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10950.

NA Back 3 (Cash Aid/FS)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.7A (3/84)

Form Instructions
(for CWD)

FOOD STAMP NOTICE OF ADMINISTRATIVE DISQUALIFICATION

Purpose:

The DFA 377.7A is used by the county to notify an individual that he/she has been found guilty of committing an intentional program violation, that he/she will be disqualified for a certain period of time, and provides information to the rest of the household concerning its eligibility for food stamps during the disqualification period.

The back of the DFA 377.7A explains the rest of the household's right to request a state hearing if it disagrees with the amount of food stamp benefits it will receive during the disqualification period. If the household requests a hearing, benefits **will not** continue until the hearing at the level prior to this notice.

NOTE: If the household has reported a change in circumstances which also affects its benefit level, this change must be computed separately from the disqualification. A Notice of Change (DFA 377.4) showing the change in circumstances must be attached to the DFA 377.7A when: (1) the change in benefits due to the change in circumstances and the change in benefits due to the disqualification are effective the same date, **and** (2) sufficent time exists for the Notice of Change to be issued on a timely basis. The Notice of Administrative Disqualification must show only the benefit level resulting from excluding the disqualified individual.

Preparation:

The DFA 377.7A should be completed and sent to the individual found guilty of committing an intentional program violation. This notice need not be issued 10 days before the effective date of the disqualification but must be sent in sufficient time for the individual to receive the notice before the disqualification period begins. Complete an original and two copies of the DFA 377.7A entering the following identifying information:

- Individual's name and mailing address
- Case name
- Case number
- Worker number
- District (if applicable)
- Date of Notice

Disqualification Decision

Check the first box if the individual was found guilty of committing an intentional program violation at an administrative disqualification hearing. Enter the date of the hearing.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.7A (3/84)

Check the second box if the individual was found guilty of committing an intentional program violation by a court of law. Enter the date of the court decision.

Disqualification Penalty

Check the appropriate box and enter the specific information concerning the individual's disqualification period.

- Check the first box if the household is currently otherwise eligible to participate in the Program. Enter the number of months the disqualified individual will not receive food stamp benefits and the effective date of the disqualification.

- Check the second box if the household is not currently otherwise eligible to participate in the Program. Enter the number of months the disqualified individual will not receive food stamp benefits when applying and found eligible in the future because of the disqualification.

- Check the third box if the individual has been permanently disqualified.

Notice to the Other Members of Your Household (This section is not completed if the disqualified individual is the only household member.)

Enter the name of the disqualified individual. Check the appropriate box and enter the specific information concerning the household's benefit level after excluding the disqualified individual.

- Check the first box if the rest of the household is still eligible to receive food stamps, and either its benefits for the following month are not affected by a reported change in circumstances, or a timely Notice of Change has already been provided. Enter the current allotment, the new allotment and the effective date of the change.

- Check the second box if the household has reported a change in circumstances which changes the benefit level it would have received based on the disqualification alone, and a timely Notice of Change has not yet been provided. Enter the amount the household would have received based only on the disqualification. Attach a completed Notice of Change explaining the other change(s). If the household requests a state hearing on the benefit level shown on the Notice of Change, benefits will continue pending the hearing at the level shown on the Notice of Administrative Disqualification.

- Check the third box if the household is no longer eligible for food stamps as a result of excluding the disqualified individual from the benefit computation.

- Check the fourth box if the household's certification period has expired.

Manual Section(s)

Enter the applicable specific manual section(s) for the above action(s).

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.7A (3/84)

Contact Person

Enter the name and telephone number the household may contact to ask questions.

Distribution:

The original and one copy are provided to the disqualified individual. The second copy is filed in the case record.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 377.7B (3/84)

State of California - Health and Welfare Agency — Department of Social Services

FOOD STAMP REPAYMENT NOTICE

Case Name:
Case Number:
District:
Worker:
Phone:
Date of Notice:

EXTRA FOOD STAMPS WERE ISSUED

☐ After reviewing your food stamp file, we found you received more food stamps than you were entitled to receive.

☐ After reviewing the food stamp file for _____, whom you sponsor, we found he/she received more food stamps than he/she was entitled to receive.

The extra food stamps were issued because:

THIS IS WHAT YOU OWE

$ _____ in extra food stamps were issued for the period _____.
This amount was reduced by $ _____ because we owed the household benefits from past months or we received repayment of part of the amount owed. You now owe $ _____.

If you believe that the amount you owe is wrong, you may request a state hearing, unless you already had a hearing on the amount you owe.

THIS IS WHAT YOU MUST DO

☐ You must repay the extra food stamp benefits. Please complete the attached Repayment Agreement, sign and return it to the County Welfare Department.

☐ If you do not return an acceptable Repayment Agreement within 30 days after the date of this notice, your household's food stamp benefits will be reduced to $ _____ effective _____.

YOU DID NOT REPAY AS AGREED

☐ You must contact us to explain why you did not repay food stamp benefits as you agreed. If you can no longer afford to pay the amount due as agreed, you may ask to renegotiate your agreement.

☐ If we do not hear from you within 10 days of the date of this notice, your household's food stamp benefits will be reduced to $ _____ effective _____.

The above action is required by the following Food Stamp Manual Section(s):

If you have any questions, please contact me:	Name	Phone Number

You have the right to request a state hearing if you believe this action is wrong. See the back of this notice for a state hearing request.

DFA 377.7B (3/84) *Required Form — No Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.7B (3/84)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S Department of Agriculture. Authority W&IC 10950.

NA Back 3 (Cash Aid/FS)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.7B (3/84)

Form Instructions
(for CWD)

FOOD STAMP REPAYMENT NOTICE

Purpose:

The DFA 377.7B is used by the county to notify an individual that he/she must repay food stamps which were overissued. Collection action is generally initiated against the household which received the overissuance. If household membership has changed since the overissuance occurred, collection action is initiated against either (1) the household containing a majority of the individuals who were household members at the time the overissuance occurred; or, (2) if the household containing a majority of the individuals cannot be located, the household containing the head of household at the time the overissuance occurred. For sponsored alien households, collection action is initiated against the alien household, the sponsor, or both, as appropriate.

This notice is initially sent at the same time as the Food Stamp Repayment Agreement, DFA 377.7C, and is sent again if the individual fails to make repayment as agreed. The DFA 377.7B and DFA 377.7C are also sent at 30-day intervals to individuals who are not currently participating in the Program and to individuals whose overissuance resulted from an administrative error. For these individuals, allotment reduction cannot be invoked and repayment notices are sent until repayment is made or the criteria for suspending collection action are met.

The back of the DFA 377.7B explains the individual's and/or household's right to request a state hearing. The household against whom collection action has been initiated for an intentional program violation may request a state hearing on the amount owed only if a state hearing was not held in conjunction with the administrative disqualification hearing. If the household requests a hearing because of an allotment reduction invoked by the county as a result of the household's failure to repay as agreed an inadvertent household error claim or an intentional program violation claim, the reduction **will not** be delayed pending the results of the hearing.

NOTE: The CWD should attempt to contact the individual to discuss the terms of repayment prior to sending the first DFA 377.7B.

Preparation:

The DFA 377.7B should be completed and sent to the individual against whom collection action is initiated.

