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CHAPTER 25-600 FORMS

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25-600 MANDATORY AND RECOMMENDED FORMS USED IN OR AFFECTING FISCAL FUNCTIONS 25-600

The following SDSS forms are mandatory, except for those marked * which are recommended only. If mandatory forms are not suitable to special mechanical equipment of a county, forms designed by the county, adapted to such mechanical use, may be used in lieu thereof upon prior written approval of SDSS. Such forms, to be approved, must accomplish the purposes and provide all of the data required on mandatory forms.

Wherever possible in each of the following nine (9) categories of forms, parenthetical reference is made in the category title to that chapter in Division 25 of the Manual of Policies and Procedures which contains general information relating to the area of activity of the forms in that category.

FORM NUMBER

I. AUTHORIZATION AND AUTHORIZATION CONTROL (see Chapter 25-200)

ABCD 278L	List of Authorizations to Start, Change or Stop Aid Payments
ABCD 278M	Authorizations to Start, Change or Stop Aid Payments
*ABCD 821	Batch Voucher of Individual County Authorizations
*ABCD 822	Register of County Authorizations

II. AID CLAIMS (see Chapter 25-700)

A. Monthly Claims

ABCD 801	Aid Payroll (Contra Roll)
ABCD 820	Reconciliation Statement, County Authorizations to Auditor's Payments
AD 800A	Summary Report of Assistance Expenditures - Adoption Assistance Program/Federal
AD 800B	Summary Report of Assistance Expenditures - Adoption Assistance Program/Nonfederal (includes Aid for the Adoption of Children-AAC)
CA 800	Summary Report of Assistance Expenditures - Aid to Families with Dependent Children
CA 800 FC (FED)	Summary Report of Assistance Expenditures - Federal Children in Foster Care
* CA 800 FC.1 (FED)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from Federal Funds
* CA 800 FC.2 (FED)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from State Funds
CA 800A FC (NONFED)	Summary Report of Assistance Expenditures - Nonfederal Children in Foster Care
DFA 843	Federal Funds Claimable Based on the Expenditures for Refugee Resettlement, Cuban Program Phasedown and Cuban/Haitian Entrant Recipients in Receipt of Nonfederal AFDC-FC
DFA 844 RDP	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Demonstration Project Recipients (RDP)
DFA 847	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement, Cuban Program Phasedown and Cuban/Haitian Entrant Recipients in Receipt of Federal AFDC-FC
DFA 859	Federal Funds Claimable Based on Expenditures for Time Eligible Refugees and Entrants in Receipt of General Assistance
DFA 863	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement and Cuban/Haitian Entrant Recipients in Receipt of Emergency Assistance - Unemployed Parent

25-600 MANDATORY AND RECOMMENDED FORMS USED IN OR AFFECTING FISCAL FUNCTIONS (Continued) 25-600

SC 800	Summary Report of Special Circumstances
SOC 800	Summary Report of Assistance Expenditures Emergency Assistance - Foster Care
SOC 801	Summary Report of Assistance Expenditures Emergency Assistance - Unemployed Parent

B. Quarterly Claims

AD 800	Certification - Adoption Cost of Care Subvention Under W&IC 16106
AD 801A	Adoption Cost of Care Claim (W&I Code Section 16106)
DFA 837	Summary Report of Assistance Expenditures Old Age Security, Aid to the Blind, and Aid to the Disabled
EL 800	Summary Report of Uncollected Loans (For Claiming Against the Emergency Revolving Fund)

C. (Deleted by Manual Letter No. FMC-86-04, effective 7/1/86.)

D. (Deleted by Manual Letter No. FMC-86-04, effective 7/1/86.)

III. CLAIMS FOR ADMINISTRATIVE EXPENDITURES (see Chapter 25-800)

As the County Welfare Department Administrative Expense Claim is frequently modified due to program changes during the fiscal year, many of the individual form numbers and names are not identified below. The forms listed below are not displayed in Section 25-605 since they are subject to revision each quarter. Updates and current form numbers for the Administrative Expense Claim will be transmitted to the counties on a current basis via All-County Letter.

The Administrative Expense Claim is composed of the following form categories:

DFA 43	Eligibility and Nonservice Time Study
DFA 46	Social Services Time Study
DFA 47	Social Services Time Study Summary and Program Allocations
DFA 48	Electronic Data Processing Time Study (all other)
DFA 48A	Electronic Data Processing Time Study (statewide systems)
DFA 50	Staff Development Time Study
DFA 52	Employment Services Time Study
DFA 53	Employment Services Time Study Summary and Program Allocations
DFA 323	Eligibility and Nonservices Time Study Summary and Program Allocations
DFA 325.1	Expenditures Schedule and Certification
DFA 325.1A	Electronic Data Processing Schedule (all other)
DFA 325.1AA	Electronic Data Processing Schedule (statewide systems)
DFA 325.1B	Direct Cost Schedule
DFA 327.1-.11	Expenditures Distribution and Funding Pages
DFA 403	Reconciliation of Time Studies to Allocable Salary Pools
DFA 419	Claim Summary Sheet
DFA 856	Welfare Fraud Time Study

25-600 MANDATORY AND RECOMMENDED FORMS USED IN OR AFFECTING FISCAL FUNCTIONS (Continued) **25-600**

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (see Section 25-950)

CS 355	DA Employee's Child Support Time Study for IV-D Functions
CS 356.1	IV-D Child Support Expenditure Schedule and Certification (front)
CS 356.2	IV-D Child Support Expenditure Schedule and Certification (back)
CS 356.3	IV-D Child Support Time Summary and Activity Allocation Ratios
CS 356.4	IV-D Child Support Program Distribution, Total Allocable Costs
CS 356.5	IV-D Child Support Program Distribution, Direct Costs
CS 356.6	IV-D Child Support Program Distribution, Total Allocable and Direct Costs
CS 356.7	IV-D Child Support Program Distribution Report of Total Expenditures
CS 356.8	IV-D Child Support Program - Personal Services
CS 357	Group A Individual Employee Worksheet, Local IV-D Agency - Direct Costs

VI. CHILD SUPPORT SPACE COST CLAIM REQUEST FORMS (Obsolete. Deleted by Manual Letter No. FMC-88-02, effective 9/1/88.)

VII. CHILD SUPPORT INCENTIVE CLAIMS (see Chapter 25-900)

CS 278L	Child and Spousal Support Case History and List of Authorizations
CS 278M	Child and Spousal Support Transmittal/Action Document
CS 800	Summary Report of Child and Spousal Support Payments
CS 801	Child and Spousal Support Payroll Form for Collections and Disbursement
CS 801A	Summary CS 800 Reconciliation - Intracounty/Interstate
CS 801B	Intercounty Summary CS 800 Reconciliation
CS 820	Child/Spousal Support Collections Summary Report
CS 821	Support Collection Report
CS 822	Summary CS 820 Reconciliation Statement
CS 831	Collection Agency - Accounts Receivable

VIII. OVERPAYMENT AND REPAYMENT RECEIVABLE RECORDS (see Chapter 25-400)

*ABCD 830	Overpayment Receivable Record
ABCD 831	Repayment Receivable Record

IX. MISCELLANEOUS FORMS

GEN 215	Claim for Reimbursement - Local Agency Special Project (see Chapter 25-800)
*Suggested Form H	Substitute Payee Certification
GEN 127	Notice of Form Change

25-601 FORMS SUPPLY 25-601

Forms developed for operation of the welfare programs will be printed by SDSS and made available to the county welfare departments and other agencies requiring their use.

SDSS will keep users informed of new and revised forms, where to order a supply, whether the form is free or sold, whether an initial supply is being sent and whether old issues of a revised form may be used.

SDSS will make available semiannually the County Forms Catalogue, listing free and sold forms available through the SDSS Warehouse.

25-602 RETENTION SCHEDULES 25-602

State forms listed in Chapter 25-600 and their supporting records must be retained by the county as required by 23-353 unless notification has been received from SDSS that there are unresolved audit issues or that records must be retained for other needs of the department. The exceptions are:

1. ABCD 830 original shall be retained in the case record.

2. All DFA 117 forms shall be retained for the minimum period after disposal of the property.

This retention schedule is for fiscal purposes of SDSS and does not authorize the county to destroy any of these records which have a longer retention period required by other laws or regulations.

25-605 FORMS 25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (see Chapter 25-200)

ABCD 278L

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

LIST OF AUTHORIZATIONS TO START, CHANGE, OR STOP AID PAYMENTS

CASE NUMBER

CASE NAME | COUNTY | DISTRICT

PAYEE NAME AND ADDRESS (1)

PAYEE NAME AND ADDRESS (2)

I certify that the Statement of Facts Supporting Eligibility for Assistance is on file or that the facts have been verified by investigation; that the supporting evidence is open to inspection in the Department by duly authorized state and federal representatives; and that, to the best of my knowledge and belief, the action and amount specified are correct under existing law.

EFFECTIVE DATE	FED PERS COUNT		E	NONFED PERS COUNT		CONTINUING GRANT AMOUNT	SUPPLEMENTAL PAYROLL		TYPE OF ACTION REASON FOR CHANGE	APPROVED (INITIAL AND DATE)		AUTHORIZED BY DATE
	A	CH	P	A	CH		SUPPLEMENTAL AMOUNT	TOTAL AMOUNT		WORKER	SUPR.	

ABCD 278L (11/78) A=ADULT(S) CH=CHILD(REN) EP=ESSENTIAL PERSON(S) 71-8971-4850 50 M – OSP

25-605 FORMS (Continued) 25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

Reverse of ABCD 278L

NAME	BIRTHDATE	APPLICATION DATE	RESTORATION SIGNED	REMARKS
ELIGIBLE RELATIVE				
ELIGIBLE RELATIVE				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
ESSENTIAL PERSON				
ESSENTIAL PERSON				
ESSENTIAL PERSON				

DATE	REPAYMENT AMOUNT	ABATEMENTS		REMARKS
		AMOUNT	MONTH APPLICABLE	

25-605 FORMS (Continued) 25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

ABCD 278M and Reverse

NAME, ADDRESS, CASE NO., PERSONS COUNT, CURRENT AUTHORIZATION

☐ AFDC ☐ BHI ☐ AAC ☐ APSB ☐ ____
☐ ____ ☐ SC ☐ EL ☐ CR ☐ IRAP

I certify that the Statement of Facts Supporting Eligibility for Assistance is on file or that the facts have been verified by investigation; that the supporting evidence is open to inspection in the Department by duly authorized state and federal representatives; and that, to the best of my knowledge and belief, the action and amount specified are correct under existing law.

AUTHORIZED BY THE COUNTY OF

AUTHORIZED SIGNATURE DATE

CHANGE PAYEE TO:
NAME
STREET ADDRESS
CITY

CHANGE CONTINUING GRANT

EFFECT DATE	FED PERSONS COUNT A	FED PERSONS COUNT CH	EP	NONFED PERSONS COUNT A	NONFED PERSONS COUNT CH	CONTINUING GRANT AMOUNT	FIRST WARRANT AMOUNT	SECOND WARRANT AMOUNT	EXCESS OF STATE BASE	TYPE OF ACTION: REASON FOR CHANGE	CODE

ISSUE SUPPLEMENTAL WARRANT

EFFECT DATE	FED PERSONS COUNT A	FED PERSONS COUNT CH	EP	NONFED PERSONS COUNT A	NONFED PERSONS COUNT CH	TOTAL GRANT	PRIOR GRANT	WARRANT AMOUNT	EXCESS OF STATE BASE	TYPE OF ACTION: REASON FOR CHANGE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY

AUTHORIZATIONS TO START, CHANGE, OR STOP AID PAYMENTS

DEPARTMENT OF SOCIAL SERVICES

ABCD 278M (7-83)

ABBREVIATION KEY

A — Adult(s)
CH — Child(ren)
EP — Essential Person(s)
AFDC — Aid to Families with Dependent Children
BHI — Boarding Homes and Institutions
AAC — Aid to the Adoption of Children
SC — Special Circumstances
EL — Emergency Loans
CR — Cuban Refugee
IRAP — Indo-Chinese Refugee Assistance Program

25-605 FORMS (Continued) 25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

ABCD 821

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

BATCH VOUCHER

OF INDIVIDUAL COUNTY AUTHORIZATIONS

PROGRAM _____ COUNTY ACTION DATE _____ BATCH VOUCHER NO. _____, 19 ____

To be filed in county available for audit.
Key:
A – Adult(s) EP – Essential Persons
CH – Child(ren)

MONTH OF CLAIM ( ) (

		Change Authorization Continuing Grant Future Month				Authorizations Affecting Current and Prior Months									
						Current Month				Prior Months					
Case Number	Effective Date	From	Persons Count	To	Persons Count	Issue Warrant	Persons Count	Cancel Warrant	Persons Count	Issue Warrant	Persons Count	Cancel Warrant	Persons Count
(1)	(2)	(3)	A CH EP	(4)	A CH EP	(5)	A CH EP	(6)	A CH EP	(7)	A CH EP	(8)	A CH EP

ABCD 821 (9/79)

25-605 FORMS (Continued) 25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

Reverse of ABCD 821

INSTRUCTIONS

Form ABCD 821

Month of Claim. In space above "Future Month" section, show month following month of "County Action Date." In space above "Authorizations Affecting Current and Prior Months" section, show same month as "County Action Date."

Exception: If "County Action Date" falls between master payroll cut-off date and end of month show next subsequent month over "Future Month" section.

Example: County Action Date June 29. Master Payroll cut-off date June 27. In "Future Month" section show "August" as month of claim. In Current and Prior Month section:

(a) Show June if warrant is to be written in June, or
(b) Show July if warrant is to be written in July.

Column 1. Post case number from Form 278-M.

Column 2. Post "Effective Date" for future month from entry in "Change Continuing Grant" line of Form 278-M; for current and prior month from appropriate line in " Issue Supplemental Warrant" section.

Column 3. Post prior grant amount as shown in preprint section of Form 278-M.

Column 4. Post new continuing grant amount.

Column 5. Post amount of supplemental authorization for current month shown in "Warrant Amount" column of Form 278-M.

Column 6. Post amount of warrant for current month, or for prior month *issued in current month,* authorized to be canceled. (Shown in parenthesis in "Prior Grant" column of Form 278-M and/or in "Type of Action, Reason for Change.")

Column 7. Post amount of supplemental authorization for prior month shown in "Warrant Amount" column.

Column 8. Post amount of warrant for prior month *issued in prior month* authorized to be canceled.

Posting to "Register of County Authorizations" ABCD 822. Authorizations for both the current and the future month are posted to the same batch voucher. From this single batch voucher column totals are posted to current and future month "Registers of County Authorizations." Column totals from "Change Authorization -- Future Month" section are posted to the Register for the future month, and column totals from "Authorizations Affecting Current and Prior Months" section are posted to the current month Register.

Persons count. Entries made in column headed "PC" to the right of the money column represent *changes* in the *eligible* persons count; e.g., in an AFDC case added child increases eligible persons count in master deck from 3 to 4. Post "1" (not 4) in "PC" column beside the money entry in Column 4, showing that a count of 1 has been added to the previous total. Make no entry in "PC" Column 3.

Persons count entries will be made for new cases, restorations, added or discontinued child, adult or essential person in AFDC, discontinuances and cancellation of warrant. No persons count entry is to be made for a supplemental increase payment when a previously issued warrant remains in effect.

Enter in Column 6 (Cancel current month warrant) rather than Column 8 (Cancel prior month warrant) persons count for prior month warrant *issued in current month* authorized to be cancelled.

25-605 FORMS (Continued) 25-605

I. AUTHORIZATION AND AUTHORIZATION CONTROL (Continued)

ABCD 822

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

REGISTER OF COUNTY AUTHORIZATIONS

PROGRAM _____ MONTH _____, 19__

To be filed in county available for audit.