Complete an original and two copies of the DFA 377.7B entering the following identifying information:

- Name and mailing address of individual against whom collection action is initiated
- Case name
- Case number
- Worker number
- District (if applicable)
- Date of Notice

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.7B (3/84)

Extra Food Stamps Were Issued

Complete this section unless the notice is sent because the individual did not repay as agreed. Check the appropriate box for the individual against whom collection action is initiated.

- Check the first box for all collection actions, except those initiated against the sponsor of an alien household.

- Check the second box when collection action is initiated against the sponsor of an alien household. Enter the sponsored alien's name.

In the space provided, explain the reason for the overissuance.

This is What You Owe

Enter the following information for all cases:

- The amount of food stamps overissued.

- The period of time food stamps were overissued.

- The amount of lost benefits not restored and/or payments received used to offset the amount of food stamps to be repaid.

- The amount that the individual now owes.

This is What You Must Do

- Check the first box if this is the first time the DFA 377.7B is being sent to the individual. Attach a Food Stamp Repayment Agreement. In addition, check the first box if the DFA 377.7B has previously been sent for an administrative error or to a household not currently participating in the Program, but the individual did not sign and return a Food Stamp Repayment Agreement. Attach a Food Stamp Repayment Agreement.

- Check the second box when the claim was established for an inadvertent household error or an intentional program violation, and the household is currently participating in the Program (the first box must also be checked.) Enter the amount the household's allotment will be reduced to if allotment reduction is invoked, and enter the effective date of the reduction.

You Did Not Repay As Agreed

- Check the first box if the individual has failed to make repayment as agreed.

- Check the second box if the CWD will reduce a participating household's allotment because the individual failed to repay as agreed a claim based on an inadvertent household error or an intentional program violation (the first box must also be checked). Enter the amount the household's allotment will be reduced to, and enter the effective date of the reduction.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.7B (3/84)

Manual Section

Enter the applicable specific manual section(s) for the above action(s).

Contact Person

Enter the name and telephone number the individual may contact to ask questions.

Distribution:

The original and one copy are provided to the individual. The second copy is filed in the case record.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 377.7C (3/84)

State of California - Health and Welfare Agency — Department of Social Services

FOOD STAMP REPAYMENT AGREEMENT

Case Number

Worker

Name

Case Name

Address

TERMS AND CONDITIONS

You must repay extra food stamp benefits in one or a combination of the methods described below:

1. Lump Sum Payment — You may repay all or part of the amount owed at one time with cash and/or coupons, including returning coupons already received.
2. Installments — You may repay all or part of the amount owed in monthly installments with cash and/or coupons, including returning coupons already received.
3. Benefit Reduction — If you are currently receiving food stamps, you may repay by having your household's benefits reduced for all or part of the amount owed. Repayment by this method will be based on the terms checked below:
   - ☐ At least 10% of your monthly allotment or $10 each month, whichever is greater.
   - ☐ At least 20% of your monthly allotment or $10 each month, whichever is greater.
   - ☐ Discussion with you about the amount to be reduced.
4. Court-Ordered Repayment
   - ☐ The court ordered that you repay as indicated below. These repayment terms cannot be changed by you or by the County.

If we have not already contacted you to discuss the terms of this Agreement, or if you have any questions about this form, please contact me: _____ at (phone number) _____

AGREEMENT

I, _____, the undersigned, understand this Agreement is entered into between me and _____ County because extra food stamps in the amount of $ _____ were issued. I agree to repay this amount to the County by the method(s) checked below:

1. Lump Sum Payment
   - ☐ Repay by a lump sum cash payment of $ _____ due on _____.
   - ☐ Repay by a lump sum coupon payment of $ _____ due on _____.
2. Installments
   - ☐ Repay by monthly cash payments of $ _____ due on the _____ day of each month beginning _____ through _____.
   - ☐ Repay by monthly coupon payments of $ _____ due on the _____ day of each month beginning _____ through _____.
3. Benefit Reduction
   - ☐ Repay by having my household's benefits reduced by $ _____ each month, beginning _____ _____ through _____.

I understand that if my circumstances change, I may ask the County to reconsider the terms checked above. I understand that if I cannot reach an agreement with the County, I may ask for a state hearing.

Signed by _____ on _____ (Date) at _____ County, California.

After completing and signing this Agreement, return all copies to the County Welfare Department in the envelope provided. Do not send cash or coupons through the mail with this Agreement. When accepted by the County, a signed copy of this Agreement will be sent to you. A request for a State Hearing is on the back of the Food Stamp Repayment Notice sent to you with this Agreement.

COUNTY USE ONLY

The above signed Agreement has been accepted by _____ on _____ (Date)

for _____ County. Payments should be made at:

_____ (Signature of Authorized County Official)

DFA 377.7C (3/84) *Required Form — No Substitutes Permitted*

63-1230 STATE FORMS AND INSTRUCTIONS (Continued) 63-1230

DFA 377.7C (3/84)

Form Instructions
(for CWD)

FOOD STAMP REPAYMENT AGREEMENT

Purpose:

The DFA 377.7C is used by the county to secure a written repayment agreement with an individual who received an overissuance of food stamps. This agreement is sent to the individual along with the Food Stamp Repayment Notice, DFA 377.7B (11/88) and the Repayment Notice - Final Notice, DFA 377.7B1 (11/88).

NOTE: The CWD should attempt to contact the individual to discuss the terms of repayment prior to sending the first Food Stamp Repayment Notice and Agreement.

Preparation:

Complete an original and three copies of the DFA 377.7C. Additional copies may be required by the county's internal system. Enter the following identifying information:

- Case number
- Worker
- Name of individual against whom collection action is initiated
- Case name
- Address

Terms and Conditions

Check the appropriate box in item 2 for the formula which will be used for benefit reduction based on the type of claim. Check the first box (10% or $10.00) for a claim based on an inadvertent household error; the second box (20% or $20.00) for an intentional program violation; or, the third box for an administrative error.

Check the box in item 4 if the court ordered the terms of repayment of an intentional program violation claim. Complete the appropriate sections of the Agreement to reflect the court-ordered terms before sending the Agreement to the individual.

Enter the appropriate telephone number in the space provided following item 4.

63-1230 STATE FORMS AND INSTRUCTIONS (Continued) 63-1230

DFA 377.7C (3/84)

Agreement

Enter the individual's name, the county name, and the amount to be repaid in the spaces provided.

If the CWD was able to contact the individual and establish the terms of repayment, check the appropriate box(es) under the repayment options and enter the agreed-upon amounts and dates.

If the CWD was unable to contact the individual or is unable to establish the terms of repayment, do not enter any information under the repayment options.

Initial Distribution:

The original and two copies are provided to the individual along with the Food Stamp Repayment Notice (DFA 377.7B and DFA 377.7B1) and a return envelope. The third copy is retained by the CWD pending receipt of the signed Agreement.

County-Use Section

When the signed Agreement is returned by the individual, determine if the terms are acceptable as specified by regulation. Enter the following information in the section marked "To be completed by the County":

- Name of county official accepting Agreement
- Date
- Name of county
- Address where payments should be sent
- Signature of authorized county official

Final Distribution:

The original signed Agreement is filed in the county unit responsible for collections. One signed copy showing the County's acceptance of the Agreement is provided to the individual and the second signed copy is filed in the case record. The pended copy is discarded. The second signed copy is filed in the case record and the pended copy is destroyed. Additional copies should be distributed in accordance with specific county needs.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 377.9 (3/81)

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

(COUNTY STAMP)

NOTICE OF RESTORATION OF LOST FOOD STAMP BENEFITS AND RIGHT TO REQUEST A STATE HEARING

Case Name:
Case No:
Worker No:
District:
Date:

☐ A determination has been made that you are eligible for a restoration of lost food stamp benefits in the amount of $_____ for the month(s) of _____ due to:

☐ There is an unpaid claim against your household in the amount of $_____. Your entitlement to the lost benefits described above has been offset by this claim and your total entitlement has been reduced to $_____. The unpaid balance of the claim is $_____.

This entitlement will be issued to you in one lump sum, unless installments are requested by you. Please contact your worker if you would like the amount due you paid in installments.

This action is required by the following laws and/or Food Stamp Manual Sections: 63–802

If you have any questions, please contact me.

ELIGIBILITY WORKER	TELEPHONE NUMBER	DATE

If you disagree with this computation, you have the right to request a state hearing with the State Department of Social Services. See reverse for your state hearing rights.

DFA 377.9 9/80 Required Form – Substitutes Prohibited

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.9 (3/81)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

AFDC: If your AFDC is being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, you can continue to receive AFDC until the hearing.

FOOD STAMPS: If your food stamps are being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, your food stamps may continue until the hearing or until the end of your current period of eligibility, whichever comes first, unless you check the box at the bottom of the page.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

Teletypewriter (TTY) only: (800) 952-8349 *

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to

☐ AFDC ☐ Food Stamps ☐ Medi-Cal

Reasons for my request:

I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Food Stamps: If any portion of food stamps provided to you while awaiting the hearing decision is determined to be an overissuance, the county may recover the value of the overissuance. If you want to avoid the possibility of such an overissuance, you may check the box below:

☐ I want my food stamps terminated or reduced to the new amount determined by the county until the hearing decision. If the hearing decision is in my favor, the county will make up the food stamps I lose as a result of checking this box.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.9 (3/81)

Form Instructions
(for Eligibility Worker)

NOTICE OF RESTORATION OF LOST FOOD STAMP BENEFITS AND RIGHT TO REQUEST A STATE HEARING

Purpose:

The DFA 377.9 is used by the Eligibility Worker to notify a food stamp household of its eligibility for restoration of lost benefits and, if applicable, of the offsetting of such benefits by unpaid claims.

The backside of the DFA 377.9 explains the household's right to request a hearing and provides instructions on how to appeal the intended action.

Preparation:

Complete an original and two copies of the DFA 377.9 entering the following identifying information:

- Head of household's name and mailing address
- Case name
- Case number
- Worker number
- District (if applicable)
- Date

Check the first box and enter the following information:

- The amount of food stamp benefits which the household is eligible to have restored.
- The month(s) for which these benefits were lost.
- The reason why the benefits were lost and the Food Stamp Manual section governing the restoration.

Check the second box if the household has an unpaid claim which offsets all or a portion of the lost benefits to which it is entitled. Enter the following information:

- The amount of the unpaid claim.
- The remaining lost benefit entitlement, if any, after the unpaid claim has been deducted from the original entitlement, or zero if the entire entitlement was offset by the unpaid claim.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 377.9 (3/81)

- The balance of the unpaid claim, if any, or zero if the entire amount of the unpaid claim was offset.

Signature Block

Enter Eligibility Worker's name, telephone number and date.

Distribution:

The original and one copy are mailed to the household. The second copy is filed in the case record.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 386 (8/80) Repealed by Manual Letter 84-13, 2/15/84

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 842 (6/81)

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/PROCEDURAL ERROR [ ] HOUSEHOLD ERROR [ ] POTENTIAL FRAUD	

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

11. SUMMARY OF FOOD STAMP OVERISSUANCE — Include on this page only those overissuance months which are within 12 months prior to date of discovery.

ISSUANCE MONTH/YEAR	ACTUAL BASIS FOR ISSUANCE: HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	CORRECT BASIS FOR ISSUANCE: HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	ISSUANCE VERIFICATION: DMI	AIB/MIB	REDEMPTION
Continue on reverse for potential fraud	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.
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.

DATE: DATE:

ELIGIBILITY WORKER SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE

REVIEW BY COUNTY REVIEW OFFICER

ACTION TAKEN:

COUNTY REVIEW OFFICER SIGNATURE	DATE

DFA 842 (6/81) *Required Form – Substitutes Permitted*

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

DFA 842 (6/81)

14. SUMMARY OF FOOD STAMP OVERISSUANCE (CONTINUATION) — Include all other overissuance months not listed on the front if the basis of the claim is potential fraud.

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

DOCUMENTATION

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 ▶		

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

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 842 (6/81)
(Instructions Revised 3/84)

Form Instructions
(For Eligibility Worker)

CLAIM DETERMINATION WORKSHEET

Purpose:

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 quarterly report DFA 209, Status of Claims Against Households.

The first page of the worksheet documents overissuances which occurred within the 12 months prior to the date of discovery. If the basis for the claim determination is inadvertent household error or administrative error, only the first page is completed. If the basis for claim determination is potential intentional program violation, the first page is completed, if applicable, and the second page is completed for overissuances which occurred more than 12 months prior to the date of discovery. Additional forms may be used as needed to document the amount of claim. However no amount of overissuance which occurred in a month more than six years from the date the overissuance was discovered or prior to March 1, 1979 may be included.

For example, if the date of discovery is March 10, 1984, an inadvertent household error claim or administrative error claim covering the period March 1983 through March 1984 would be documented on the first page. A potential intentional program violation claim covering the period January 1, 1979 through March 1984, with a discovery date of March 10, 1984, would be documented as follows: March 1983 through March 1984 would be documented on the first page. February 1983 through March 1979 would be documented on the second page and additional pages as needed. Do not establish a claim for January and February 1979.

NOTE: Collection action on claims covering overissuances which occurred within the 12 months prior to the date of discovery may be initiated immediately regardless of the basis for the claim determination. Collection action on claims covering overissuances which occurred more than 12 months prior to the date of discovery may be initiated only after an individual has been found guilty of committing an intentional program violation.

Preparation:

Complete the number of copies required for your internal system as soon as an overissuance is discovered and it is determined that a claim should be established.

1-7. Enter the following identifying information.

— Name of Head of Household

— Case Name (if different)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 842 (6/81)
(Instructions Revised 3/84)

— Case Number

— Address

— Telephone Number

— Birthdate

— Social Security Number

NOTE: If a claim applies to a sponsored alien household, enter the name of both the head of household and the sponsor in item 1. Document if collection action is initiated against the sponsor, the alien, or both.

8. Date of Discovery

Enter the date the overissuance became known to the CWD.

9. Basis for Claim Determination

Check the appropriate box for the cause of the overissuance. For purposes of completing this section, the types of claims are as follows:

— **Inadvertent Household Error Claim** (Check household error box on form.)

A claim in which an overissuance was caused by a misunderstanding or unintended error on the part of the household (or sponsor of an alien household).

— **Administrative Error Claim** (Check administrative/procedural error box on form.)

A claim in which the overissuance was caused by the CWD.