A—Adult(s)
CH—Child(ren)
EP—Essential Person(s)

BATCH VOUCHER NUMBER	COUNTY ACTION DATE	AUTHORIZATION CHANGES TO MASTER PAYROLL						SUPPLEMENTAL PAYMENTS AND WARRANT CANCELLATIONS AUTHORIZED											
								CURRENT MONTH						PRIOR MONTHS					
		AMOUNTS DELETED	PERSONS COUNT			AMOUNTS ADDED	PERSONS COUNT				PERSONS COUNT				PERSONS COUNT				
			A	CH	EP		A	CH	EP	PAYMENTS	A	CH	EP	CANCEL-LATIONS	A	CH	EP	CANCEL-LATIONS	A	CH	EP
(1)	(2)	(3)				(4)				(5)				(6)				(7)				(8)*			

*NOT INCLUDED IN RECONCILIATION STATEMENT. USE AS CONTROL TO WARRANTS ACTUALLY CANCELED AND REPORTED ON CLAIM.

ABCD 822 (3/79)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (see Chapter 25-700)

A. Monthly Claims -- ABCD 801

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

AID PAYROLL (CONTRA ROLL)

PROGRAM

COUNTY	DATE (MO. YR.)
TYPE OF ROLL	WARRANTS DATED (EXCEPT AS SHOWN IN COLUMN 12)

CASE NUMBER AND NAME	CODE	MONTH AND YEAR	FED PERSONS COUNT		E	NONFED PERSONS COUNT		TOTAL AID PAID	COUNTY SUPPL. AID (AFDC-FG ONLY)	WARRANT NUMBER	REMARKS
			A	CH	P	A	CH				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
PAGE TOTALS											

KEY
A-ADULT(S)
CH-CHILD(REN)
EP-ESSENTIAL PERSON(S)

ABCD 801 (3-79)

PAGE NUMBER

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- ABCD 820

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

RECONCILIATION STATEMENT
COUNTY AUTHORIZATIONS TO AUDITOR'S PAYMENTS

Program_____

County_____ **Month of**_____ 19____

INSTRUCTIONS

If persons counts in Items 1 through 10 include nonfederal persons and essential persons, Item 12 must also include nonfederal persons and essential persons. Forward one copy with each monthly claim to **Department of Social Services, 744 P Street, Sacramento 95814.**

	AMOUNT	PERSONS COUNT
1. Continuing aid payments previously authorized in master deck control for previous month. (Item 4 of the reconciliation statement, Form ABCD 820, of the previous month)	$	
2. Less total of prior authorization amounts deleted from master deck control for this month. (Column 3 ABCD 822)		
Subtotal		
3. Plus total of new amounts authorized to be added to master deck control for this month. (Column 4 ABCD 822)		
4. Net amount of authorized continuing aid payments in master deck control for this month		
5. Plus current month supplemental warrants authorized. (Column 5 ABCD 822)	$	
6. Total amount of warrants authorized to be issued this month for this month		
7. Plus amount of aid authorized to be paid this month for prior months. (Column 7 ABCD 822)		
8. Total amount of warrants authorized to be issued this month		
9. Less payments for current month and for prior months ISSUED THIS MONTH authorized to be canceled. (Column 6 ABCD 822)		
10. Net total of aid authorized to be paid this month		
11. Amount claimed this month		
12. Persons claimed this month		
13. Difference, if any, between Items 10 and 11		
14. Difference, if any, between Items 10 and 12		

(Explain any differences below or on a separate sheet)

ABCD 820 (2/80)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- AD 800A

STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

SUMMARY REPORT OF ASSISTANCE EXPENDITURES - ADOPTION ASSISTANCE PROGRAM/FEDERAL

For State Use → ☐ DSS ☐ County Welfare ☐ County Auditor

COUNTY | DATE (MONTH YEAR)

A PERSONS COUNT	B AMOUNTS	SOURCE DOCUMENTS
		1. Main Payroll
		2. Current Month Supplemental Payroll
( )	( )	3. Current Month Cancellation Contra Roll
		5. Prior Months Supplemental Payroll
		6. Subtotal (reconciliation totals)
( )	( )	7. Prior Months Cancellation Contra Roll
( )	( )	8. Abatements and Repayments
		9. Schedule of Adjustments (show minus items in parentheses)
		10. Subtotals (Lines 7, 8, 9)
		11. DSS Office Audit Corrections (for state use only)
		12. **TOTAL**
	13. Net payments not subject to .5 Federal funding	
	14. The amount in Line 13A subject to Federal funding	

C: _____ 15. Line 12B minus Line 13A plus Line 14A x .5

D: _____ 16. Line 12B minus Line 15C

	B	C FEDERAL Enter Line 15 C	D STATE Enter Line 16D	
GRAND TOTALS	$	$ (Line 15C)	$ (Line 16D)	17.
(FOR STATE USE)				18.
				19.
(FOR COUNTY USE) A CH				20.
				21.

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of the Adoption Assistance Program in and for aforesaid county, that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code, that the aid payments, allotments for payments in kind, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR | DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts, that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for the Adoption Assistance Program made by the county, that said amounts correctly reflect Federal and State Shares in the aid payments claimed and that warrants therefore have been issued, or funds made available for the payments in kind listed herein according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER | DATE

AD 800A (10 82)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of AD 800A

INSTRUCTIONS FOR USE OF FORM AD 800A

1. Enter county name, month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with amounts shown on the integrated payroll or contra foll.) Line 4 has been omitted from the form because there are no provisions to reduce grants to zero due to prior overpayments.
3. Enter the subtotals in Lines 6 and 10, and totals in Lines 12A and B.
4. Line 13A - For children receiving AAP payments in excess of the foster family home rate enter the total assistance payments (minus any cancellations, abatements, etc.).
5. Line 14A - Enter that amount in line 13A subject to 50 percent federal funding.
6. Line 15C - Subtract line 13A from line 12B, then add line 14A and multiply by .5 to determine 50 percent federal share.
7. Line 16D - Subtract line 15C from line 12B to determine the state share.
8. Line 17C - Enter line 15C.
9. Line 17D - Enter line 16D.
10. Lines 18 and 19 - Reserved for the application of adjustments made by the state (Federal and/or State Field Audit Exceptions, etc.).
11. Lines 20 and 21 - Included at county request and use is optional. If adjustments are reported in line 9 which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

AD 800A (Back) Instructions (10/82)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- AD 800B

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

SUMMARY REPORT OF ASSISTANCE EXPENDITURES - ADOPTION ASSISTANCE PROGRAM/NONFEDERAL (INCLUDES AID FOR THE ADOPTION OF CHILDREN-AAC)

For State Use ☐ DSS ☐ County Welfare ☐ County Auditor

COUNTY	DATE (MONTH, YEAR)

A PERSONS COUNT	B AMOUNTS	SOURCE DOCUMENTS
		1. Main Payroll
		2. Current Month Supplemental Payroll
( )	( )	3. Current Month Cancellation Contra Roll
		5. Prior Months Supplemental Payroll
		6. Subtotal (reconciliation totals)
( )	( )	7. Prior Months Cancellation Contra Roll
( )	( )	8. Abatements and Repayments
		9. Schedule of Adjustments (show minus items in parentheses)
		10. Subtotals (Lines 7, 8, 9)
		11. DSS Office Audit Corrections (for state use only)
		12. **TOTAL**

		B	C STATE	
GRAND TOTALS		$ (Line 12B)	$ (Line 12B)	13.
(FOR STATE USE)				14.
				15.
(FOR COUNTY USE)	PERS CTS			16.
				17.

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of the Adoption Assistance Program in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, allotments for payments in kind, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for the Adoption Assistance Program made by the county; that said amounts correctly reflect the aid payments claimed and that warrants therefore have been issued, or funds made available for the payments in kind listed herein according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

AD 800B (10-82)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of AD 800B

INSTRUCTIONS FOR USE OF FORM AD 800B

1. Enter county name, month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with amounts shown on the integrated payroll summary. (For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.) Line 4 has been omitted from the form because there are no provisions to reduce grants to zero due to prior overpayments.
3. Enter the subtotals in Lines 6 and 10, and totals in Lines 12A and B.
4. Line 13B - Enter line 12B.
5. Line 13C - Enter line 12B.
6. Lines 14 and 15 - Reserved for the application of adjustments made by the state (State Field Audit Exceptions, etc.).
7. Lines 16 and 17 - Included at county request and use is optional. If adjustments are reported in Line 9 which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

AD 800B (Back) Instructions (10/82)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800

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

SUMMARY REPORT
OF ASSISTANCE EXPENDITURES
AID TO FAMILIES WITH DEPENDENT CHILDREN

☐ FAMILY GROUP (FG)
☐ UNEMPLOYED (U)

(INSTRUCTIONS ON REVERSE SIDE OF FORM)

FOR STATE USE → ☐ DSS ☐ COUNTY WELFARE ☐ COUNTY AUDITOR

COUNTY | DATE (MONTH YEAR)

A FEDERAL PERSONS COUNTS		B NONFEDERAL PERSONS COUNTS		C TOTAL AID	SOURCE DOCUMENTS
ADULTS	CHILDREN	ADULTS	CHILDREN		
					1 Main Payroll
					2 Current Month Supplemental Payroll
( )	( )	( )	( )	( )	3 Current Month Cancellation Contra Roll
					4 Zero Grant
					5 Prior Months Supplemental Payroll
					6 Subtotal (reconciliation totals)
( )	( )	( )	( )	( )	7 Prior Months Cancellation Contra Roll
( )	( )	( )	( )	( )	8 Abatements
					9 Schedule of Adjustments (show minus items in parentheses)
					10 Subtotals (Lines 7, 8, 9)
					11 DSS Office Audit Corrections (for State Use Only)
					12 Total

		D	
	13 Total Federal Persons Col A (Ad + Ch)		13 12C minus 19A × 15A × 5
	14 Total Persons Col A (Ad + Ch) + Col B (Ad + Ch)		14 19A × 15A × 5
%	15 Federal Ratio (13A ÷ 14A carry to 4 places)	15 17A × $1.00	E
	16 Number of Assistance Units represented by 14A (total persons)	16 18A × $2.00	
	17 Federal AU's (16A × 15A, rounded to nearest whole number)	17 15E × 16E	
	18 Nonfederal AU's (16A minus 17A)		
	19 Immediate need payments not subject to state participation		

			D FEDERAL (Line 13D × 14D)	E STATE (Line 12C minus 19A minus 13D minus 17E) × 89.2%	F COUNTY (Line 12C minus 17E minus 20D minus 20E)
		C 20			
	21	REPAYMENTS	( )	( )	( )	( )
	22	GRAND TOTALS	$ (Line 12C and 21C)	$ (Line 20D and 21D)	$ (Line 17E + 20E + 21E)	$ (Line 20F and 21F)
	23	(FOR STATE USE)				
	24					
	25	(FOR COUNTY USE) A Ch				
	26					

I hereby certify under penalty of perjury that I am the official responsible for the administration of Aid to Families with Dependent Children in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

I hereby certify, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts, that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Aid to Families with Dependent Children made by the county; that said amounts correctly reflect Federal, State and County Shares in the aid payments claimed and that warrants therefore have been issued, according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR | DATE | SIGNATURE OF COUNTY AUDITOR OR CONTROLLER | DATE

CA 800 (1 85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800

INSTRUCTIONS FOR USE OF FORM CA 800 (FG AND U)

1. Enter county name and month and year of claim in space provided.
2. Complete Lines 1 through 5, and 7 through 9, in accordance with the amounts shown on the integrated payroll summary. (For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.) All money amounts on this form may be rounded to the nearest dollar.
3. Enter the subtotals in Lines 6 and 10 and the total in Line 12.
4. Line 13A — Add Column A (total federal persons).
5. Line 14A — Add Column A (total federal persons) and Column B (total nonfederal persons).
6. Line 15A — Divide 13A (total federal persons) by 14A (total persons) to determine federal ratio.
7. Line 19A — Determine amount of immediate need not subject to state participation.

Federal and nonfederal AUs are computed as follows.

8. Line 16A — Enter the total Assistance Units (cases) from the CA 237 report.
9. Line 17A — Multiply 16A (total number of AUs) by 15A (federal ratio) to determine federal AUs.
10. Line 18A — Subtract 17A (total federal AUs) from 16A (total number of AUs) to determine nonfederal AUs.

Federal share is computed as follows.

11. Line 13D — Subtract 19A (immediate need payments not subject to state participation) from 12C (net total aid paid), then multiply by 15A (federal ratio) and by .5 to determine 50 percent federal share of total aid paid.
12. Line 14D — Multiply 19A (immediate need payments not subject to state participation) by 15A (federal ratio) and by .5 to determine 50 percent federal share of these payments.

State share is computed as follows:

13. Line 15E — Multiply 17A (total federal AUs) by $1.00 (the state share of the $2.00 grant increase effective 6/1/73 for federal AUs).
14. Line 16E — Multiply 18A (total nonfederal AUs) by $2.00 (the state share of the $2.00 grant increase effective 6/1/73 for nonfederal AUs).
15. Line 17E — Add 15E (state share of grant increase for federal AUs) and 16E (state share of grant increase for nonfederal AUs) to determine the total state share of the 6/1/73 increase.

Compute total federal, state, and county shares as follows:

16. Line 20D — Add Lines 13D (federal share of net total aid paid) and 14D (federal share of immediate need payments not subject to state participation) to determine total federal share.
17. Line 20E — Subtract Lines 19A (immediate need payments not subject to state participation), 13D (federal share of net total aid paid), and 17E (total state share of 6/1/73 increase) from Line 12C (net total aid paid), then multiply by 89.2 percent (state share of participation) to determine basic state share. (Total state share is shown in Line 22E.)
18. Line 20F — Subtract Lines 17E (total state share of 6/1/73 increase), 20D (total federal share), and 20E (basic state share) from Line 12C (total aid paid) to determine total county share.
19. Line 21C — Enter total repayments from Repayment Contra Rolls.
20. Line 21D, E, and F — Enter the federal, state, and county shares of repayments determined in accordance with ratio shown in MPP Section 25-570.2.
21. Line 22C, D, E, and F — Enter grand totals.
22. Line 23 and 24 — Reserved for the application of adjustments made by the state (Federal and/or State Field Audit Exceptions, etc.).
23. Lines 25C and F and 26B, C, D, E, F — Included at county request and use is optional. If adjustments are reported in Line 9 which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

CA 800 (1/85) Back

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800 FC (FED)

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

SUMMARY REPORT OF ASSISTANCE EXPENDITURES - FEDERAL CHILDREN IN FOSTER CARE
(Instructions on Reverse Side of Form)

For State Use ☐ DSS ☐ County Welfare ☐ County Auditor

COUNTY | DATE (MONTH, YEAR)

A. PERSONS COUNT	B. AMOUNTS	SOURCE DOCUMENTS
		1. Main Payroll
		2. Current Month Supplemental Payroll
( )	( )	3. Current Month Cancellation Contra Roll
		5. Prior Months Supplemental Payroll
		6. Subtotal (reconciliation totals)
( )	( )	7. Prior Months Cancellation Contra Roll
( )	( )	8. Abatements
		9. Schedule of Adjustments (show minus items in parentheses)
		10. Subtotals (Lines 7, 8, 9)
		11. DSS Office Audit Corrections (for state use only)
		12. **TOTAL**

13. Amount not Reimbursable from Federal Funds.

14. Amount not Reimbursable from State Funds.

		C FEDERAL (Line 12B minus Line 13A) x .5	D STATE (Line 12B minus Line 15A minus Line 15C) x .95	E COUNTY (Line 12B minus Line 15C minus Line 15D)	
	15. Line 14A x .5 B.				15.
REPAYMENTS	( )	( )	( )	( )	16.
GRAND TOTALS	(Lines 12B and 16B)	(Lines 15C and 16C)	(Lines 15D and 16D)	(Lines 15E and 16E)	17.
					18.
					19.
FUNERAL COSTS (11-405.2)					20.
(FOR COUNTY USE) PERS CTS					21.
					22.

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Aid to Families with Dependent Children in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR | DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Aid to Families with Dependent Children made by the county; that said amounts correctly reflect Federal, State and County Shares in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER | DATE

CA 800 FC (FED) (10/85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800 FC (FED)

INSTRUCTIONS FOR USE OF FORM CA 800 FC (FEDERAL)

1. Enter county name and month and year of claim in space provided.

2. Complete Lines 1 through 5 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary (for nonintegrated payrolls enter grand totals shown for each payroll or contra roll). All money amounts on the Form CA 800 FC (Federal) may be rounded to the nearer dollar. **Note:** Line 4 (Zero Grant Persons Count) has been deleted because under the AFDC-FC Program there is no provision for reducing a grant to zero to recover a previous overpayment.