— **Potential Intentional Program Violation Claim** (Check potential fraud box on form.)

A claim in which a household member is suspected of intentionally violating program rules or regulations to receive more food stamps. A claim is handled as an intentional program violation claim only after an administrative disqualification hearing official or a court of appropriate jurisdiction has determined that a household member (or the sponsor of an alien household) has committed an intentional program violation.

10. Explanation of Overissuance

Explain how and why the overissuance occurred. If the overissuance resulted from a change in circumstances, indicate the date the change occurred and the date the household reported the change to the CWD.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 842 (6/81)
(Instructions Revised 3/84)

11. Summary of Food Stamp Overissuance

Complete this section for all claims where overissuances occurred within the 12 months prior to the date of discovery. Space is provided for 14 months to include the current month's issuance if benefits have already been issued at the time the worksheet is completed, and to include the following month's issuance if sufficient time does not exist to provide a timely notice of benefit reduction. If potential intentional program violation and only a few months fall within the 12-month period prior to the date of discovery include only those months in this section. Record the remaining months on the second page (Item 14).

Issuance Month and Year

Enter the month and year of all overissuances which occurred within the 12 months prior to the date of discovery. Enter the date for the current and following month's issuances, if appropriate.

Actual Basis for Issuance

— HH Size

Enter the household size used in the original benefit computation.

— Adjusted Income

Enter the net adjusted income from the original benefit computation.

— Allotment

Enter the allotment actually received by the household for each overissuance month.

Correct Basis for Issuance

— HH Size

Enter the correct household size for each overissuance month.

— Adjusted Income

Enter the correct net adjusted income for each overissuance month.

— Allotment

Enter the correct allotment the household should have received.

Issuance Verification

Use of this section to verify issuance of the benefits covered by the claim is a county option. If this section is not used for this purpose, verification of issuance must be documented in some other manner. For verification of ATP usage, the DFA 332.1, Verification of Food Stamp ATP Usage, may be used.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 842 (6/81)
(Instructions Revised 3/84)

Check the type of issuance (direct mail, ATP or HIR). Verify redemption of the ATP/HIR by noting the date of redemption, serial number or other appropriate information in the redemption column.

11a. Total

Enter the total food stamp allotment actually received by the household for the overissuance months.

11b. Total

Enter the total food stamp allotment which should have been correctly received by the household for the overissuance months.

12. Total Food Stamp Overissuance

Subtract correct total allotment (11b) from allotment actually received (11a) and enter the remainder.

13. Claim Offsetting Lost Benefits Not Restored

Complete this section only if the household is due lost benefits which have not been restored or payment against the claim has been received. Enter the date that the claim is offset by lost benefits or payments. Space is provided to record a second offsetting should this occur while the claim is still open. Any additional offsetting may be shown in the documentation section.

13A. Enter total food stamp overissuance from line 12.

13B. Enter any lost benefits not restored.

13C. Enter any payment received toward the claim.

13D. Subtract 13B and 13C from 13A and enter the remainder for the amount of the food stamp claim to be collected.

Signature Block

Enter Eligibility Worker's name and date.

Enter Eligibility Worker Supervisor's name and date of review.

The first page must be signed by the Eligibility Worker and Eligibility Worker Supervisor even if there is a continuation on the second page.

Review By County Review Officer

Use this section to enter the action to be taken to collect the claim, and if it is referred for intentional program violation investigation. This section may also be used to record information such as the dates of repayment notices and the amounts collected; if the claim was suspended, and the date and reason; the date the claim is considered uncollectible and the date collection action is terminated.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) 63-1230

DFA 842 (6/81)
(Instructions Revised 3/84)

14. Summary of Food Stamp Overissuance

Complete this section only for potential intentional program violation claims where overissuances occurred more than 12 months prior to the date of discovery.

Issuance Month/Year

Enter the month and year of all overissuances which occurred more than 12 months prior to the date of discovery. Use an additional sheet, if necessary.

Actual Basis for Issuance

— HH Size

Enter the household size used in the original benefit computation.

— Adjusted Income

Enter the net adjusted income from the original benefit computation.

— Bonus/Allotment

Enter the allotment actually received by the household for each overissuance month.

Correct Basis for Issuance

— HH Size

Enter the correct household size for each overissuance month.

— Adjusted Income

Enter the correct net adjusted income for each overissuance month.

— Bonus/Allotment

Enter the correct allotment the household should have received.

Issuance Verification

Use of this section to verify issuance of the benefits covered by the claim is a county option. If this section is not used for this purpose, verification of issuance must be documented in some other manner. For verification of ATP usage, the DFA 332.1, Verification of Food Stamp ATP Usage, may be used.

Check the type of issuance (direct mail, ATP or HIR). Verify redemption of the ATP/HIR by noting the date of redemption, serial number or other appropriate information in the redemption column.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

DFA 842 (6/81)
(Instructions Revised 3/84)

14a. Subtotal This Page

Enter the total food stamp allotment received by the household from this page.

14b. Subtotal First Page

Enter the total allotment received by the household from item 11a of the first page.

14c. Total Both Pages

Add 14a and 14b and enter total.

14d. Subtotal This Page

Enter total food stamp allotment which should have correctly been received by the household from this page.

14e. Subtotal First Page

Enter total allotment which should have correctly been received by the household from item 11b of the first page.

14f. Total Both Pages

Add 14d and 14e and enter total.

15. Total Food Stamp Overissuance

Subtract correct total food stamps (14f) from food stamps actually received (14c) and enter remainder.

16. Claim Offsetting Lost Benefits Not Restored

Complete this section only if the household is due lost benefits not restored or payment against the claim has been received and this offsetting was not done on the first page. Enter the date that the claim is offset by the lost benefits or payments. Space is provided to record a second offsetting should this occur while the claim is still open. Any additional offsetting may be shown in the documentation section.

16A. Enter total food stamp overissuance from line 15.

16B. Enter any lost benefits not restored.

16C. Enter any payment received toward the claim.

16D. Subtract 16B and 16C from 16A and enter the remainder for the amount of food stamp intentional program violation claim to be collected.

Signature Block

Enter Eligibility Worker's name and date.

Enter Eligibility Worker Supervisor's name and date of review.

Documentation

Use this section if additional space is required to document action taken on the claim or to document other information required by the county.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

NA 960X (1/84)

State of California
Health and Welfare Agency

Department of Social Services

Notice of Action

If you have questions or want more information about this action, please contact your worker.

Case Name :
Case Number :
Worker :
Phone :
Date of Notice :

We have not received your monthly report (CA 7) due this month.

Your ☐ Food Stamps ☐ Cash Aid will stop effective _____ . To stop this action, provide your complete CA 7 so that we receive it by the first working day of next month.

☐ If we get your complete CA 7 by _____ , we will send you your benefits on time.

☐ Even if you stop this action by getting your CA 7 in, your benefits will be up to 10 days late next month.

Penalty For Families With Earned Income (Cash Aid Only). Even if you stop this action by getting your CA 7 in, you will not get credit for your work expense disregards because you failed to report or verify all earned income on time. Work expense disregards are the standard work expense, dependent care expense, and the $30 and 1/3 earnings disregards. If you had a good reason for being late, this penalty will not be applied. You must tell your worker the reason.