3. Enter the subtotals in Lines 6 and 10 and the totals in Line 12.

4. Line 13A - Enter the net amount not reimbursable from federal funds.
(Example: Social worker services, interest on original acquisition mortgages and costs incurred for leasebacks in accordance with the AFDC-Foster Care Group Home Rate Listing).

5. Line 14A - Enter the amount not reimbursable from state funds.
(Example: Total payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling.)

6. Line 15A - Enter the total nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling (Line 14A x .5).

7. Line 15C - Enter the federal share: total aid paid (12B) minus the amount not reimbursable from federal funds (13A) multiplied by 50 percent.

8. Line 15D - Enter the state share: total aid paid (12B) minus the total nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling (15A) minus federal share (15C) multiplied by 95 percent.

9. Line 15E - Enter the county share: total aid paid (12B) minus federal share (15C) minus state share (15D).

10. Line 16 - Enter the total repayments as reported on the Repayment Contra Roll.

11. Line 17 - Enter grand totals.

12. Lines 18 and 19 - Reserved for state use.

13. Line 20 - To be used for claiming of reimbursement for funeral costs for foster care children in accordance with MPP Handbook Section 11-405.2 (see also MPP Handbook Section 25-753).

14. Lines 21 and 22 - Included at county request and use is optional. If adjustments are reported in Line 9 which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

25-605 FORMS (Continued)

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800 FC.1 (FED)

STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

FOSTER CARE FACILITY EXPENDITURE STATEMENT
AMOUNTS NOT REIMBURSABLE FROM FEDERAL FUNDS

Page ____ of ____

Check one

AFDC FC ☐

EA-FC ☐

(INSTRUCTIONS ON REVERSE SIDE OF FORM)

COUNTY

DATE (MONTH YEAR)

A. FACILITY NAME	B. PROGRAM NUMBER	C. ORIGINALLY CLAIMED					D. REVISED					E. ADJUSTED				
		1 PERSONS COUNT	2 AID PAID	3 SOCIAL WORKER (%)	4 NONFED OTHER (%)	5 TOTAL SOCIAL WORKER, NONFED OTHER AMOUNT	1 PERSON COUNT	2 AID PAID	3 SOCIAL WORKER (%)	4 NONFED OTHER (%)	5 TOTAL SOCIAL WORKER NONFED OTHER AMOUNT	1 PERSON COUNT	2 AID PAID	3 SOCIAL WORKER (%)	4 NONFED OTHER (%)	5 TOTAL SOCIAL WORKER NONFED OTHER AMOUNT

CA 800 FC 1 (FED) (10-85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800 FC.1 (FED)

INSTRUCTIONS FOR USE OF FORM CA 800 FC. 1 (Fed)

1. Enter county name, facility name, program number, page number, month and year in the spaces provided, and check the program designation block
2. Lines C1, D1, E1 — Enter persons count for payments coded E (E is to be used for payments that include Nonfed other amounts and or social worker services in accordance with the AFDC FC Group Home Rate Listing.)
3. Line C2, D2, E2 — Enter the amount paid (Do not enter any amounts in these columns for payments above the state set rate Social worker services and Nonfed other percentages should be applied to the state set rate.)
4. Lines C3, D3, E3 — Enter the social worker services percentage from the AFDC FC Group Home Rate Listing
5. Lines C4, D4, E4 — Enter the Nonfed other percentage from the AFDC FC Group Home Rate Listing
6. Lines C5, D5, E5 — Enter the total social worker services Nonfed other amounts Column 2 multiplied by the total of columns 3 and 4.
7. Enter the subtotals for columns 2 and columns 5 on each page.
8. Enter the grand total for columns 2 and columns 5 on the last page

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800 FC.2 (FED)

STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

Page ____ of ____

Check one

AFDC-FC ☐

EA-FC ☐

COUNTY

DATE (MONTH, YEAR)

FOSTER CARE FACILITY EXPENDITURE STATEMENT AMOUNTS NOT REIMBURSABLE FROM STATE FUNDS

A. FACILITY NAME/CASE NAME	B. PROGRAM NUMBER/CASE NUMBER	C. ORIGINALLY CLAIMED			D. REVISED			E. ADJUSTED		
		(1) PERSON COUNT	(2) TOTAL AID PAID	(3) TOTAL AMOUNT NOT REIMBURSABLE FROM STATE FUNDS	(1) PERSON COUNT	(2) TOTAL AID PAID	(3) TOTAL AMOUNT NOT REIMBURSABLE FROM STATE FUNDS	(1) PERSON COUNT	(2) TOTAL AID PAID	(3) TOTAL AMOUNT NOT REIMBURSABLE FROM STATE FUNDS

CA 800 FC 2 (FED) (9 85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- CA 800A FC (NONFED)

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

SUMMARY REPORT OF ASSISTANCE EXPENDITURES - NONFEDERAL CHILDREN IN FOSTER CARE

(Instructions on reverse side of form)

For State Use ☐ DSS ☐ County Welfare ☐ County Auditor

COUNTY | DATE (MONTH, YEAR)

A PERSONS COUNT	B AMOUNTS	SOURCE DOCUMENTS
		1. Main Payroll
		2. Current Month Supplemental Payroll
( )	( )	3. Current Month Cancellation Contra Roll
		5. Prior Months Supplemental Payroll
		6. Subtotal (reconciliation totals)
( )	( )	7. Prior Months Cancellation Contra Roll
( )	( )	8. Abatements
		9. Schedule of Adjustments (show minus items in parentheses)
		10. Subtotals (Lines 7, 8, 9)
		11. DSS Office Audit Corrections (for state use only)
		12. **TOTAL**

		C STATE (Line 12B x .95)	D COUNTY (Line 12B minus Line 13C)	
				13.
REPAYMENTS	( )	( )	( )	14.
GRAND TOTALS	(Lines 12B and 14B)	(Lines 13C and 14C)	(Lines 13D and 14D)	15.
				16.
				17.
FUNERAL COSTS (11-405.2)				18.
(FOR COUNTY USE) PERS CTS				19.
				20.

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Aid to Families with Dependent Children in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR | DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Aid to Families with Dependent Children made by the county; that said amounts correctly reflect State and County Shares in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER | DATE

CA 800A FC (NONFED) (10/85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of CA 800A FC (NONFED)

INSTRUCTIONS FOR USE OF FORM CA 800A FC (NONFEDERAL)

1. Enter county name and month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary (for nonintegrated payrolls enter grand totals shown for each payroll or contra roll). All money amounts on the Form CA 800A FC (Non-Federal) may be rounded to the nearer dollar. **Note:** Line 4 (Zero Grant Persons Count) has been deleted because under the AFDC-FC Program there is no provision for reducing a grant to zero to recover a previous overpayment.
3. Enter the subtotals in Lines 6 and 10 and the totals in Line 12.
4. Line 13C - Enter the state share: total aid paid (12B) multiplied by 95 percent
5. Line 13D - Enter the county share: total aid paid (12B) minus state share (13C).
6. Line 14 - Enter the total repayments as reported on the Repayment Contra Roll.
7. Line 15 - Enter grand totals.
8. Lines 16 and 17 - Reserved for State Use.
9. Line 18 - To be used for claiming of reimbursement for funeral costs for foster care children in accordance with EAS Manual Section 11-405.2 (see also Fiscal Handbook Section 25-753).
10. Lines 19 and 20 - Included at county request and use is optional. If adjustments are reported in Line 9 which affect total aid paid, this space may be used for reconciling total expenditures as reported by the welfare department with the county auditor's records of expenditures.

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 843

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

FEDERAL FUNDS CLAIMABLE BASED ON THE EXPENDITURES FOR REFUGEE RESETTLEMENT, CUBAN PROGRAM PHASEDOWN AND CUBAN/HAITIAN ENTRANT RECIPIENTS IN RECEIPT OF NONFEDERAL AFDC-FC

COUNTY		DATE (MONTH/YEAR)
REFUGEE RESETTLEMENT PROGRAM RECIPIENTS	**EXPENDITURES**	**PERSONS COUNT**
(Subsequent to 3/31/81, expenditures for time-eligible refugees only are claimable).		
1. Refugee Resettlement Recipients in receipt of nonfederal AFDC-FC (Do not include unaccompanied refugee minors).	$	
2. Federal funds claimable for Refugee Resettlement Program recipients (Line 1 x 100%).	$	
CUBAN PROGRAM PHASEDOWN RECIPIENTS	**EXPENDITURES**	**PERSONS COUNT**
3. Cuban Program Phasedown recipients in receipt of nonfederal AFDC-FC.	$	
4. Federal funds claimable for Cuban Program Phasedown recipients (Line 3 x _____%).*	$	
CUBAN / HAITIAN ENTRANTS	**EXPENDITURES**	**PERSONS COUNT**
5. Cuban/Haitian Entrants in receipt of nonfederal AFDC-FC. (Do not include unaccompanied entrant minors).	$	
6. Federal funds claimable for Cuban/Haitian Entrants (Line 5 x 100%).	$	
7. State share of additional federal funds claimable:		
a. Total nonreimbursable rate increase paid:		
(1) In behalf of Refugee Resettlement recipients (Amount x 100%).	$	
(2) In behalf of Cuban Program Phasedown recipients (Amount x _____%). *	$	
(3) In behalf of Cuban/Haitian Entrants (Amount x 100%).	$	
b. Total state share of claimable amount: (Line 2 minus a(1) above) plus (Line 4 minus a(2) above) plus (Line 6 minus a(3) above) x 95%.	$	
8. County share of additional federal funds claimable: (Line 2 plus Line 4 plus Line 6 minus Line 7b).	$	

* Complete in accordance with instructions from DSS.

CERTIFICATION

This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and amounts in support of this claim are available for review and audit.

SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE

DFA 843 (4/81)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 843

INSTRUCTIONS FOR USE OF FORM DFA 843

Enter the county name and the month and year of the claim in the space provided.

Complete the following 2 items in accordance with data for Refugee Resettlement recipients of nonfederal AFDC-FC as summarized at the end of the nonfederal AFDC-FC payroll:

1. Enter total expenditures and persons count in Line 1.

2. Compute the federal funds claimable by multiplying Line 1 by 100%. Enter the amount in Line 2.

Complete the following 2 items in accordance with data for Cuban Program Phasedown recipients of nonfederal AFDC-FC as summarized at the end of the nonfederal AFDC-FC payroll:

3. Enter total expenditures and persons count in Line 3.

4. Compute the federal funds claimable by multiplying Line 3 by the applicable percentage. Enter the amount in Line 4.

Complete the following 2 items in accordance with data for Cuban/Haitian Entrant recipients of nonfederal AFDC-FC as summarized at the end of the nonfederal AFDC-FC payroll:

5. Enter total expenditures and persons count in Line 5.

6. Compute the federal funds claimable by multiplying Line 5 by 100%. Enter the amount in Line 6.

Determine the state share of additional federal funds claimable as follows:

Determine the nonreimbursable rate increases paid for recipients included in this report. If an amount was paid in behalf of:

7. a(1) Refugee Resettlement recipients, multiply the amount by 100% and enter in Line 7a(1).

   a(2) Cuban Program Phasedown recipients, multiply the amount by the applicable percentage and enter in Line 7a(2).

   a(3) Cuban/Haitian Entrants, multiply the amount by 100% and enter in Line 7a(3).

   b. Compute the state share of the additional federal funds claimable by multiplying the total of: Line 2 minus Line a(1); Line 4 minus Line a(2) and Line 6 minus Line a(3) by 95%. Enter the amount in Line 7b.

8. Enter the county share of the additional federal funds claimable in Line 8. (Add Lines 2, 4 and 6 and subtract Line 7b).

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 844 RDP

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

ADDITIONAL FEDERAL FUNDS CLAIMABLE BASED ON THE NONFEDERAL SHARE OF EXPENDITURES FOR REFUGEE DEMONSTRATION PROJECT RECIPIENTS (RDP)

☐ FAMILY GROUP
☐ UNEMPLOYED

NOTE: Complete in accordance with instructions from DSS.

COUNTY: DATE (MONTH/YEAR):

REFUGEE DEMONSTRATION PROJECT RECIPIENTS	EXPENDITURES	PERSONS COUNT
	A.	
1. Total for those cases which include one or more time eligible Refugee Demonstration Project Recipients.	$	B. FEDERAL / C. NONFEDERAL / D. TOTAL
2. Federal Percentage (1B ÷ 1D) _____ %		
3. Expenditures reported in Item 1 which were made in behalf of federally eligible persons. (Item 2 × 1A)	$	
4. Nonfederal share of amount in Item 3. (3A × .5)	$	
5. Expenditures reported in Item 1 which were made in behalf of nonfederal persons. (1A minus 3A)	$	
6. Total nonfederal share of RDP expenditures in Item 1. (4A + 5A)	$	
7. Time eligible percentage (7C ÷ 7B) _____ %		B. TOTAL (SAME AS 1D ABOVE) / C. TIME ELIGIBLE REFUGEE COUNT
8. Additional federal funds claimable for time eligible Refugee Demonstration Project recipients. (Item 7 × 6A)	$	
9. Total state share of additional federal funds claimable (Line 8) × 89.2%.	$	
10. County share of additional federal funds claimable. (Line 8 minus Line 9)	$	

CERTIFICATION

This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and accounts in support of this claim are available for review and audit.

SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE

DFA 844 RDP (2/85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 844 RDP

INSTRUCTIONS FOR USE OF FORM DFA 844 RDP

Complete the following 10 items in accordance with data for all cases (AUs) which include one or more time eligible Refugee Demonstration Project recipients.

1. In Line 1A enter total expenditures; in 1B enter the federal persons count, in 1C enter the nonfederal persons count; and in 1D enter the total persons count.

2. Determine the federal percentage by dividing federal persons count by the total persons count. Enter the percentage in Line 2.

3. Multiply total expenditures reported in 1A by the federal percentage (Item 2) to determine the amount expended in behalf of federally eligible persons. Enter the amount in Line 3.

4. In Line 4 enter the nonfederal share of expenditures shown in Line 3 (Line 3 multiplied by 50%).

5. In Line 5 enter that portion of the expenditures in 1A made in behalf of nonfederal persons: Subtract 3A (portion expended in behalf of federal persons) from 1A (total expended).

6. Determine the total nonfederal share by adding 4A and 5A. Enter the amount in Line 6.

7. In 7B enter the total persons count shown in Line 1, Column D. In 7C enter the time eligible persons count. Determine the time eligible percentage by dividing the time eligible person count by total persons count. Enter the percentage in the space provided in Line 7.

8. Enter the additional federal funds claimable for time eligible Refugee Demonstration Project recipients in Line 8: Multiply the nonfederal share of RDP expenditures (Item 6) by the percentage shown in Item 7.

9. Compute the state share of additional federal funds claimable by multiplying the total of: Line 8 by 89.2 percent. Enter the amount in Line 9.

10. Enter the county share of the additional federal funds claimable in Line 10. (Line 8 minus Line 9).

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 847

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

ADDITIONAL FEDERAL FUNDS CLAIMABLE BASED ON THE NONFEDERAL SHARE OF EXPENDITURES FOR REFUGEE RESETTLEMENT, CUBAN PROGRAM PHASEDOWN AND CUBAN/ HAITIAN ENTRANT RECIPIENTS IN RECEIPT OF FEDERAL AFDC–FC

COUNTY | DATE (MONTH/YEAR)

REFUGEE RESETTLEMENT PROGRAM RECIPIENTS	EXPENDITURES	PERSONS COUNT
(Subsequent to 3/31/81, expenditures for time–eligible refugees only are claimable).		
1. Refugee Resettlement Recipients in receipt of federal AFDC–FC (Do not include Cuban Program Phasedown recipients).	$	
2. Nonfederal share of amount shown in Item 1 (Line 1 x .5).	$	
3. Additional federal funds claimable for Refugee Resettlement Program recipients (Line 2 x 100%).	$	

CUBAN PROGRAM PHASEDOWN RECIPIENTS	EXPENDITURES	PERSONS COUNT
4. Cuban Program Phasedown recipients in receipt of federal AFDC–FC.	$	
5. Nonfederal share of amount shown in Item 4 (Line 4 x .5).	$	
6. Additional federal funds claimable for Cuban Program Phasedown recipients (Line 5 x_____%). *	$	

CUBAN / HAITIAN ENTRANTS	EXPENDITURES	PERSONS COUNT
7. Cuban/Haitian Entrants in receipt of federal AFDC–FC.	$	
8. Nonfederal share of amount shown in Item 7 (Line 7 x .5).	$	
9. Additional federal funds claimable for Cuban/Haitian Entrants (Line 8 x 100%).	$	

10. State share of additional federal funds claimable:
    a. Total nonfederal share of nonreimbursable rate increase paid:
       (1) In behalf of Refugee Resettlement recipients (Amount x 100%). $
       (2) In behalf of Cuban Program Phasedown recipients (Amount x _____%). * $
       (3) In behalf of Cuban/Haitian Entrants (Amount x 100%). $
    b. Total state share of claimable amount: (Line 3 minus a(1) above) plus (Line 6 minus .(2) above) plus (Line 9 minus a(3) above) x 95%. $

11. County share of additional federal funds claimable: (Line 3 plus Line 6 plus Line 9 minus Line 10b). $

* Complete in accordance with instructions from DSS.