Medi-Cal. If your Medi-Cal eligibility changes, we will tell you before we make the change.

Regulations. This action is required by the following State regulations which are available for your review at the County Welfare Department.
Manual of Policies and Procedures: 40-105.1, 40-181.22, 44-113.2 (Cash Aid); 63-504.27, 63-504.3 (Food Stamps).

Child Support. The District Attorney's Office can help you locate an absent parent, legally establish your child's paternity, and collect child support. To obtain or continue these services, you must ask the District Attorney's Office.

Family Planning Services. Information is available from the County Welfare Department on request.

State Hearing. If you are dissatisfied with this action, your benefits may continue unchanged if you ask for a State Hearing before the effective date of this action. Read the back for important information about your right to appeal this action.

NA 960X (1 84) CA 7 Not Received--Discontinuance

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

NA 960X (1/84)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10950.

NA Back 3 (Cash Aid/FS)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

NA 960X (1/84)
(Instructions Revised 4/13/84)

Form Instructions
(for the Eligibility Worker)

NOTICE OF ACTION (CA 7 NOT RECEIVED--DISCONTINUANCE)

Purpose:

The NA 960X is used by the Eligibility Worker to notify a recipient of the discontinuance of Food Stamps and/or Cash Aid because of a late CA 7.

The back of the NA 960X explains the household's right to request a state hearing and provides instructions on how to appeal the action. The back also provides information needed by the household to receive continued benefits pending a hearing if benefits are decreased or discontinued.

Preparation:

The NA 960X must be mailed or given to the recipient no later than ten days before the end of the current month.

Complete an original and two copies of the NA 960X entering the following identifying information:

- Recipient's name and mailing address
- Case Name
- Case Number
- Worker
- Phone Number
- Date of Notice

Check the appropriate box(es) for Food Stamps and/or Cash Aid and enter the effective date of the discontinuance.

Benefits On Time/Benefits 10 Days Late - DO NOT USE THESE BOXES. Either leave the check-boxes blank or cross out both statements.

Distribution:

The original and one copy are provided to the recipient. The second copy is filed in the case record.

63-1230 STATE FORMS & INSTRUCTIONS (Continued)

63-1230

NA 960Y (1/84)

State of California
Health and Welfare Agency

Department of Social Services

Notice of Action

If you have questions or want more information about this action, please contact your worker.

Case Name :
Case Number :
Worker :
Phone :
Date of Notice :

The monthly report (CA 7) you sent us this month is not complete.

Your ☐ Food Stamps ☐ Cash Aid will stop effective _____. To stop this action, provide your complete CA 7 so that we receive it by the first working day of next month. You must:

☐ Complete the circled items on the enclosed CA 7, and send or bring it to this office.

☐ Send or bring to this office the following information:

☐ If we get your complete CA 7 by _____, we will send you your benefits on time.

☐ Even if you stop this action by getting your CA 7 in, your benefits will be up to 10 days late next month.

☐ **Additional Information Requested** (Food Stamps Only). In addition to doing the above, you must give us the following information so that we can figure out the amount of your food stamps. You must get this information to us by the first working day of next month. If we ask for proof of an expense and you do not give it, the expense will not be allowed. Also, if you do not give other information we ask for, your food stamps may be decreased or stopped.

☐ **Penalty** (Cash Aid Only). Even if you stop this action by getting your CA 7 in, you will not get credit for your work expense disregards because you failed to report or verify all earned income on time. Work expense disregards are the standard work expense, dependent care expense, and the $30 and 1/3 earnings disregards. If you had a good reason for being late, this penalty will not be applied. You must tell your worker the reason.

Medi-Cal. If your Medi-Cal eligibility changes, we will tell you before we make the change.

Regulations. This action is required by the following State regulations which are available for your review at the County Welfare Department.
Manual of Policies and Procedures: 40-105.1, 40-181.22, 40-181.24, 44-113.2 (Cash Aid); 63-504.27, 63-504.3 (Food Stamps).

Child Support. The District Attorney's Office can help you locate an absent parent, legally establish your child's paternity, and collect child support. To obtain or continue these services, you must ask the District Attorney's Office.

Family Planning Services. Information is available from the County Welfare Department on request.

State Hearing. If you are dissatisfied with this action, your benefits may continue unchanged if you ask for a State Hearing before the effective date of this action. Read the back for important information about your right to appeal this action.

NA 960Y (1/84) CA 7 Incomplete--Discontinuance Reminder

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

NA 960Y (1/84)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip Code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10950.

NA Back 3 (Cash Aid/FS)

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

NA 960Y (1/84)
(Instructions Revised 4/6/84)

Form Instructions
(for the Eligibility Worker)

NOTICE OF ACTION (CA 7 INCOMPLETE--DISCONTINUANCE/REMINDER)

Purpose:

The NA 960Y is used by the Eligibility Worker to notify a recipient of the discontinuance of Food Stamps and/or Cash Aid because of a late CA 7. The NA 960Y is also used to request missing verification or additional information from a food stamp household when the CA 7 is also incomplete.

The back of the NA 960Y explains the household's right to request a state hearing and provides instructions on how to appeal the action. The back also provides information needed by the household to receive continued benefits pending a hearing if benefits are decreased or discontinued.

NOTE: When a CA 7 submitted by a food stamp household is complete, but is missing other verification/information, the DFA 377.4, Food Stamp Notice of Change, must be used instead of the NA 960Y.

Preparation:

The NA 960Y must be mailed or given to the recipient no later than ten days before the end of the current month.

Complete an original and two copies of the NA 960Y entering the following identifying information:

- Recipient's name and mailing address
- Case Name
- Case Number
- Worker
- Phone Number
- Date of Notice

Complete the discontinuance portion of the notice as follows:

Check the appropriate box(es) for Food Stamps and/or Cash Aid and enter the effective date of the discontinuance.

Check the appropriate box for the action the recipient must take to reverse the discontinuance. If applicable, specify in the space provided the information and/or verification which must be provided.

Benefits On Time/Benefits 10 Days Late - DO NOT USE THESE BOXES. Either leave the check boxes blank or cross out both statements.

Additional Information Requested (Food Stamps Only). Check this box when an incomplete CA 7 is missing verification/information of a deduction and/or contains questionable information for the Food Stamp Program. Specify in the space provided the additional verification and/or information which is required.

63-1230 STATE FORMS & INSTRUCTIONS (Continued) **63-1230**

NA 960Y (1/84)
(Instructions Revised 4/6/84)

Food Stamp benefits may not be reduced, suspended, or terminated based on this reminder notice if the household submits a complete CA 7 but fails to provide all other requested verification/ information. A timely notice of adverse action must be provided to the household before the adverse action is taken. (See the special instructions in the All-County Letter transmitting this material.)

Penalty (Cash Aid Only). Check this box if the Cash Aid recipient is normally entitled to the earned income disregards.

Distribution:

The original and one copy are provided to the recipient. The second copy is filed in the case record.

63-1250 FORM MODIFICATION POLICY 63-1250

.1 Overview

The Food Stamp Program Management Branch (FSPMB) goal for the food stamp forms program is to increase program effectiveness, efficiency and equity. One of the means to achieve this goal is to provide statewide guidelines for form usage by designating all forms as: 1) Required - No Substitutes, 2) Required - Substitutes Permitted, or 3) Recommended, in accordance with the FSPMB criteria for designating forms (see Appendix 1).

The FSPMB form modification policy provides the flexibility to meet individual county needs, while ensuring that the program's goals are met. Where county modification of a state form is required to meet or enhance program goals and the related justification has not been specifically provided for in this policy, the county should submit the request for FSPMB consideration.

The review of any county modification request is separated into two levels: 1) the overall justification for not using the state form, and 2) adherence to specific standards for any variations from the state form. The evaluation criteria for each level of review are determined by the designation of the state form being modified and the form's preparation and interface (manual or computer). For each designated form, specific modification criteria is provided (Appendix 3) indicating where variations will not be considered for each of the form's components; i.e., placement, language and data elements.

.2 Required Form — No Substitutes

.A Overall justification for not using the state form.

Acceptable justification includes:

- Form is computer-generated (EDP only).
- County has state hearing intake at the local level (EDP and Manual).
- County has different contact point than is specified on the state form (EDP and Manual).
- County has high frequency payment system (EDP only).

All other justifications are unacceptable.

.B Variation Standards

Variations in placement and data elements, where allowable, will be evaluated against the following standards after the overall justification is accepted.

All variations in placement and data elements must:

- Be clear.

63-1250 FORM MODIFICATION POLICY (Continued) **63-1250**

- Contain all required data elements on the state form within the system (for example, computer-generated notices of action may print out only applicable message(s), but all messages must be contained within the computer program).

Variations in language will be permitted only as described below, and will be evaluated against the following standards.

All language variations must:

- Be clear.
- Use common program language.
- Be required by the special county circumstance which provides the overall justification for modification (for example, state hearing intake at the local level, high frequency payment system), or
- Be required to present a logical explanation to the client by interfacing with additional information provided by the county (for example, inclusion of the budget computation on a Notice of Action).

.3 **Required Form — Substitutes Permitted**

.A Overall justification for not using the state form.

Acceptable justification includes:

- Function of the form is computerized, such as Budget Worksheet (EDP only).

In addition to the above justification, counties with the above EDP justification must provide one or more of the following types of justification for any variances from the state form. Manual counties must provide one of the following as overall justification for not using the state form:

- Form is not computerized, but EDP interface requires modification (EDP and Manual).
- County has state hearing intake at the local level (EDP and Manual).
- County has high frequency payment system (EDP and Manual).
- Additional county-specific information is required for processing, gathering data, etc., (EDP and Manual).
- The addition of information will eliminate other forms (EDP and Manual).
- Modification will contribute to county-specific error reduction (EDP and Manual).
- Modification will result in cost savings (EDP and Manual).

63-1250 FORM MODIFICATION POLICY (Continued) **63-1250**

- Modification is required by county's organizational structure (EDP and Manual).
- Modification will contribute to increased efficiency (EDP and Manual).

Examples of unacceptable justification include:

- County wishes to vary placement, language or data elements (EDP and Manual).
- Internal procedures/instructions would have to be revised (EDP and Manual).
- County has own form for purpose of state form (EDP and Manual).

.B Variation Standards

Variation in placement, language and data elements, where allowable, will be evaluated against the following standards after the overall justification has been accepted.

All variations must:

- Be clear.
- Be in accord with regulatory requirements.
- Ensure consistent treatment of recipients from county to county.
- Use common program language (such as "gross income", "standard deduction", "excess shelter costs", etc.).
- Provide adequate audit trail and documentation.
- Be in an order that achieves an accurate computation or a logical explanation to clients.
- Not have the potential to create errors.
- Provide adequate space for documentation/computation where necessary.
- Contain all data elements on the state form unless they are contained elsewhere in the case file, are deleted due to a combination, or are unnecessary for the specific county (explanation from county is required).
- Reflect the intent of the state form.

.4 Recommended Form, No State Form, State Form Not Yet Designated

.A Overall justification.

No justification is required for forms in these categories.

63-1250 FORM MODIFICATION POLICY (Continued) **63-1250**

.B Forms will be evaluated against the following standards.

All forms must:

- Be clear.
- Be in accord with applicable regulatory requirements.
- Ensure consistent treatment of recipients from county to county.
- Use common program language.
- Be in an order that presents a logical explanation to clients.
- Not have the potential to create errors.

.5 **Exemptions from Form Modification Policy**

.A Manual Section 63-300.2 specifies that overprinting of required forms for the following purposes is acceptable and does not require prior state approval:

- To identify CWD.
- To add information to the "County Use Only" section.
- To add EW instructions.

.B Local printing of forms on regular, colored or larger paper does not require prior state approval as long as camera-ready copies provided by the state are used and no modifications are made beyond those listed in (1) above.

.C Internal county forms which do not involve the determination or notification of eligibility or benefit level, or the notification of client rights and responsibilities need not be submitted for review.

.6 **Extensions of Time to Implement**

Implementation schedules for state forms generally provide adequate lead time for counties to achieve timely implementation. In those cases where timely implementation is not possible, counties must request an extension of time to comply providing any supporting justification and an estimate of the additional time required to achieve implementation.

Examples of acceptable justification include:

- Time required to reprogram EDP system.
- Time required to print forms locally when a modification is approved.
- Time required to revise procedures and train staff.

63-1250 FORM MODIFICATION POLICY (Continued) **63-1250**

.7 **County Modification Requests**

Requests will be considered on a county-by-county basis, except for case data counties which will be considered as one system. Counties within the case data system which require modifications from the approved system will be considered separately.

Any request for modification must contain the following:

.A Overall justification for the modification as described under acceptable justification.

.B An explanation of deletions or combinations of data elements. Any additional information which would assist in evaluating the variations should be provided.

.C A copy of the modified form.

NOTE: All counties using computerized forms must submit modification requests after either making the necessary programming changes to comply with the state form or determining that variations are required. All applicable messages must be submitted for approval as well as a sample computer-generated form showing the format which will be used. Only the portion of each message which relates to the language on the state form must be reviewed. Computerized explanations which would be entered in blank spaces if the state form were used are not subject to review or standardization unless the county requests such a review.

County modification requests should be sent to the Food Stamp Program Corrective Action Bureau. Requests will be reviewed by the FSPMB and counties will be notified of the results of the review within 30 days of receipt of the request.

63-1251 FORM MODIFICATION POLICY — APPENDICES 63-1251

.1 Appendix I — Form Designations

Required Form-No Substitutes

Forms assigned to this category meet one or more of the following criteria:

1) The specific form or its function is required by regulation or law.
2) The state form is a modification of an FNS-required form.
3) Uniformity is necessary in gathering or reporting data.
4) The form is used to communicate regulatory information to clients.
5) The form involves the determination, documentation or notification of client eligibility.

Forms typically assigned to this category include applications, most notices of action, state or federal reports.

Required Form-Substitutes Permitted

Forms assigned to this category meet: (1) one or more of the criteria for a Required Form-No Substitutes; and (2) one or more of the following criteria:

1) The specific form or its function is required by regulation or law, but the form contains optional items.
2) Some county organizational structures are not compatible with the state form as designed.
3) The potential of operational incompatibility with some counties' systems is identified during the development/revision process.

Forms typically assigned to this category include worksheets, some notices of action and issuance-related forms.