CERTIFICATION

This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and amounts in support of this claim are available for review and audit.

SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE

DFA 847 (1/81)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 847

INSTRUCTIONS FOR USE OF FORM DFA 847

Enter the county name and the month and year of the claim in the space provided.

Complete the following 3 items in accordance with data for Refugee Resettlement recipients of federal AFDC-FC as summarized at the end of the AFDC-FC payroll:

1. Enter total expenditures and persons count in Line 1.
2. In Line 2, enter the nonfederal share of the expenditures shown in Line 1 (Line 1 multiplied by 50%).
3. Determine the additional federal funds claimable by multiplying Line 2 by 100%. Enter the amount in Line 3.

Complete the following 3 items in accordance with data for Cuban Program Phasedown recipients of federal AFDC-FC as summarized at the end of the AFDC-FC payroll:

4. Enter total expenditures and persons count in Line 4.
5. In Line 5, enter the nonfederal share of the expenditures shown in Line 4 (Line 4 multiplied by 50%).
6. Determine the additional federal funds claimable by multiplying Line 5 by the applicable percentage. Enter the amount in Line 6.

Complete the folliwing 3 items in accordance with data for Cuban/Haitian Entrant recipients of federal AFDC-FC as summarized at the end of the AFDC-FC payroll:

7. Enter total expenditures and persons count in Line 7.
8. In Line 8, enter the nonfederal share of the expenditures shown in Line 7 (Line 7 multiplied by 50%).
9. Determine the additional federal funds claimable by multiplying Line 8 by 100%. Enter the amount in Line 9.

Determine the state share of additional federal funds claimable as follows:

Determine the nonfederal share of nonreimbursable rate increases paid for recipients included in this report. If an amount was paid in behalf of:

10. a(1) Refugee Resettlement recipients, multiply the amount by 100% and enter in Line 10a(1).

    a(2) Cuban Program Phasedown recipients, multiply the amount by the applicable percentage and enter in Line 10a(2).

    a(3) Cuban/Haitian Entrants, multiply the amount by 100% and enter in Line 10a(3).

    b. Determine the state share of the additional federal funds claimable by multiplying the total of: Line 3 minus Line a(1); Line 6 minus Line a(2) and Line 9 minus Line a(3) by 95%. Enter the amount in Line 10b.

11. Enter the county share of the additional federal funds claimable in Line 11. (Add Lines 3, 6 and 9 and subtract Line 10b).

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 859

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

FEDERAL FUNDS CLAIMABLE BASED ON EXPENDITURES FOR TIME ELIGIBLE REFUGEES AND ENTRANTS IN RECEIPT OF GENERAL ASSISTANCE

FOR STATE USE

- ☐ SDSS
- ☐ County Welfare
- ☐ County Auditor

COUNTY

DATE (MONTH) (YEAR)

A PERSONS COUNT	B TOTAL AID PAID	SOURCE DOCUMENTS
		1. Main Payroll
		2. Current month supplemental payroll
( )	( )	3. Current month cancellation contra roll
		5. Prior months supplemental payroll
		6. SUBTOTAL *(reconcilliation totals)*
( )	( )	7. Prior months cancellation contra roll
( )	( )	8. Abatements and repayments
		9. Schedule of adjustments *(show minus items in parentheses)*
		10. SUBTOTAL *(Lines 7, 8, 9)*
		11. SDSS office audit corrections *(for state use)*
		12. **TOTALS**

		C FEDERAL SHARE	
GRAND TOTALS Refugees and Entrants			13.
	Enter Line 12B	Line 13B x 100%	

CERTIFICATION

I hereby certify, under penalty of perjury, that I am the official responsible for the Administration of General Assistance in and for the aforesaid county; that the above information is correct to the best of my knowledge and belief; that payment for these expenditures has not been received; and that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code.

SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE
		19

DFA 859 (4/85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 859

INSTRUCTIONS FOR USE OF FORM DFA 859

1. This form can be used for claiming federal reimbursement of General Assistance expenditures for time eligible refugees and entrants.

2. Enter county name and the month and year of the claim in the space provided.

3. Complete Lines 1 through 5, and 7 through 9 in accordance with the amounts shown on the integrated payroll summary. *(On nonintegrated payrolls, enter grand totals shown for each payroll or contra-roll.)*

4. Enter the subtotals on Lines 6 and 10 and totals on Line 12.

5. The federal share is computed as follows:

   a. For time eligible refugees and entrants — (Line 13) Line 13c: Multiply Line 13B (total aid paid) by 100% (federal reimbursement for time eligible refugees and entrants aided on the General Assistance Program).

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- DFA 863

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P STREET - M.S. 8-300
SACRAMENTO, CA 95814

ADDITIONAL FEDERAL FUNDS CLAIMABLE BASED ON THE NONFEDERAL SHARE OF EXPENDITURES FOR REFUGEE RESETTLEMENT AND CUBAN/HAITAIN ENTRANT RECIPIENTS IN RECEIPT OF EMERGENCY ASSISTANCE — UNEMPLOYED PARENT

COUNTY

DATE (MONTH/YEAR)

REFUGEE RESETTLEMENT PROGRAM RECIPIENTS	EXPENDITURES A.	PERSONS COUNT B.	PERSONS COUNT C.
(Subsequent to 7/31/81, expenditures for time-eligible refugees only are claimable.)			
1. Totals for those EA-UP cases which include one or more time eligible Refugee Resettlement Recipients	$	TOTAL	
2. Nonfederal share of amount in Item 1A (1A x .5)	$		
3. Time-eligible percentage (3C ÷ 3B)_____ %.....		TOTAL	TOTAL TIME ELIGIBLE REFUGEE COUNT
4. Additional federal funds claimable for time eligible Refugee Resettlement Program recipients (Line 3 percentage x 2A)	$		

CUBAN/HAITIAN ENTRANTS	EXPENDITURES A.	PERSONS COUNT B.	PERSONS COUNT C.
5. Totals for those EA-UP cases which include one or more time-eligible Cuban/Haitian Entrants	$	TOTAL	
6. Nonfederal share of amount in Item 5A (5A x .5)	$		
7. Time-eligible percentage (7C ÷ 7B)_____ %.....		TOTAL	TOTAL TIME ELIGIBLE CUBAN/HAITIAN COUNT
8. Additional federal funds claimable for time eligible Cuban/Haitian Entrants (Line 7 percentage x 6A)	$		

9. State share of additional federal funds claimable:

a. County supplement paid in behalf of Refugee Resettlement Programs Recipients (Amount x 100%) ..... $

b. County supplement paid in behalf of Cuban/Haitian Entrants (Amount x 100%) ..... $

c. Total state share of additional federal funds claimable (Line 4A minus Line 9a) plus (Line 8A minus Line 9b) x 89.2% $

10. County share of additional federal funds claimable (Line 4A plus Line 8A minus Line 9c) ..... $

CERTIFICATION

This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and accounts in support of this claim are available for review and audit.

SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE

DFA 863 (10 82)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of DFA 863

INSTRUCTIONS FOR USE OF FORM DFA 863

Enter the county name and the month and year of the claim in the space provided.

Complete the following 5 items in accordance with data for all Emergency Assistance - UP cases which include one or more time-eligible Refugee Resettlement Recipients as summarized at the end of the EA—UP payroll.

1. Line 1A - Enter total expenditures.
2. Line 1B - Enter the total persons count.
3. Line 2A - Enter the nonfederal share of expenditures; multiply Line 1A x 50 percent.
4. Line 3 - Enter the total persons counts in Line 3B; enter the time-eligible persons counts in Line 3C. Determine the time-eligible percentage by dividing the time-eligible persons count by total persons count. Enter the percentage in the space provided in Line 3.
5. Line 4A - Enter the additional federal funds claimable for time-eligible Refugee Resettlement Program Recipients in Line 4A: Multiply the nonfederal share of EA expenditures (Line 2A) by the percentage shown in Line 3.

   Complete the following 5 items in accordance with data for all Emergency Assistance - UP cases which include one or more time-eligible Cuban/Haitian recipients as summarized at the end of the EA—UP payroll.

6. Line 5A - Enter total expenditures.
7. Line 5B - Enter total persons count.
8. Line 6A - Enter the nonfederal share of expenditures; multiply Line 5A x 50 percent.
9. Line 7 - Enter the total persons counts in Line 7B; enter the time-eligible persons counts in Line 7C. Determine the time-eligible percentage by dividing the time-eligible persons count by total persons count. Enter the percentage in the space provided in Line 7.
10. Line 8A - Enter the additional federal funds claimable for time-eligible Cuban/Haitian Entrants recipients in Line 8A: Multiply the nonfederal share of EA expenditures (Line 6A) by the percentage shown in Line 7.
11. Line 9a - If county supplement was paid in behalf of Refugee Resettlement recipients, multiply the amount by 100% and enter in Line 9a.
12. Line 9b - If county supplement was paid in behalf of Cuban/Haitian Entrants, multiply the amount by 100% and enter in Line 9b.
13. Line 9C - Compute the state share of additional funds claimable: (Line 4A minus Line 9a) plus (Line 8A minus Line 9b) multiplied by 89.2 percent.
14. Line 10 - Enter the county share of additional federal funds claimable: Line 4A plus Line 8A minus Line 9c.

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- SC 800

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

SUMMARY REPORT OF SPECIAL CIRCUMSTANCES

For State Use ☐ DSS ☐ County Welfare ☐ County Auditor

COUNTY	DATE (MONTH, YEAR)	FISCAL YEAR

AGED (A)	BLIND (B)	DISABLED (C)	SOURCE DOCUMENTS
			1. Main Payroll
			2. Current month supplemental payroll
( )	( )	( )	3. Current month cancellation contra roll
			5. Prior months supplemental payroll
			6. SUBTOTAL (reconciliation totals)
( )	( )	( )	7. Prior months concellation contra roll
( )	( )	( )	8. Abatements
			9. Schedule of adjustments (show minus items in parentheses)
			10. SUBTOTAL (Lines 7, 8, 9)
			11. SDSW office audit corrections **(For state use only)**
			12. TOTAL

GRAND TOTALS (Item 12, Columns A, B and C)	$
(FOR STATE USE)	

*I **HEREBY CERTIFY**, under penalty of perjury, that I am the official responsible for the administration of Special Circumstances in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.*

*I **HEREBY CERTIFY**, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code: that the amounts claimed herein are in accordance with authorization for Special Circumstances made by the county: that said amounts correctly reflect State share in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.*

SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

SC 800 (9/76)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- SOC 800

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, M.S. 8-300

STATE USE ONLY
☐ DSS ☐ County Welfare
☐ County Auditor

SUMMARY REPORT OF ASSISTANCE EXPENDITURES
EMERGENCY ASSISTANCE - FOSTER CARE

COUNTY

DATE (MONTH, YEAR)

(Instructions on Reverse side of Form.)

A PERSONS COUNT	B AMOUNTS		
		1.	Main Payroll.
		2.	Current Month Supplemental Payroll.
( )	( )	3.	Current Month Cancellation Contra Roll.
		5.	Prior Months Supplemental Payroll.
		6.	**Subtotal** (Reconciliation Totals).
( )	( )	7.	Prior Months Cancellation Contra Roll.
( )	( )	8.	Abatements.
		9.	Schedule of Adjustments. (Show Minus Items in Parentheses.)
		10.	**Subtotals** (Lines 7, 8, 9).
		11.	DSS Office Audit Corrections (For State Use Only).
		12.	**Total.**

13. Amounts not Reimbursable from Federal Funds

14. Amount not Reimbursable from State Funds

		C	D FEDERAL (LINE 12B MINUS LINE 13A) x .5	E STATE (LINE 12B MINUS LINE 15A MINUS LINE 15D) x .95	F COUNTY (LINE 12B MINUS LINE 15D MINUS LINE 15E)
	15. Line 14A x .5				
16	Repayments				
17	**Grand Totals**	(Line 12B and Line 16C)	(Line 15D and Line 16D)	(Line 15E and Line 16E)	(Line 15F and Line 16F)
	FOR STATE USE				
18					
19					
	FOR COUNTY USE				
20					
21					

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Emergency Assistance in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesiad county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Emergency Assistance made by the county, that said amounts correctly reflect Federal, State and County Shares in the aid payments claimed and that warrants therefore have been issued according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

SOC 800 (10 85)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of SOC 800

INSTRUCTIONS FOR USE OF FORM SOC 800

1. Enter county name, month and year of claim in space provided.

2. Complete Lines 1 through 5 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary. *(For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.)* All money amounts on this form may be rounded to the nearer dollar.

3. Enter the subtotals in Lines 6 and 10 and the total in Line 12.

4. Line 13A - Enter the net amount not reimbursable from federal funds (Example: Non Federal Other Amounts in accordance with The AFDC-Foster Care Group Home Rate Listing.)

5. Line 14A - Enter the amount not reimbursable from state funds. (Example: Total payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling.)

6. Line 15A - Enter the total nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participation because of the state rate ceiling (Line 14A x .5).

7. Line 15D - Enter the federal share in Line 15D: total aid paid (Line 12B) minus amounts not reimbursable from federal funds (Line 13A) multiplied by 50 percent.

8. Line 15E - Enter the state share in Line 15E: total aid paid (Line 12B) minus the nonfederal share of the payment made for basic costs above the state set rate which is not allowable for state participatiton because of the state rate ceiling (Line 15A) minus federal share (Line 15D) multiplied by 95 percent.

9. Line 15F - Enter the county share in Line 15F: total aid paid (Line 12B) minus federal share (Line 15D) minus state share (Line 15E).

10. Line 16C - Enter the total repayments as reported on the Repayment Contra Roll.

11. Line 16D, E and F - Enter federal, state and county shares of repayments determined in accordance with the federal, state, and county EA repayment sharing ratios.

12. Line 17 - Enter Grand Totals.

13. Line 18 and 19 - Reserved for the application of adjustments made by the state *(federal and/or state field audit exceptions, etc.)*

14. Lines 20 and 21 - Included at county request and use is optional.

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- SOC 801

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, M.S. 8-300

SUMMARY REPORT OF ASSISTANCE EXPENDITURES
EMERGENCY ASSISTANCE - UNEMPLOYED PARENT
(Instructions on Reverse of Form.)

STATE USE ONLY
☐ DSS ☐ County Welfare
☐ County Auditor

COUNTY

DATE (MONTH, YEAR)

A PERSONS COUNT ADULTS	CHILDREN	B TOTAL AID	
			1. Main Payroll.
			2. Current Month Supplemental Payroll.
( )	( )	( )	3. Current Month Cancellation Contra Roll.
			4. Zero Grant
			5. Prior Months Supplemental Payroll.
			6. Subtotal (Reconciliation Totals).
			7. Prior Months Cancellation Contra Roll.
( )	( )	( )	8. Abatements.
			9. Schedule of Adjustments (Show Minus Items in Parenthesis).
			10. Subtotals (Lines 7, 8, 9).
			11. DSS Office Audit Corrections (For State Use Only).
			12. Total.

		C	D FEDERAL (LINE 12B x .50)	E STATE (LINE 12B MINUS LINE 13A MINUS LINE 14D x 89.2%)	F COUNTY (LINE 12B MINUS LINE 14D MINUS LINE 14E)
	13. Immediate Need Payments not Subject to State Participation.				
	14.				
15.	Repayments				
16.	Grand Totals (FOR STATE USE)	(LINE 12B AND LINE 15C)	(LINE 14D AND LINE 15D)	(LINE 14E AND LINE 15E)	(LINE 14F AND LINE 15E)
17.					
18.	(FOR COUNTY USE)				
19.					
20.					

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Emergency Assistance in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the aid payments, allotments for payments in kind, aid repayments and adjustments reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the Department of Social Services.

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with authorizations for Emergency Assistance made by the county; that said amounts correctly reflect Federal, State and County Shares in the aid payments claimed and that warrants therefore have been issued, or funds made available for the payments in kind listed herein according to law and the rules and regulations of the Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE	SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

SOC 801 (6/83)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

A. Monthly Claims -- Reverse of SOC 801

INSTRUCTIONS FOR USE OF FORM SOC 801

1. Enter county name, month and year of claim in space provided.
2. Complete Lines 1 through 5 and 7 through 9 in accordance with the amounts shown on the integrated payroll summary. *(For nonintegrated payrolls, enter grand totals shown for each payroll or contra roll.)* All money amounts on the Form SOC 801 may be rounded to the nearer dollar.
3. Enter the subtotals in Lines 6 and 10 and the totals in Line 12.
4. Line 13A - Determine amount of immediate need not subject to state participation.
5. Line 14D - Enter the federal share in Line 14D: total aid paid (Line 12B) multiplied by 50 percent.
6. Line 14E - Enter the state share in Line 14E: total aid paid (Line 12B) minus Immediate Need Payments not subject to state participation (Line 13A) minus federal share (Line 14D) multiplied by 89.2 percent.
7. Line 14F - Enter the county share in Line 14F: total aid paid (Line 12B) minus federal share (Line 14D) minus state share (Line 14E).
8. Line 15C - Enter the total repayments as reported on the Repayment Contra Roll.
9. Line 15D, E and F. - Enter federal, state and county shares of repayments determined in accordance with the current federal, state, and county EA sharing ratios.
10. Line 16 - Enter Grand Totals.
11. Line 17 and 18 - Reserved for the application of adjustments made by the state *(federal and/or state field audit exceptions, etc.)*
12. Lines 19 and 20 - Included at county request and use is optional.

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- AD 800

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

CERTIFICATION - ADOPTION COST OF CARE SUBVENTION
UNDER W&IC 16106

FROM _____ COUNTY

FOR QUARTER ENDING _____, 19___ _____ FISCAL YEAR
(For State Use Only)

Forward three copies to the State Department of Social Services, 744 P Street, Sacramento 95814

1. Total Claimable Cost of Care Under W&IC 16106
(From Form AD 801A, Column 5) . . . . . .$_____

FOR STATE USE ONLY

I hereby certify, under penalty of perjury, that I am duly authorized to make this claim on behalf of the county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; and that the amounts claimed for cost of care have been expended in accordance with law, and the rules and regulations of the State Department of Social Services.

_____

TITLE _____

DATE _____, 19_____

I hereby certify, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; and that the records of this county indicate the amounts claimed are due and owing the county from the State of California according to law.

_____

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER

DATE _____, 19_____

AD 800 (5/78)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- AD 801A

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

COUNTY

QUARTER ENDING , 19

ADOPTION COST OF CARE CLAIM
(W & I Code Section 16106)

(1) NAME OF CHILD AND STATE CASE NUMBER	(2) DATE OF COURT COMMITMENT	(3) PERIOD IN WHICH THE SERVICES WERE GIVEN	(4) NAME OF PAYEE	WARRANT (5) AMOUNT	WARRANT (6) NUMBER	WARRANT (7) DATE	(8) IF #5 IS ONLY PORTION OF WARRANT, ENTER FULL AMOUNT HERE.

AD 801 A (10/83)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- DFA 837

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

SUMMARY REPORT OF ASSISTANCE EXPENDITURES
Old Age Security, Aid to the Blind, and Aid to the Disabled

FOR STATE USE ONLY

☐ SDSS ☐ COUNTY WELFARE ☐ COUNTY AUDITOR

COUNTY | DATE | QUARTER ENDING | YEAR

A. OLD AGE SECURITY

Column 1	Column 2	Column 3	Column 4	
Total	**Federal**	**State**	**County**	
				1. Repayments (Federal 48%, State 37%, County 15%)
				2. Adjustments (Refer to sharing ratio block below)
				3. State use only line
				4. Total

B. AID TO THE BLIND

Column 1	Column 2	Column 3	Column 4	
Total	**Federal**	**State**	**County**	
				1. Repayments (Federal 48%, State 37%, County 15%)
				2. Adjustments (Refer to sharing ratio block below)
				3. State use only line
				4. Total

C. AID TO THE DISABLED

Column 1	Column 2	Column 3	Column 4	
Total	**Federal**	**State**	**County**	
				1. Repayments (Federal 48%, State 37%, County 15%)
				2. Adjustments (Refer to sharing ratio block below)
				3. State use only line
				4. Total

FEDERAL PERCENTAGE BLOCK

OAS	AB	ATD

5. Federal Percentage to be used for adjustments.
(Use Nov. 1973 claims for OAS, AB, and ATD Federal percentages)

SHARING RATIOS FOR ADJUSTMENTS

	Federal	State	County
OAS	Federal % shown in above block X amount of the adjustment X 50%	Part A – Line 2 Col. 1 minus Col. 2	———
AB		Part B – Line 2 Col. 1 minus Col. 2	———
ATD		Part C – Line 2 Col. 1 minus Col. 2 x 50%	Part C – Line 2 Col. 1 minus Col. 2 and Col. 3

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Adult–Close Out Programs (Old Age Security, Aid to the Blind, and Aid to the Disabled) in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that all payments and collections reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.

COUNTY WELFARE DIRECTOR SIGNATURE DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with the law and the rules and regulations of the State Department of Social Services.

COUNTY AUDITOR OR CONTROLLER SIGNATURE DATE

DFA 837 (9/80)

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- Reverse of DFA 837

INSTRUCTIONS FOR USE OF FORM DFA 837

A. Enter county name and quarter and year of claim in space provided.

B. Line 1, Col. 1 – Enter total repayments from Repayment Contra Rolls.

C. Line 1, Col 2, 3, 4 – Enter the federal, state and county share of repayments determined in accordance with ratio printed on Line 1.

D. Line 2, Col. 1 – Enter the net amount of all other transactions.

E. Line 2, Col. 2, 3, 4 – Enter the federal, state and county share of all other transactions using the sharing ratio applicable to the specific program.

F. Line 3 – Reserved for the application of adjustments made by the state (Federal and/or State Field Audit Exceptions, etc.)

G. Line 4, Col. 1, 2, 3, 4 – Enter grand totals.

25-605 FORMS (Continued) 25-605

II. AID CLAIMS (Continued)

B. Quarterly Claims -- EL 800

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

Submit to: *DEPARTMENT OF SOCIAL SERVICES*
CLAIMS AUDIT AND CONTROL BUREAU
744 P STREET, M.S. 19–15
SACRAMENTO, CALIFORNIA 95814

SUMMARY REPORT OF UNCOLLECTED LOANS
(For Claiming Against the Emergency Revolving Fund)

FOR STATE USE

☐ DSS ☐ COUNTY WELFARE ☐ COUNTY AUDITOR

COUNTY	DATE (MONTH, YEAR)

FISCAL YEAR 19_____(Third prior Fiscal Year and beyond)

Uncollected Emergency Loans ..... $ _____
Abatements ..... $ (_____)
Amount of Reimbursement to County ..... $ _____

FISCAL YEAR 19_____(Second prior Fiscal Year)

Uncollected Emergency Loans ..... $ _____
Abatements ..... $ (_____)
Amount of Reimbursement to County ..... $ _____

FISCAL YEAR 19_____(First prior Fiscal Year)

Uncollected Emergency Loans ..... $ _____
Abatements ..... $ (_____)
Amount of Reimbursement to County ..... $ _____

CURRENT FISCAL YEAR

Uncollected Emergency Loans ..... $ _____
Abatements ..... $ (_____)
Amount of Reimbursement to County ..... $ _____

TOTAL FOR CURRENT, FIRST PRIOR, AND SECOND PRIOR FISCAL YEARS

Total Uncollected Emergency Loans ..... $ _____
Total Abatements ..... $ (_____)
Total Amount of Reimbursement to County ..... $ _____

TOTAL FOR THIRD PRIOR FISCAL YEAR AND BEYOND

Total Uncollected Emergency Loans ..... $ _____
Total Abatements ..... $ (_____)
Total Amount of Reimbursement to County ..... $ _____

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of Emergency Loans in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the uncollected loans and abatements reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.

SIGNATURE OF COUNTY WELFARE DIRECTOR	DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts claimed herein are in accordance with law and the rules and regulations of the State Department of Social Services.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

EL 800 (3/79)

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES

CA 355

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

DISTRICT ATTORNEY EMPLOYEE'S CHILD SUPPORT TIME STUDY FOR IV-D FUNCTIONS

PART I	EMPLOYEE INFORMATION		
1. NAME	2. CLASSIFICATION	3. COUNTY	4. MONTH/YEAR

PART II – INSTRUCTIONS ON BACK OF FORM

PART III DAILY TIME STUDY

	ACTIVITIES		DAYS 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Grand Total
1	Administration																																	
2	Collection and Distribution																																	
3	Establishment of Paternity	AFDC																																
		Non-AFDC																																
4	Location of Absent Parents	AFDC																																
		Non-AFDC																																
5.	Establishment of Support	AFDC																																
		Non-AFDC																																
6	Enforcement of Support	AFDC																																
		Non-AFDC																																
7	Total: Lines 3, 4, 5, and 6																																	
8	Total: Lines 1 through 6																																	
9	Non-Child Support	a. Disregard																																
		b. Other																																
10	Subtotal (Add Lines 8 and 9a and b)																																	
11	Nonallocable: Vacation, Sick Leave, Coffee Breaks, etc.																																	
12	DAILY GRAND TOTAL																																	

SAMPLE

EMPLOYEE *I hereby certify that this is a true and accurate report of my time, and the function performed as shown above.*

SIGNATURE OF EMPLOYEE — DATE

SUPERVISOR *I hereby certify the employee's daily time records have been examined and that, to the best of my knowledge and belief, this time record is true and correct, and the functions were performed as shown above.*

SIGNATURE OF SUPERVISOR — DATE

CA 355 (1-88)

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

Reverse of CA 355

PART II INSTRUCTIONS

STAFF REQUIRED TO TIME STUDY

Time studies are to be completed by:

1. All District Attorney staff engaged in AFDC and non-AFDC-related child support casework. This would include District Attorney employees outside the Family Support Division who bill the Family Support Division for time spent in child support activities.

2. Employees of other county agencies who bill the Family Support Division for child support activities.

3. Personnel normally required to time study include:

   a. District Attorneys and Deputy District Attorneys (when actually engaged in casework).

   b. Investigators

   c. Interviewers

   d. First Line Supervisors

   e. SEIF Processing staff

      (1) First Line Supervisors

      (2) Clerical Staff

   f. Budget Computation Staff

Time studies are optional for certain clerical personnel and for certain supervisors above the first line of supervision (see Fiscal Manual 25-960.23 and 25-960.24).

PART III

A. ACTIVITY DEFINITIONS

1. Administration – Activities of personnel engaged in the administration of the Child Support Enforcement Program. These activities include workload planning, program review, budget preparation, Family Support Council Meetings, execution of agreements with public and private providers, etc. District Attorneys, and administrative officers typically record time in this activity.

2. Collection and Distribution – These are the activities of staff members engaged in the processing of child support collections. These activities include receipt and posting of child support payments, computation of recoupment, pass on, and preparation of Forms CS 800 and CS 820. DA and Welfare staff processing and distributing Child Support payments typically record time in this activity.

3. Establishment of Paternity – Activities of staff members engaged in the determination of paternity in child support cases. Typical activities would include investigation, administration of polygraph and blood tests, making referrals to other states and counties, time in court, and cooperating with other states and counties to establish paternity in child support cases.

4. Location of Absent Parents – Activities undertaken by staff members to locate parents who have deserted their families. Activities would include investigation leading to location, utilization of the Parent Locator Service and making referrals to other state and local agencies.

5. Establishment of Support Obligation – Activities of staff members related to determining the ability of an absent parent to support his family, bringing court actions to secure child support orders.

6. Enforcement of Support Obligation – Activities of staff members, enforcing support obligations through appropriate legal remedies, including IRS, FTB AND UIB intercept systems, etc. This activity also includes investigations and prosecution of fraud related to child support

7. Non-AFDC – Any child support activities related to cases which are not linked to an aid program.

8. Non-Child Support – Any activities by staff members not related to the child support program such as welfare fraud, and issuing disregard payments, notices and disregard inquiries. Separate disregard activities from other activities on Line 9a, to aid in reimbursement from the IV-A agency.

B. SPECIAL INSTRUCTIONS

1. Record time in 15 minute increments (e.g., 3.25 hours, 3.50 hours, 3.75 hours).

2. Time spent on coffee breaks, is to be charged as nonallocable along with vacation and sick leave.

3. Holiday time should be treated as weekends.

4. All full-time employees participating in time study must show a total of 8 hours of time per working day. No overtime should be included.

5. Charge travel time to the activity with which it is associated.

6. Percentage of time spent should be based on applying subtotal on Line 10 against each item 1 through 9 (a and b) not daily grand total against these items.

SAMPLE

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.1

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

IV-D CHILD SUPPORT EXPENDITURE SCHEDULE AND CERTIFICATION

Please round all figures to nearest dollar. If additional space is needed, attach a separate sheet.

COUNTY | QUARTER ENDING

	ALLOCABLE COSTS Column 1	DIRECT COSTS Column 2	TOTAL Column 3
A. PERSONAL SERVICES — LOCAL IV-D AGENCY (Non EDP)			
1. Casework Staff (Legal, Investigative, etc.)	$	$	
2. Administrative Support	$	$	
3. Clerical Support	$	$	
TOTAL IV-D AGENCY PERSONAL SERVICES	$	$	$
B. OPERATING COSTS — LOCAL IV-D AGENCY (Non EDP)			
1. Space (itemize)			
_____ $ _____			
_____ $ _____	$		
2. Personal Property (Non EDP Equipment)	$		
3. Training and Travel	$		
4. Microfilm	$		
5. Other Operating Costs	$		
TOTAL IV-D AGENCY OPERATING COSTS	$		$
C. INDIRECT COSTS — LOCAL IV-D AGENCY			
1. Approved Indirect Cost Rate (_____%)	$		
2. Countywide Overhead (FMC 74-4/A-87)	$		
TOTAL IV-D AGENCY INDIRECT COSTS	$		$

D. PURCHASE OF SERVICES/COOPERATIVE AGREEMENTS (Non EDP) (itemize)

Agency	Code	Personal Services	Operating Costs	Indirect Costs			
		$	$	$	$	$	
		$	$	$	$	$	
		$	$	$	$	$	
		$	$	$	$	$	
TOTAL PURCHASE OF SERVICE COSTS					$	$	$

CS 356.1 (11/85) (Formerly CA 356)

SAMPLE

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.2

DEPARTMENT OF SOCIAL SERVICES

	ALLOCABLE COSTS Column 1	DIRECT COSTS Column 2	TOTAL Column 3
E. ELECTRONIC DATA PROCESSING (EDP) (itemize)			
Agency Code / Activity Code / Account Number / Personal Services / Operating Costs / Indirect Costs			
$ $ $	$	$	
$ $ $	$	$	
$ $ $	$	$	
$ $ $	$	$	
TOTAL EDP COSTS	$	$	$
F. LABORATORY COSTS (itemize)			
$ $			
$ $		$	
Less lab costs recovered		($)	
TOTAL LABORATORY COSTS		$	$
G. ABATEMENTS (itemize)			
$ $			
$ $			
TOTAL ABATEMENTS		($)	($)
H. TOTAL DISTRICT ATTORNEY SUPPORT COSTS	$	$	$
I. SUPERIOR COURT SYSTEM — EXPEDITED PROCESS COSTS: Personal Services $ Operating Costs $ Indirect Costs $			$
J. GRAND TOTAL IV-D COSTS			$

SAMPLE

CODES:

Agency	Code	Activity	Code
Private	A	Feasibility Study	C1
Public	B	Developmental/Imple	C2
		Ongoing	C3

Contact Person _____

Telephone Number _____

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the child support program in and for said county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts reported herein have been expended and are properly chargeable as expenditures for administration of the child support program in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Benefits and Services Advisory Board.