Recommended Forms

Forms assigned to this category meet one or more of the following criteria:

1) The form does not involve the determination, documentation or notification of client eligibility.
2) The form or its content is not required by regulation or law.

Forms assigned to this category will not generally be developed and printed by the FSPMB.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) 63-1251

.2 Appendix 2 — Definitions

Data Element - Each independent unit of information is considered a data element for purposes of identifying form-specific modification criteria. In some cases a data element is a single word, such as "date", and in other cases a data element is a complete message, such as, "If you have any questions, please contact me".

Form Designation - Required Form-No Substitutes, Required Form-Substitutes Permitted, and Recommended Form are the three form designations used under this policy.

Form Modification - Except as provided under "Exemptions from Modification Policy", any designated form used by a county which has been altered in any way or which has not been obtained from state-printed stocks is considered a form modification. This includes, but is not limited to, computer-generated forms and county-printed forms where either a state-provided camera-ready copy was not used or the camera-ready copy was altered.

Form-Specific Modification Criteria - For each designated form, variations in placement, language and data elements which will not be considered are identified under form-specific modification criteria. The development of these criteria is based upon the reasons for assigning a form its designation.

Internal County Form - A form required for internal county use which does not involve the determination or notification of eligibility or benefit level, or the notification of client rights and responsibilities is considered an internal county form and is not subject to review under this policy. Some examples of internal county forms are route slips, some verification forms, and case narratives.

Justification - The overriding county-specific situation presented as the reason for modifying a state-required form is a justification. Acceptable justifications for each category of form designation are provided in this policy.

Language - The specific wording used on a form is considered language for purposes of identifying form-specific modification criteria.

Placement - The order of data elements as they appear on a form is considered placement for purposes of identifying form-specific modification criteria.

Recommended Form - Forms assigned this designation are optional county forms. Should a county elect to modify a recommended form, the modification must be reviewed by the FSPMB to ensure that the modifications meet the variation standards for a Recommended Form.

Required Form — No Substitutes - Forms assigned this designation must be implemented by all counties unless a modification request, based on acceptable justification for a form with this designation, is approved by the FSPMB.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) 63-1251

Required Form — Substitutes Permitted - Forms assigned this designation must be implemented by all counties unless a modification request, based on acceptable justification for a form with this designation, is approved by the FSPMB.

Variation Standards - Where acceptable justification is provided and where modification is permitted, variation standards are the guidelines used to review specific modifications to ensure that program goals are met.

Variations - Any deviations from the placement, language or data elements on the state form are considered variations. Allowable variations, when overall form modification is justified, are identified for each designated form.

.3 Appendix 3 — Form-Specific Modification Criteria

For each designated form, the specific modification criteria define the portions of a given form which may not be modified regardless of the justification. These criteria are based upon the regulatory and administrative needs for the form as well as the reasons the form was assigned its designation.

The criteria are also based upon the preparation or interface of the form; i.e., computer or manual. For those forms or form functions that may be computerized, the criteria is identified as EDP only, Manual only, or EDP and Manual. These criteria address only **changes** to the placement, and **changes or deletion** of the language and data elements on the state form.

The addition of data elements is permitted when acceptable justification for modifying a state form is provided, and those additions are evaluated against the variation standards outlined for the designation of the state form.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

Monthly Eligibility Report CA 7 (2/84)

Required Form - No Substitutes Permitted

Placement - No modification permitted except those required to accommodate a different method of addressing the form (Manual only).

- No modification permitted except (1) those related to EDP requirements; and (2) those required to accommodate a different method of addressing the form (EDP only).

Language - No modification permitted (EDP and Manual).

Data Elements - No modification permitted (EDP and Manual).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

CA 8 (2/84)

Statement Of Facts For Additional Persons
(Supplemental Application for Food Stamps and Request for Cash Aid)

Required Form - No Substitutes Permitted

Placement - No modification permitted.

Language - No modification permitted.

Data Elements - No modification permitted.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 Appendix 3 - Form-Specific Modification Criteria (Continued)

Application For Food Stamps - Part 1 DFA 285-A1 (11/83)

Required Form - No Substitutes Permitted

Placement - No modification permitted.

Language - No modification permitted.

Data Elements - No modification permitted.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 Appendix 3 - Form-Specific Modification Criteria (Continued)

DFA 285-B (12/83)

Food Stamp Budget Worksheet

Required Form - Substitutes Permitted

Placement - The order of the sections in Parts 1, 2 and 3 may not be modified though the data entry elements within Sections A, B, C, E, F and J may be modified as long as the result of the computation is correct (Manual only).

- The order of the sections in Parts 1, 2 and 3 and their data entry elements may be modified due to EDP requirements as long as the result of the computation is correct (EDP only).

Language - Regulatory language in Parts 1, 2 and 3 may not be modified although additions will be considered (EDP and Manual).

Data Elements - The following data elements may not be deleted from the form: case name, case number, classification, all data elements in Parts 1, 2, and 3, first-month budget column, documentation column, EW initials and date, and all data elements in Sections M and N of Part 5 (Manual only).

- The following data elements may not be deleted from the system; case name, case number, and all data elements in Parts 1, 2, 3 and 5 (EDP only).

- All other data elements may be modified if documented elsewhere in the case record/system (EDP and Manual).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 285-C (11/83)

Supplemental Application For Food Stamps — Special Medical Deductions

Required Form - No Substitutes Permitted

Placement - No modification permitted.

Language - No modification permitted.

Data Elements - No modification permitted.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 285-D (12/83)

Food Stamp Budget Worksheet — Special Medical/Shelter Deductions

Required Form - Substitutes Permitted

Placement - The order of the sections in Parts 1, 2 and 3 may not be modified though the data entry elements within the sections may be modified as long as the result of the computation is correct (Manual only).

- The order of the sections in Parts 1, 2 and 3 and their data entry elements may be modified due to EDP requirements as long as the result of the computation is correct (EDP only).

Language - Regulatory language in Parts 1, 2 and 3 may not be modified although additions will be considered (EDP and Manual).

Data Elements - The following data elements may not be deleted from the form: case name, case number, classifications, all data elements in Parts 1, 2 and 3, first-month budget column, documentation column, EW initials and date, and all data elements in Sections K and L of Part 5 (Manual only).

- The following data elements may not be deleted from the system; case name, case number, and all data elements in Parts 1, 2, and 5 (EDP only)

- All other data elements may be modified if documented elsewhere in the case record/system (EDP and Manual).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 287 (4/80)

Food Stamp Program Identification Card

Required Form - Substitutes Permitted

Placement - Modification permitted to accommodate data element revisions (EDP and Manual).

Language - No modification permitted to regulatory language; i.e., head of household, authorized representative (EDP and Manual).

Data Elements - No modification permitted except (1) serial numbers and photos may be added; and, (2) data elements for signature of emergency authorized representative, number of persons in household, and household eligible for delivered meals may be deleted (EDP and Manual).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 303 (1/83)

Replacement Affidavit/Authorization

Required Form - Substitutes Permitted

Placement - No modification permitted.

Language - No modification permitted except that non-ATP counties may delete all language concerning ATPs.

Data Elements - No modification permitted except that non-ATP counties may delete all data elements concerning ATPs.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) 63-1251

.3 Appendix 3 — Form-Specific Modification Criteria (Continued)

DFA 377.1 (12/83)

Food Stamp Notice of Action

Required Form - No Substitutes Permitted

Placement - No modification permitted (Manual only).

- No modification permitted except those related to EDP requirements (EDP only).

Language - No modification permitted except that on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (Manual only).

- No modification permitted except (1) on the back, the address for submitting a hearing may be modified in counties with state hearing intake at the local level; (2) references to "month" may be modified to accommodate a high frequency payment system; and (3) message endings may be modified to accommodate the inclusion of a budget computation (EDP only).

Data Elements - No modification permitted except that each section (Approval, Denial, Pending) may be printed as its own form (Manual only).

- No modification permitted except that all data elements need not appear on one form; i.e., computer prints out only applicable message(s), but all messages are contained in the computer program (EDP only).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 377.2 (12/83)

Food Stamp Notice of Expiration of Certification

Required Form - No Substitutes Permitted

Placement - No modification permitted (Manual only).

- No modification permitted except those related to EDP requirements (EDP only).

Language - No modification permitted except on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (EDP and Manual).

Data Elements - No modification permitted except that any option in Message 3 not provided by the county may be deleted.

- No modification permitted except (1) any option in Message 3 not provided by the county may be deleted; and, (2) all data elements need not appear on one form; i.e., computer prints out only applicable message(s), but all messages are contained in the computer program (EDP only).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) 63-1251

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

(DFA 377.3 (9/80) Repealed by Manual Letter No. 84-13, 2/15/84)

DFA 377.4 (12/83)
(Criteria revised 4/6/84)

Food Stamp Notice Of Change

Required Form - No Substitutes

Placement* - No modification permitted (Manual only).

- No modification permitted except those related to EDP requirements (EDP only).

Language* - No modification permitted except that on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (Manual only).

- No modification permitted except (1) the wording in the Change, Suspension or Termination section may be modified to accommodate the inclusion of a budget computation, and (2) on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (EDP only).

Data Elements - No modification permitted except that each section (Change, Suspension, Termination and Proposed Change) may be printed as its own form. (Manual only).

- No modification permitted except that all data elements need not appear on one form; i.e., computer prints out only applicable message(s), but all messages are contained in the computer program (EDP only).

* The additional explanations provided with All-County Letter 84-47 dated April 19, 1984 must be used without modification in accordance with the instructions contained in the letter.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 377.5 (12/83)

Food Stamp Household Change Report

Required Form - No Substitutes Permitted

Placement - No modification permitted.

Language - No modification permitted.

Data Elements - No modification permitted.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

(DFA 377.3 (9/80) Repealed by Manual Letter No. 84-13, 2/15/84)

(DFA 377.6 (2/79) repealed by Manual Letter 84-13, 2/15/84)

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 377.7A (3/84)

Food Stamp Notice of Administrative Disqualification

Required Form - No Substitutes Permitted

Placement - No modification permitted (Manual only).

- No modification permitted except those related to EDP requirements (EDP only).

Language - No modification permitted except, on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (EDP and Manual).

Data Elements - No modification permitted

- No modification permitted except that all data elements need not appear on one form; i.e., computer prints out only applicable message(s), but all messages are contained in the computer program (EDP only).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 377.7B (3/84)

Food Stamp Repayment Notice

Required Form - No Substitutes Permitted

Placement - No modification permitted (Manual only).

- No modification permitted except those related to EDP requirements (EDP only).

Language - No modification permitted except, on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (EDP and Manual).

Data Elements - No modification permitted (Manual only).

- No modification permitted except that all data elements need not appear on one form; i.e., computer prints out only applicable message(s), but all messages are contained in the computer program (EDP only).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

DFA 377.7C (3/84)

Food Stamp Repayment Agreement

Required Form - No Substitutes Permitted

Placement - No modification permitted.

Language - No modification permitted.

Data Elements - No modification permitted.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) 63-1251

.3 Appendix 3 — Form-Specific Modification Criteria (Continued)

DFA 377.9 (3/81)

Notice of Restoration of Lost Food Stamp Benefits and Right to Request a State Hearing

Required Form - Substitutes Permitted

Placement - No modification permitted (Manual only).

- No modification permitted except those related to EDP requirements (EDP only).

Language - No modification permitted except (1) to accommodate county procedures for handling restorations; i.e., contact for questions or requests for installments; (2) on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level; and, (3) the reference on the back to 10 days to request aid paid pending may be modified to meet the requirements of **Ortiz** vs. **Woods** and **Harley** vs. **Woods** (Manual only).

- No modification permitted except (1) to accommodate county procedures for handling restorations; i.e., contact for questions or requests for installments; (2) on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level; (3) wording may be modified to accommodate a high frequency payment system; and, (4) the reference on the back to 10 days to request aid paid pending may be modified to meet the requirements of **Ortiz** vs. **Woods** and **Harley** vs. **Woods** (EDP only).

Data Elements - No modification permitted except to accommodate county procedures for handling restorations (Manual only).

- No modification permitted except (1) to accommodate county procedures for handling restorations; and, (2) all data elements need not be on one form; i.e., computer prints out only applicable message(s) but all messages are contained in computer program (EDP only).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

(DFA 386 (8/80) Repealed by Manual Letter No. 84-13, 2/15/84)

DFA 842 (6/81)

Claim Determination Worksheet

Required Form - Substitutes Permitted

Placement - Modification permitted to accommodate data element revisions.

Language - Modification permitted.

Data Elements - The following data elements may not be deleted from the form: Items 1, 2, 3, 8, 9, 10, 12, 13, 15, 16, all signatures, and Review by County Review Officer section. Items 11 and 14 may not be deleted except for Issuance Verification section as long as verification of issuance is documented elsewhere.

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

NA 960X (1/84)
(Criteria Revised 1/30/84)

Notice of Action (CA 7 Not Received—Discontinuance)

Required Form - No Substitutes Permitted.

Placement - No modification permitted (Manual only).

- No modification permitted except those related to EDP requirements (EDP only).

Language - No modification permitted except that on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (EDP and Manual only).

Data Elements - No modification permitted except that the two data elements concerning the timing of benefits (late or on time) may be deleted.

- No modification permitted except that (1) the two data elements concerning the timing of benefits (late or on time) may be deleted; and (2) all other data elements need not appear on one form; i.e., computer prints out only applicable message(s), but all messages are contained in the computer program (EDP only).

63-1251 FORM MODIFICATION POLICY — APPENDICES (Continued) **63-1251**

.3 **Appendix 3 — Form-Specific Modification Criteria** (Continued)

NA 960Y (1/84)
(Criteria Revised 4/6/84)

Notice of Action (CA 7 Incomplete — Discontinuance/Reminder)

Required Form - No Substitutes Permitted

Placement - No modification permitted (Manual only)

- No modification permitted except those related to EDP requirements (EDP only).

Language - No modification permitted except that on the back, the address for submitting a hearing request may be modified in counties with state hearing intake at the local level (EDP and Manual only).

Data Elements - No modification permitted except that the two data elements concerning the timing of benefits (late or on time) may be deleted. (Manual only.)

- No modification permitted except that (1) the two data elements concerning the timing of benefits (late or on time) may be deleted; and (2) all other data elements need not appear on one form; i.e., computer prints out only applicable message(s) but all messages are contained in the computer program (EDP only).