SIGNATURE OF COUNTY DISTRICT ATTORNEY | DATE

I hereby certify, under penalty of perjury, that I am the official in aforesaid county, responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the expenditures reported herein have been authorized by the district attorney and that warrants therefore have been issued or expenditures otherwise incurred according to law.

SIGNATURE OF COUNTY AUDITOR | DATE

CS 356.2 (7-87)

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.3

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

COUNTY	QUARTER ENDING

IV—D CHILD SUPPORT TIME SUMMARY AND ACTIVITY ALLOCATION RATIOS

LINE	ACTIVITIES		TOTAL ALLOCABLE HOURS 1/	ALLOCATION RATIO 3/
	1		2	3
A	Administration			
B	Collection and Distribution			
C	Establishment of Paternity			
D	Location of Absent Parent			
E	Establishment of Support			
F	Enforcement of Support			
G	Non-Child Support	Disregard a		
		Other b		
H	GRAND TOTAL HOURS 2/			1.000000

SAMPLE

1/ For Lines A through F, accumulate monthly totals of all hours (AFDC and Non-AFDC) by activity from Grand Total Column of CS 355's. Line G, items a and b must agree with Line 9, a and b of the CS 355's.

2/ Enter monthly total of all hours recorded on Line 10 of CS 355's.

3/ Ratios are obtained by dividing hours recorded in each activity by Grand Total Hours Line H, Column 2.

MODIFICATION A COMPUTATION OF AFDC AND NON-AFDC HOURS

LINE	Hours	Ratio 7/
	1	2
A	AFDC 4/	
B	Non-AFDC 5/	
C	TOTAL 6/	

4/ Enter monthly total of AFDC related hours recorded on Lines 3, 4, 5 and 6 of CS 355's.

5/ Enter monthly total of Non-AFDC related hours recorded on Lines 3, 4, 5 and 6 of CS 355's.

6/ Enter the sum of Lines A and B.

7/ Divide hours on Lines A and B by hours recorded on Line C.
Transfer ratios recorded in Column 2 to MODIFICATION B, CS 356.7.

CS 356.3 (10-85) (FORMERLY CA 356)

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.4

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

IV-D CHILD SUPPORT PROGRAM DISTRIBUTION
TOTAL ALLOCABLE COSTS

COUNTY | QUARTER & YEAR

			LOCAL IV-D AGENCY			PURCHASE OF SERVICES 2/			ELECTRONIC DATA PROCESSING 3/			
			Personal Services	Operating Costs	Indirect Costs	Personal Services	Operating Costs	Indirect Costs	Personal Services	Operating Costs	Indirect Costs	TOTALS
	Activities	Ratios 1/	CS 356.1, A, Col. 1 times Col. 2 ratios	CS 356.1, B, Col. 1 times Col. 2 ratios	CS 356.1, C, Col. 1 times Col. 2 ratios	CS 356.1, D times Col. 2 ratio	CS 356.1, D times Col. 2 ratio	CS 356.1, D times Col. 2 ratio	CS 356.2, E times Col. 2 ratio	CS 356.2, E times Col. 2 ratio	CS 356.2, E times Col. 2 ratio	Sum of Col 3 thru 11
	1	2	3	4	5	6	7	8	9	10	11	12
A	Administration											
B	Collection and Distribution											
C	Establishment of Paternity											
D	Location of Absent Parent											
E	Establishment of Support											
F	Enforcement of Support											
G	Non-Child Support: a. Disregard											
	Non-Child Support: b. Other											
H	TOTALS	1.000000										4/

1/ Bring ratios forward from CS 356.3, Column 3.

2/ Prepare subtotals of only those costs reported as Allocable in Column 1, on the CS 356.1, Group D, and transfer to the appropriate Column 6, 7 and 8.

3/ Prepare subtotals of only those costs reported as Allocable in Column 1, on the CS 356.2, Group E, and transfer to the appropriate Column 9, 10 and 11.

4/ This total must agree with CS 356.2, Group H, Column 1.

CS 356.4 (11) (REVISED 11-1-84)

SAMPLE

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.5

STATE OF CALIFORNIA • HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SER

IV-D CHILD SUPPORT PROGRAM DISTRIBUTION
DIRECT COSTS (Excluding Lab costs)

COUNTY	QUARTER ENDING

		LOCAL IV-D AGENCY			PURCHASE OF SERVICES 1/			ELECTRONIC DATA PROCESSING 2/				
		Personnel Services	Operating Costs	Indirect Costs	Personnel Services	Operating Costs	Indirect Costs	Personnel Services	Operating Costs	Indirect Costs	Abatements	Totals
LINE	Activities	CS 357 Col. 4		CS 357 Col. 5	CS 356.1 D	CS 356.1 D	CS 356.1 D	CS 356.2 E	CS 356.2 E	CS 356.2 E	CS 356.2 G Col. 2	Sum of Col. 2 Thru 11
	1	2	3	4	5	6	7	8	9	10	11	12
A	Administration										( )	
B	Collection and Distribution										( )	
C	Establishment of Paternity											
D	Location of Absent Parent											
E	Establishment of Support											
F	Enforcement of Support											
G	Total										( )	

SAMPLE

1/ Prepare subtotals of only those costs reported as Direct in Column 2, on the CS 356.1, Group D, and transfer to appropriate Column 5, 6, and 7.
2/ Prepare subtotals of only those costs reported as Direct in Column 2, on the CS 356.2, Group E, and transfer to appropriate Column 8, 9, and 10.

CS 356.5 (11-84)

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.6

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

IV-D CHILD SUPPORT PROGRAM DISTRIBUTION
TOTAL ALLOCABLE AND DIRECT COSTS (Excluding Lab costs)

COUNTY	QUARTER ENDING

LINE	Activities		LOCAL IV-D AGENCY			PURCHASE OF SERVICES			ELECTRONIC DATA PROCESSING			Subtotal	Abatements	Totals
			Personal Services	Operating Costs	Indirect Costs	Personal Services	Operating Costs	Indirect Costs	Personal Services	Operating Costs	Indirect Costs			
			CS 356.6, Col. 1 Plus 356.5, Col. 2	356.6 Col. 1	356.6, Col. 2 Plus Col. 4 356.5	356.6, Col. 5 Plus 356.5 Col. 5	356.6, Col. 7 Plus 356.5 Col. 6	356.6, Col. 8 Plus 356.5 Col. 7	356.6, Col. 9 Plus 356.5 Col. 8	356.6, Col. 10 Plus 356.5 Col. 9	356.6, Col. 11 Plus 356.5 Col. 10	Sum of Col. 6 thru 10	356.5, Col. 11	Col. 11 Less Col. 12
	1		2	3	4	5	6	7	8	9	10	11	12	13
A	Administration												( )	
B	Collection and Distribution												( )	
C	Establishment of Paternity													
D	Location of Absent Parent													
E	Establishment of Support													
F	Enforcement of Support													
G	Subtotal												( )	
H	Non-Child Support	a. Disregard												
		b. Other												
I	TOTALS												( )	

CS 356.6 (Rev.)

SAMPLE

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.7

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

IV-D CHILD SUPPORT PROGRAM DISTRIBUTION REPORT OF TOTAL EXPENDITURES

COUNTY	QUARTER ENDING

LINE	Activities		EXPENDITURES FOR THE QUARTER (Round to nearest dollar) Total 1/		Federal 2/		County 3/
			1		2		3
A	Administration	01				03	
B	Collection and Distribution	04				06	
C	Establishment of Paternity	07				09	
D	Location of Absent Parent					12	
E	Establishment of Support			14		15	
F	Enforcement of Support			17		18	
G	Subtotal			20		21	
H	Non-Child Support	22				23	
		24				25	
I	Laboratory Co	26	4/	27	5/	28	
J	TOTAL DISTRICT	29	6/	30		31	
K	SUPERIOR COURT SYSTEM—EXPEDITED PROCESS	32	7/	33		34	
L	GRAND TOTAL 8/	35		36		37	

1/ Bring figures forward from CS 356.6, Column 13 (except Lines I, J, and K).
2/ Multiply Column 1, Lines A through G and Line K by the Federal Financial Participation Rate applicable for this period.
3/ County Share is Column 1 less Column 2.
4/ Bring figure forward from CS 356.2, Group F, Column 3.
5/ Multiply column I by 90% special Federal Financial Participation Rate.
6/ Total must agree with CS 356.2, Group H, Column 3.
7/ Bring figure forward from CS 356.6, Group I, Column 3.
8/ Column 1 should agree with CS 356.2, Group J, Column 3.

These two Modifications are for statistical reporting purposes only. They have no effect on your claim.

MODIFICATION B – AFDC AND NON AFDC IDENTIFICATION

LINE	Identification 1		Ratio 2		Child Support Costs 11/ 3
A	AFDC 9/	38	.	39	
B	NON AFDC 10/	40	.	41	
C	TOTAL		1.000000	42	

9/ Bring ratio forward from CS 356.3, Mod A, Column 2, Line A.
10/ Bring ratio forward from CS 356.3, Mod A, Column 2, Line B.
11/ Multiply Column 2 ratios by Child Support Costs, Subtotal above, Line G, Column 1.
12/ All expenditure items for Mod C, are obtained from CS 356.6, Subtotal, Line G, Columns 2 through 11, and Column 13.
13. Bring figure forward from CS 356.2, Group F, Column 3.

CS 356.7 (11/86)

MODIFICATION C—SPECIFIC EXPENDITURE ITEM SUMMARY 12/

LINE	Expenditure Item 12/ 1		Personal Services 2		Operating Costs 3		Indirect Costs 4	
A	Local IV-D	43		44		45		
B	Purchase of Services	46		47		48		
C	EDP	49		50		51		
D	Lab costs			52	13/			
E	Abatements			53	( )			
F	TOTAL	54		55		56		

SAMPLE

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 356.8

STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

COUNTY	QUARTER ENDING

IV-D CHILD SUPPORT PROGRAM — PERSONAL SERVICES

These two modifications are for statistical reporting purposes only. There is no fiscal effect on the claim.

MODIFICATION D — EDP PERSONAL SERVICES

LINE	SOURCE	EDP PERSONAL SERVICES 1/	RATIO 2/
		COLUMN 1	COLUMN 2
A	LOCAL IV-D AGENCY		
B	PURCHASE OF SERVICES		
C	TOTAL		1.000000

1/ Figures from CS 356.2, Part E, Personal Services Column
2/ Divide Column 1, Line A, by Column 1, Line C
Divide Column 1, Line B, by Column 1, Line C

SAMPLE

MODIFICATION E — PERSONAL SERVICES

LINE	SOURCE	LOCAL IV-D AGENCY	PURCHASE OF SERVICES	TOTAL
		COLUMN 1	COLUMN 2	COLUMN 3
A	EDP PERSONAL SERVICES	3/	4/	
B	OTHER PERSONAL SERVICES	5/	6/	
C	GRANT TOTAL			7/

3/ Multiply the Ratio from MOD. D, Column 2, Line A Times MOD. C, Line C, Column 2.
4/ Multiply the Ratio from MOD. D, Column 2, Line B Times MOD. C, Line C, Column 2.
5/ Figure from MOD C, Line A, Column 2.
6/ Figure from MOD. C, Line B, Column 2.
7/ This Grant Total Must Equal MOD. C, Line F, Column 2.

CS 356.8 (12/86)

25-605 FORMS (Continued) 25-605

V. CLAIMS FOR CHILD SUPPORT ADMINISTRATIVE EXPENDITURES (Continued)

CS 357

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

GROUP A INDIVIDUAL EMPLOYEE WORKSHEET
LOCAL IV—D AGENCY — DIRECT COSTS

Use of this form is required for claiming any Direct Group A costs on the CS 356.1.

COUNTY	FISCAL YEAR	QUARTER ENDING
EMPLOYEE NAME		CLASSIFICATION

		TOTALS
A. 1. Child Support Hours		
2. Total Hours	+	
3. Child Support Percentage	= %	
B. 1. Child Support Percentage (A. 3.)	%	
2. Quarterly Personal Services (Salaries and Benefits)	x $	
3. Claimable Personal Services		= $
C. 1. Claimable Personal Services	$	
2. Indirect Cost Rate (Employee Division Rate)	x %	
3. Claimable Indirect Costs		= $
D. 1. Claimable Personal Services	$	
2. Claimable Indirect Costs (C. 3.)	+ $	
3. Total Claimable Costs		= $ 1/

SAMPLE

Activities	Total Child Support Hours	Ratios 2/	PERSONAL SERVICES 3/ Claimable Personal Services (B. 3. times Column 3 ratio)	INDIRECT COSTS 4/ Claimable Indirect Costs (C. 3. times Column 3 ratio)
1	2	3	4	5
Administration				Line A
Collection and Distribution				Line B
Establishment of Paternity				Line C
Location of Absent Parent				Line D
Establishment of Support				Line E
Enforcement of Support				Line F
Total		1.000000		Line G

1/ This cost will be reported on CS 356.1, Group A, Column 2.

2/ Ratios are obtained by dividing hours recorded in each activity by Total hours recorded in Column 2.

3/ Transfer costs recorded in each activity to CS 356.5, Column 3, Lines A through G.

4/ Transfer costs recorded in each activity to CS 356.5, Column 4, Lines A through G.

CS 357 (10/85)

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (See Chapter 25-900)

CS 278L

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

CHILD AND SPOUSAL SUPPORT CASE HISTORY AND LIST OF AUTHORIZATIONS

RECIPIENT:	PAYEE	STATE CASE NUMBER	COUNTY
ABSENT PARENT:	NAME	SOCIAL SECURITY NUMBER	
SUPPORT OBLIGATION:	CURRENT DOLLARS $	DATE OF COURT ORDER	

Monthly Transaction Number	Date of Collection	Amount of Collection	Mo./Yr.	Assistance Paid	Current Recoupment	Prior Recoupment	Disregard	Pass-on	Excess	Unreimbursed Assistance	Unreimbursed Assistance Pool	Authorized By Initial	Authorized By Date

SAMPLE

CS 278L (9-84) Required Form - Substitute Permitted

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 278M

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

CHILD AND SPOUSAL SUPPORT TRANSMITTAL/ACTION DOCUMENT

A COLLECTION AGENCY INFORMATION

MONTHLY TRANSACTION NUMBER | STATE CASE NUMBER

1(a) COUNTY NAME AND CODE | 1(b) COLLECTING AGENCY NAME AND CODE

2(a) ABSENT PARENT INFORMATION — ABSENT PARENT NAME | 2(b) ABSENT PARENT'S SOCIAL SECURITY NUMBER

2(c) COMPANION CASES

3 RECIPIENT INFORMATION — PAYEE NAME

	TOTAL (Column 1)
4. Amount of Collection	$
4(a). Amount of Current Obligation	$
4(b). Amount of Assigned Arrearages	$
4(c). Date of court order	4(d). Date of Collection

B DISTRIBUTION AGENCY ACTION DOCUMENT

1. TOTAL COLLECTIONS (LINE 4A, ABOVE) $ | 1(a) CURRENT $ | 1(b) ARREARAGES $ | 1(c) FUTURE $

2 CURRENT MONTH

CHECK (✓) IF APPLICABLE ☐ Emergency Assistance Case FC ☐ Emergency Assistance U

2(a). Assistance Paid	$	
2(b). Current Collection	$	Section B, Line 1(a).
2(c). Disregard		
2(d). Collection Remaining	$	Section B, Line 2(b) minus 2(c).
2(e). Recoupment	$	Section B, Line 2(a) or 2(d), whichever is less.
2(f) Pass-on	$	Section B, Line 2(d) minus Line 2(a), if amount of Line 2(d) exceeds Line 2(a).
2(g) Unreimbursed Assistance	$	Section B, Line 2(a) minus Line 2(d).
3. Recoupment of Prior Months Unreimbursed Assistance		
3(a). Unreimbursed Assistance	$	
3(b). Arrearage Collection	$	Section B, Line 1(b).
3(c). Recoupment	$	Section B, Line 3(a) or 3(b), whichever is less.
3(d). Unreimbursed Assistance Remaining	$	Section B, Line 3(a) minus Line 3(c).
3(e). Excess	$	Section B, Line 3(b) minus Line 3(c).

C. PAYMENT INFORMATION

NAME OF FAMILY

ADDRESS

PAYMENT AMOUNT	DISREGARD	PASS-ON	EXCESS
$	$	$	$

SIGNATURE OF BUDGET CLERK | DATE

CS 278M (8/84) Required Form - Substitute Permitted

SAMPLE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 800

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

SUMMARY REPORT OF CHILD AND SPOUSAL SUPPORT PAYMENTS

(Round all figures to the nearest dollar.)

FOR STATE USE: ☐ DSS ☐ COUNTY WELFARE ☐ COUNTY AUDITOR ☐ DISTRICT ATTORNEY
COUNTY CODE
MONTH

☐ Family Group (FG) Federal
☐ Family Group (FG) Non-Federal
☐ Unemployed (U) Federal
☐ Unemployed (U) Non-Federal
☐ Foster Care (FC) Federal
☐ Foster Care (FC) Non-Federal
☐ Emergency Assistance (EA) (FC)
☐ Emergency Assistance (EA) (U)

COUNTY	MONTH YEAR	PREPARED BY	PHONE ( )

A. COLLECTIONS AND DISBURSEMENT

	COLUMN 1 INTRACOUNTY Distribution	COLUMN 1 INTRACOUNTY Case Count	COLUMN 2 INTERCOUNTY Distribution	COLUMN 2 INTERCOUNTY Case Count	COLUMN 3 INTERSTATE Distribution	COLUMN 3 INTERSTATE Case Count	COLUMN 4 TOTAL Columns 1 thru 3	
1. Amount collected for disbursement							a	b
2. Disregard remitted to family							c	d
3. Pass-on remitted to family							e	f
4. Excess remitted to family							g	h
5. Total recoupment							i	

B. RECOUPMENT – CURRENT AND PRIOR

1. Current	j	(CS 801)
2. Prior	k	(CS 801)
3. Total Recoupment	l	(Column 4, Line 5)

TO BE COMPLETED AT COUNTY OPTION

C. REPAYMENT COMPUTATION

	FEDERAL	STATE	COUNTY	TOTAL (Columns 1 thru 3)
1. Recoupment only (Column 4, Line A5 x Recoupment Ratios)				

D. INCENTIVE COMPUTATION

	For Claiming County (Column 1 + Column 3)	To Collecting County (Column 2)
1. Section A, Line 1 x Federal AFDC Incentive (Federal FG, U, FC and EA programs)		
2. Section A, Line 1 x State AFDC Incentive (Federal FG, U, FC, EA and Non-Federal FG and U programs)		
3. Section A, Line 1 x Federal Non-AFDC Incentive (Non-Federal FG, U and FC programs)		

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the distribution of AFDC Child Support Collections in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the distribution of child support collections reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.

SIGNATURE OF COUNTY OR DISTRICT ATTORNEY — DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts reflected herein are in accordance with authorizations for the Child Support Enforcement Program made by the county; that said amounts correctly reflect proper distribution and that warrants therefore have been issued according to law and the rules and regulations of the State Department of Social Services.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER — DATE

CS 800 (7-88)

SAMPLE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 801

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

CHILD AND SPOUSAL SUPPORT PAYROLL FORM FOR COLLECTIONS AND DISBURSEMENT

(Do not use this revision for reporting collections made prior to July 1, 1978)

	COLLECTED BY	COLLECTED FOR
☐ WITHIN COUNTY		
☐ BETWEEN COUNTY		
☐ INTERSTATE		

COUNTY NAME	MONTH YEAR

STATE CASE NUMBER	PAYEE NAME	ABSENT PARENT	SOCIAL SECURITY NUMBER	AMOUNT COLLECTED	CURRENT MONTH COLLECTION	PRIOR MONTH COLLECTION	DISREGARD	PASS ON	EXCESS	CURRENT MONTH RECOUPMENT	MONTHLY COLLECTION	PRIOR MONTH RECOUPMENT
		Collections and Disbursement Total.....										
		Case Count.....										

SAMPLE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 801A

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

SUMMARY CS 800 RECONCILIATION — INTRACOUNTY/INTERSTATE

COUNTY | MONTH/YEAR

	AMOUNT COLLECTED FOR DIBURSEMENT	DISREGARD	PASS-ON	EXCESS	TOTAL RECOUPMENT	TOTAL RECOUPMENT CURRENT	TOTAL RECOUPMENT PRIOR
INTRACOUNTY							
Family Group (FG) Federal							
Family Group (FG) Non-Federal							
Unemployed (U) Federal							
Unemployed (U) Non-Federal							
Foster Care (FC) Federal							
Foster Care (FC) Non-Federal							
Emergency Assistance (EA) (FC)							
Emergency Assistance (EA) (U)							
INTERSTATE							
Family Group (FG) Federal							
Family Group (FG) Non-Federal							
Unemployed (U) Federal							
Unemployed (U) Non-Federal							
Foster Care (FC) Federal							
Foster Care (FC) Non-Federal							
Emergency Assistance (EA) (FC)							
Emergency Assistance (EA) (U)							

CS 801A (7/86)

SAMPLE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 801B

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

INTERCOUNTY
SUMMARY CS 800 RECONCILIATION

☐ FG (Fed) ☐ FG (Non-Fed) ☐ U (Fed) ☐ U (Non-Fed) ☐ FC (Fed) ☐ FC (Non-Fed) ☐ EA (FC) ☐ EA (U)

COUNTY MONTH YEAR

INTERCOUNTY Collecting Co	FIPS	Amt. Collected For Disbursement	Disregard	Pass-on	Excess	Total Recoupment	Total Recoupment	
							Current	Prior
TOTAL								

CS 801B (7/86)

SAMPLE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 820

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

FOR STATE USE ONLY		
☐ DSS	☐ COUNTY AUDITOR	☐ DISTRICT ATTORNEY
COUNTY CODE		
MONTH		

CHILD/SPOUSAL SUPPORT COLLECTIONS SUMMARY REPORT

COUNTY _____

MONTH/YEAR _____

CONTACT NAME _____

TELEPHONE _____

A. COLLECTIONS

Items 1-10: Do not include collections received from other jurisdictions.

		COLUMN I AFDC		COLUMN II Foster Care		COLUMN III Non-AFDC
1. Collections made through IRS Tax Offset:						
a. For any California county	01	$	02	$	03	$
b. For other state IV-D agencies	04	$	05	$		
2. Collections made through FTB Offset:						
a. For any California county	07	$	08	$		
b. For other state IV-D agencies	10	$	11			
3. Collections made through UIB Offset:						
a. For any California county	13	$				
b. For other state IV-D agencies	16	$			18	$
4. Collections made through withholdings:						
a. For any California county					21	$
b. For other state IV-D agencies					24	$
5. Collections made through liens:						
a. For any California county			26	$	27	$
b. For other state IV-D agencies			29	$	30	$
6. Collections made through Workers' Compensati						
a. For any California county	31	$	32	$	33	$
b. For other state IV-D agencies	34	$	35	$	36	$
7. Collections made through Disability Insurance:						
a. For any California county	37	$	38	$	39	$
b. For other state IV-D agencies	40	$	41	$	42	$
8. All other collections:						
a. For any California county	43	$	44	$	45	$
b. For other state IV-D agencies	46	$	47	$	48	$
9. Adjustments to previously reported collections:						
a. For any California county	49	$	50	$	51	$
b. For other state IV-D agencies	52	$	53	$	54	$

SAMPLE

CS 820 (10/88)

(Continued on Reverse)

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

Reverse of CS 820

		AFDC		Foster Care		Non-AFDC
10. Total collections:						
a. For any California county	55	$	56	$	57	$
Count	58		59			
b. For other state IV-D agencies	61	$	62	$		
Count	64		65			
11. Collections received: a. From other California counties	67	$	68	$		
Count	70		71			
b. From other state IV-D agencies	73	$				$
Count	76				78	
12. Total intracounty collections:	79	$			81	$
Count	82				84	
13. Payments to non-AFDC families					85	$
					86	
14. Collections for terminated AFDC cases (Combine collections made for and received from all jurisdictions)					87	$
Count					88	
15. Collections for non-federal foster care					89	$
Count					90	

SAMPLE

B. COLLECTIONS ELIGIBLE FOR INCENTIVES

16. Federal AFDC — Cols. I & II, 10b = _____
17. Federal non-AFDC — Col. III, 10b + 13 = _____
18. State non-AFDC — Col. III, 13 = _____

FOR STATE USE ONLY

INCENTIVES

FEDERAL:	AFDC		Non-AFDC	STATE:	Non-AFDC
Federal Line 16 x Incentive		Federal Line 17 x Incentive		State Line 18 x Incentive	

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the collection of support payments under the title IV-D Program in and for aforesaid county; that I have not violated any of the provisions of Sections 1090 and 1096, inclusive, of the Government Code; that the disbursement of support collections reflected herein have been made in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Department of Social Services.

SIGNATURE OF DISTRICT ATTORNEY DATE

I HEREBY CERTIFY, under penalty of perjury, that I am the officer in aforesaid county responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the amounts reflected herein are in accordance with authorizations for the Child Support Enforcement Program made by the county; and that warrants therefore have been issued according to law and the rules and regulations of the State Department of Social Services.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER DATE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 821

SUPPORT COLLECTION REPORT

Intracounty Collections
☐

Intercounty Collections
☐ For California Counties
☐ From California Counties

Interstate Collections
☐ For Other State IV-D Agencies
☐ From Other State IV-D Agencies

Status
☐ AFDC
☐ Foster Care
☐ Non-AFDC
☐ Nonfederal Foster Care

Page _____
County _____
Month _____ Year _____
Jurisdiction FIPS Code _____

Adjustments
☐

			AMOUNT COLLECTED									
COUNTY ID NUMBER	CASE NAME (OPTIONAL)	TRANSACTION NUMBER	TOTAL COLLECTION	IRS	FTB	UIB	WITHHOLDING	LIENS	WORKER'S COMPENSATION	DISABILITY INSURANCE	ALL OTHER COLLECTIONS	TERMINATED AFDC
COUNT												
TOTAL												

SAMPLE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 822

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

SUMMARY CS 820 RECONCILIATION STATEMENT

INTERCOUNTY/INTERSTATE — COLLECTIONS MADE BY REPORTING COUNTY FOR THE OTHER CALIFORNIA COUNTIES AND FOR OTHER STATE IV-D AGENCIES.
Data obtained from supporting CS 821 Pages _____ through _____ for the _____, 19 ____ CS 820.

	INTRACOUNTY	INTERCOUNTY	TOTAL INTRA/ INTERCOUNTY	INTERSTATE
IRS: AFDC	$	$	$	
FOSTER CARE				
NON-AFDC				
FTB: AFDC				
FOSTER CARE				
NON-AFDC				
UIB: AFDC				
FOSTER CARE				
NON-AFDC				
WITHHOLDING: AFDC				
FOSTER CARE				
NON-AFDC				
LIENS: AFDC				
FOSTER CARE				
NON-AFDC				
WORKER'S COMPENSATION: AFDC				
FOSTER CARE				
NON-AFDC				
DISABILITY INSURANCE: AFDC				
FOSTER CARE				
NON-AFDC				
ALL OTHER COLLECTIONS: AFDC				
FOSTER CARE				
NON-AFDC				
ADJUSTMENTS: AFDC				
FOSTER CARE				
NON-AFDC				
TOTAL COLLECTIONS: AFDC	$	$	$	$
COUNT				
FOSTER CARE	$	$	$	$
COUNT				
NON-AFDC	$	$	$	$
COUNT				

(Continued on Reverse)

CS 822 (10/84)

SAMPLE

25-605 FORMS (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

Reverse of CS 822

INTERCOUNTY/INTERSTATE — COLLECTIONS RECEIVED BY REPORTING COUNTY FROM OTHER CALIFORNIA COUNTIES AND OTHER STATE IV-D AGENCIES.

Data obtained from supporting CS 821 Pages _____ through _____ for the _____, 19____ CS 820.

	INTERCOUNTY	INTERSTATE
AFDC	$	$
COUNT		
FOSTER CARE	$	$
COUNT		
NON-AFDC	$	$
COUNT		

PAYMENTS TO NON-AFDC FAMILIES - Payments made to Families Not Receiving Public Assistance.

Data obtained from _____ (SOURCE), Pages _____ Through _____

NON-AFDC Payments to families $ _____ Count _____

PAYMENTS FOR TERMINATED AFDC CASES - Collections made by reporting and county and received from other jurisdictions on behalf of families who are former recipients of aid and for whom collections are being made for a 5 month period.

Data obtained from supporting CS 821 Pages _____ through _____ for the _____, 19____ CS 820.

Payments for terminated AFDC cases $ _____ Count _____

NON-FEDERAL FOSTER CARE COLLECTIONS - Collections made by reporting county on behlaf of non-federal foster care children.

Data obtained from supporting CS 821 Pages _____ through _____ for the _____, 19____ CS 820.

Non-Federal foster care payments $ _____ Count _____

SAMPLE

25-605 **FORMS** (Continued) 25-605

VII. CHILD SUPPORT INCENTIVE CLAIMS (Continued)

CS 831 and Reverse

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

COLLECTION AGENCY – ACCOUNTS RECEIVABLE ☐ WELFARE ☐ NONWELFARE

ABSENT PARENT a) Social Security No. _____ b) Name _____

RECIPIENT a) Social Security No. _____ b) Name _____

c) State Case No. _____

SUPPORT OBLIGATION a) Current $ _____ b) Date of Court Order _____

CURRENT						ARREARAGES				
COLLECTION AGENCY CODE	MONTHLY TRANSACTION NUMBER	DATE OF COLLECTION	AMOUNT RECEIVED	SEIF REIMBURSEMENT	DATE OF COLLECTION	MO / YR	DATE OF COLLECTION	AMOUNT RECEIVED	INCREASED OBLIGATION	BALANCE

CS 831 (8/79)

SAMPLE

CURRENT						ARREARAGES				
COLLECTION AGENCY CODE	MONTHLY TRANSACTION NUMBER	DATE OF COLLECTION	AMOUNT RECEIVED	SEIF REIMBURSEMENT	DATE OF COLLECTION	MO / YR	DATE OF COLLECTION	AMOUNT RECEIVED	INCREASED OBLIGATION	BALANCE

25-605 FORMS (Continued) 25-605

VIII. OVERPAYMENT AND REPAYMENT RECEIVABLE RECORDS (see Chapter 25-400)

ABCD 830

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

OVERPAYMENT RECEIVABLE RECORD

CASE NAME	CASE NUMBER	DISTRICT
ADDRESS	ELIGIBILITY WORKER	

A. SUMMARY OF OVERPAYMENT/UNDERPAYMENT

MO/YR	AMOUNT	MO/YR	AMOUNT	MO/YR	AMOUNT	MO/YR	AMOUNT
1.	$	4.	$	7.	$	10.	$
2.	$	5.	$	8.	$	11.	$
3.	$	6.	$	9.	$	12.	$

1. Net total amount (Items 1 thru 12) . . . . . $
2. Amount to be recovered by grant adjustment . . . . $
3. Amount to be recovered by voluntary cash recovery $

B. OVERPAYMENT DATA

1. Recipient Met Reporting Responsibility ☐ Recipient did not Meet Reporting Responsibility

Date of Fair Hearing _____ Date of Discovery/Fair Hearing _____

2. Reason for Overpayment

Recipient Error _____

Agency Error _____

C. SCHEDULE OF RECOVERY PLAN AND ACTUAL PAYMENTS RECEIVED

Grant Adjustments

MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.
1				5				9			
2				6				10			
3				7				11			
4				8				12			

Total Grant Adjustments Received – Items 1 thru 12 → $

Voluntary Cash Recovery

MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.	MO/YR	AMT. DUE	MO/YR	AMT. REC.
1				5				9			
2				6				10			
3				7				11			
4				8				12			

Total Voluntary Cash Recovery Received – Items 1 thru 12 → $

D. COMPUTATION OF UNRECOVERED OVERPAYMENT

1. TOTAL AMOUNT RECOVERED (grant adjustments plus voluntary cash recovery) . . . . . $
2. TOTAL UNRECOVERED OVERPAYMENT (Section A, Line 1 minus Section D, Line 1). . . . . $

ELIGIBILITY WORKER	DATE

ABCD 830 (1/80)

25-605 FORMS (Continued) 25-605

VIII. OVERPAYMENT AND REPAYMENT RECEIVABLE RECORDS (Continued)

Reverse of ABCD 830

DATE	COMMENTS/CONTACTS WITH RECIPIENT

INSTRUCTIONS

This form is for the recording of an overpayment due to a single eligibility factor whether that overpayment occurs in one month only or over a period of several months. Where more than one eligibility factor exists, refer to EAS Manual Section 44-350.5.

For each overpayment that occurs, Sections A, B, and, if possible, C, are to be completed. The original copy of the form is to remain in the case file.

Section C is separated into two sections, grant adjustments and voluntary cash recovery. After consultation with the recipient, scheduling of the amount to be recovered during the adjustment period should be done in the Month/Year and Amount Due columns.

As recoveries are made either by grant adjustment or voluntary cash recovery enter the recovery information in the appropriate part of Section C.

The box on line 1 of Section D reflects the total amount accumulated in Section C for grant adjustments and voluntary cash recovery.

REVERSE OF FORM ABCD 830

25-605 FORMS (Continued) 25-605

VIII. OVERPAYMENT AND REPAYMENT RECEIVABLE RECORDS (Continued)

ABCD 831

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

REPAYMENT RECEIVABLE RECORD

NAME

ADDRESS

STATE NUMBER

AMOUNT OF REPAYMENT DUE

EFFECTIVE DATE OF REPAYMENT

REASON FOR OVERPAYMENT

DEMAND NOTICE SENT

DATE OF VOLUNTARY AGREEMENT TO REIMBURSE

TERMS OF VOLUNTARY AGREEMENT

JUDGMENT LIENS IN EFFECT

CRIMINAL ACTIONS TAKEN

STATUTE OF LIMITATIONS DATE

Remarks	Date of Receipt	Amounts Repaid	Balance Due	Remarks	Date of Receipt	Amounts Repaid	Balance Due

ABCD 831 (8/79)

25-605 FORMS (Continued) 25-605

IX. MISCELLANEOUS FORMS (See Chapter 25-800)

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL WELFARE

CLAIM FOR REIMBURSEMENT
LOCAL AGENCY SPECIAL PROJECT

TO: Accounting Bureau
State Department of Social Welfare
744 P Street
Sacramento, California 95814

NAME AND ADDRESS OF CLAIMANT

PROJECT NUMBER	PROJECT NAME	COVERING EXPENDITURES FOR THE PERIOD _____ THRU _____

CLASSIFICATION OF EXPENDITURES	(A) TOTAL PROJECT EXPENDITURES	(B) COSTS NOT REIMBURSABLE FROM PROJECT FUNDS	(C) COSTS REIMBURSABLE FROM PROJECT FUNDS
Salaries and wages			
Employee Benefit Plans			
Travel Expenses			
Supplies, Materials, Communications and Rental of Equipment			
Equipment Purchase			
Rental of Office Space			
Alterations and Improvements			
Services of Other Governmental Agencies			
Others			
TOTAL ALL CLASSES			

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the administration of the project; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive of the Government Code; that the amounts claimed herein are properly chargeable as expenditures for administration of the project as specified in accordance with all provisions of the Welfare and Institutions Code and the rules and regulations of the State Social Welfare Board.

I HEREBY CERTIFY, under penalty of perjury, that I am the official responsible for the examination and settlement of accounts; that I have not violated any of the provisions of Sections 1090 to 1096, inclusive, of the Government Code; that the expenditures claimed herein have been authorized; and that payments therefor have been made or expenditures otherwise incurred according to law.

SIGNATURE OF WELFARE DIRECTOR OR PROJECT ADMINISTRATOR	DATE	SIGNATURE OF AUDITOR OR CONTROLLER	DATE

GEN 215 (3/73)

25-605 FORMS (Continued) 25-605

IX. MISCELLANEOUS FORMS (Continued)

**CLAIMING INSTRUCTIONS TO LOCAL AGENCIES
FOR COSTS OF SPECIAL PROJECTS
(WELFARE & INSTITUTIONS CODE, SECTIONS 18200-18204 AND 10609)**

In order that the maximum reimbursement available be provided to agencies for costs of special projects, claims for reimbursement of such costs and the reporting of expenditures will be made in the following manner:

All costs related to the project will be reported to SDSW on Form GEN 215, Claim for Reimbursement (in quadruplicate), and will be segregated into the classes as specified on the approved Budget Schedule (Form GEN 188B) form. Separate claims will be made for each project and project year. Expenditures are defined as follows:

Salaries and Wages: Salary costs for employees' time spent on the special project.

Employee Benefit Plans: The agency's share of cost of employee benefit plans paid for employees spending time on the project. Include costs for such plans as workmen's compensation insurance, unemployment insurance, health and hospital insurance, old age and survivors insurance and other retirement plans.

Travel Expense: Include agency costs for transportation, meals, lodging and incidental travel costs incurred in the performance of duties necessary to the project.

Supplies, Materials, Communications and Rental of Equipment: Include costs to the agency for general office supplies, telephone, telegraph, postage, printing, maintenance and repair of equipment; rental of equipment; heat, light, power, water, maintenance and repair of office space; janitorial supplies and services; and any other such items incidental to the operation of the project.

Equipment Purchase: Cost of equipment purchased for use in the project (including purchases on a rental purchase contract.)

Rental of Office Space: Rental cost of space occupied in the operation of the project.

Alterations and Improvements: Include costs of alterations or repairs of an extensive nature involving substantial structural changes or replacements necessary for the proper and efficient administration of the project. Do not include normal maintenance or upkeep charges.

Services of Other Governmental Agencies: Whenever a governmental agency operating an authorized project finds it necessary to obtain services from other governmental agencies to complete operations of the project for which the original agency has responsibility, the cost of such services are recognized as project costs. In such cases, costs must be determined through the counties' approved A-87 plan.

Others: Include any costs identifiable to the operation of the project which are not included in the above classifications.

Total project costs for the period will be reported in Column A of Form GEN 215.

Project costs not reimbursable from project funds will be reported in Column B.

County Welfare Departments: Project costs not reimbursable from project funds will be included in the regular Administrative Expenditures Claim and will be subject to federal and/or state reimbursement in the same manner as other administrative expenditures of county welfare departments.

Project costs reimbursable from project funds will be reported in Column C. The amounts in Column C are equal to Column A minus Column B.

Records identifying costs claimed shall be maintained on file in the county until notification of completion of audits for the applicable period is received from the State Department of Social Welfare.

25-605 FORMS (Continued) 25-605

IX. MISCELLANEOUS FORMS (Continued)

Suggested Form H

Substitute Payee Certification

_____ (Program)

I certify, under the penalty of perjury, that the _____ payment received on behalf of _____
(name) (case number)

has been spent in behalf of the above named recipient; that such expenditures whenever possible were made after discussion with said recipient; that due consideration was given to the recipients' rights before making such expenditures; that the recipients' rights were not abridged; and that the following is a true and accurate account of the assistance received:

Month of _____ 19____

Balance from last month . . . . . $_____

Received this month . . . . . _____

Expenditures this month . . . . . _____

Remainder at end of the month . . . _____

_____ _____
Name of substitute payee Date

_____
Address

_____

25-605 FORMS (Continued) 25-605

IX. MISCELLANEOUS FORMS (Continued)

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY DEPARTMENT OF BENEFIT PAYMENTS

NOTICE OF FORM CHANGE

DATE

TO:	FROM:
County Welfare Department Attn: Supply Clerk	Forms Management Unit (916) 445–1780

☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

It is suggested that this notice be placed in your Department of Benefit Payments Forms Catalog as a reference of form changes.

FORM NUMBER AND TITLE

ORDER UNIT	☐ Free ☐ Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT ☐ Yes ☐ No
☐ New ☐ Revised	DATE OF FORM	REPLACES	☐ Obsolete
SUBSTITUTE PERMITTED ☐ Yes ☐ No		DBP PERMISSION REQUIRED ☐ Yes ☐ No	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED Department of Benefit Payments Warehouse 6150 – 27th Street Sacramento, California 95822		☐ OTHER	

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☐ Use until exhausted ☐ Destroy

USE NEW FORM
☐ When supply available ☐ When effective:

USE FORM IN ACCORDANCE WITH
☐ Manual Letter No. ☐ All County Letter No.
☐ Manual Section(s) ☐ Other

ADDITIONAL INFORMATION

GEN 127 (7/76)

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25-700 AID CLAIMS 25-700

25-700 AID CLAIMS - GENERAL 25-700

This chapter relates to fiscal information on claims; manner of listing this information; forms used in claiming; rules for providing certain types of data and special instructions for compiling and submitting claims.

.1 Purpose and Functions of Aid Claims

The primary function of the aid claim is to (1) provide a record of public assistance expenditures, (2) establish the amount of reimbursement due from the state for federal and state shares of such expenditures made by the counties, (3) substantiate this amount by providing certain financial data and computations, and (4) provide information in a manner easily accessible to audit.

A secondary function is to provide certain statistical data.

25-710 EXPENDITURE REIMBURSEMENT TO COUNTIES 25-710

Upon approval of the aid claim by the State Department of Social Services (SDSS), county expenditures are reimbursed or advances are adjusted for aid payments made as follows:

.1 Expenditures incurred from county funds (Cash Claims), or

.2 Expenditures incurred from federal and state funds previously advanced (Voucher claims).

25-720 TYPES OF CLAIMS 25-720

Claims are filed monthly with SDSS and are classified as follows:

.1 Cash Claims

Cash claims are for expenditures that are paid on an after-the-fact or arrears basis to the county. Cash claims are normally for items that, on a statewide basis, are not significant in dollar volume or for which there is no authorization for the state to advance funds for the particular expenditure.

.2 Voucher Claims (Advanced Funds)

Voucher claims are applied as credits against advances made to counties. The estimated amount of federal and state funds needed are advanced to the county so that areas of major expenditures will not be initially borne by the county. These advances are deposited to a trust fund in the county treasury, and the county is accountable for these funds until they are legally expended.

25-720 TYPES OF CLAIMS (Continued) 25-720

.3 Types of Aid Claims and Governmental Participation by Program

Program	Federal Funds	State Funds
AFDC-FG&U	Advanced	Advanced
AFDC-FC/Federal	Advanced	Advanced
AFDC-FC/Nonfederal	None	Advanced
AAP/Federal	Cash	Cash
AAP/Nonfederal	None	Cash
Adoption Cost of Care	None	Cash
RCA (Includes ECA)	Advanced	None
RDP	Cash	None
Time Eligible Refugee/ Entrants on GA	Cash	None
Special Circumstance	None	Cash
Time Eligible Refugees on AFDC-FG&U, FC	Cash	None
Emergency Loan (Close-out)	None	1/
Adult (Close-out)	1/	1/
Emergency Assistance - Unemployed Parent Foster Care Time Eligible Refugees	2/	2/

1/ There are no longer claimable costs on these programs. The only activity is repayments collected and reported by counties.

2/ Current month expenditures for October 1, 1990 forward may not be claimed, unless the amounts are for prior month supplemental payments or are cancellations. The normal 18 month claiming limit applies to EA expenditures made prior to October 1, 1990 and are to be claimed as prior month adjustments. Repayments must be reported indefinitely.

25-730 FORMS USED IN AID CLAIMS 25-730

Claims for aid payments are prepared on the following forms:

.1 Reports of Expenditures

The summary Report for each program brings together totals of the various payroll, contra rolls and adjustment schedules and provides for computation of federal, state and county sharing, as applicable. For the AFDC-FG&U and AFDC-FC Programs, an additional form is required to claim additional federal funds for time-eligible refugee/entrants to be submitted with the Summary Report. For the RC Program a third form, Facility Expenditures Statement, is attached to the applicable Summary Report to identify certain segments of cost which are not reimbursable from federal and/or state funds. In the following listing these forms are listed under the Summary Report for the pertinent program.

25-730 FORMS USED IN AID CLAIMS (Continued) 25-730

The following forms are required:

Form	Program
Submitted Monthly:	
CA 800	Summary Report of Assistance Expenditures Aid to Families with Dependent Children.
DFA 844	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee and Entrant Recipients in Receipt of AFDC.
Note:	Separate Reports for AFDC-Family Group and AFDC-Unemployed are required.
CA 800 RDP	Summary Report of Assistance Expenditures Refugee Demonstration Project (RDP)
DFA 844 RDP	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Demonstration Project Recipients (RDP).
Note:	Separate Reports for RDP-Family Group and RDP-Unemployed are required.
CA 800 FC(Fed)	Summary Report of Assistance Expenditures Federal Children in Foster Care.
DFA 847	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement, Cuban Program Phasedown and Cuban/Haitian Entrant Recipients in Receipt of Federal AFDC-FC.
CA 800 FC.1(Fed)	Foster Care Facility Expenditures Statement Amounts not Reimbursable from Federal Funds. (To be attached to CA 800 FC(Fed))
CA 800 FC.2(Fed)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from State Funds. (To be attached to CA 800 FC(Fed))
CA 800A FC(Nonfed)	Summary Report of Assistance Expenditures Nonfederal Children in Foster Care.

25-730 FORMS USED IN AID CLAIMS (Continued) 25-730

Form	Program
DFA 843	Federal Funds Claimable Based on the Expenditures for Refugee Resettlement, Cuban/Haitian Entrant Recipients in Receipt of Nonfederal AFDC-FC.
SOC 801	Summary Report of Assistance Expenditures Emergency Assistance-Unemployed Parent
	Note: No new costs subsequent to September 30, 1990 may be claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.
DFA 863	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement and Cuban/Haitian Recipients in Receipt of Emergency Assistance-Unemployed Parent.
	Note: No new costs subsequent to September 30, 1990 may be claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.
SOC 800	Summary Report of Assistance Expenditures Emergency Assistance-Foster Care
	Note: No new costs subsequent to September 30, 1990 may be claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.
DFA 863A	Additional Federal Funds Claimable Based on the Nonfederal Share of Expenditures for Refugee Resettlement and Cuban/Haitian Recipients in Receipt of Emergency Assistance-Foster Care.
	Note: No new costs subsequent to Septembver 30, 1990 may be claimed on this form. See footnote #2 to Fiscal Management and Control Handbook Section 25-720.3.

25-730 FORMS USED IN AID CLAIMS (Continued) 25-730

Form	Program
CA 800 FC.1(Fed)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from Federal Funds. (To be attached to CA 800 FC(Fed))
CA 800 FC.2(Fed)	Foster Care Facility Expenditure Statement Amounts not Reimbursable from State Funds. (To be attached to CA 800 FC(Fed))
Note:	This is the same form used for the Federal FC Program.
AD 800A	Summary Report of Assistance Expenditures Adoption Assistance Program/Federal
AD 800B	Summary Report of Assistance Expenditures Adoption Assistance Program/Nonfederal (Includes Aid for the Adoption of Children - AAC)
DFA 846	Summary Report of Assistance Expenditures Refugee Cash Assistance Program (RCA) (Includes Entrants)
DFA 859	Federal Funds Claimable Based on Expenditures for Time Eligible Refugees and Entrants in Receipt of General Assistance.
SC 800	Summary Report of Special Circumstances
Submitted Quarterly:	
AD 800	Certification - Adoption Cost of Care Subvention under Welfare and Institutions Code (W&IC Section 16106.
EL 800	Summary Report of Uncollected Loans.
DFA 837	Summary Report of Assistance Expenditures Old Age Security, Aid to the Blind and Aid to the Disabled.

The Summary Reports provide for the certification of county officials. The certification shall be accomplished by the affixing of the personal signatures of the county welfare director and the county auditor or representatives of these officers who are properly authorized. If the certification is accomplished by an authorized representative, the representative signs his own name and uses his own title.

25-730 FORMS USED IN AID CLAIMS (Continued) 25-730

.2 Reconciliation Statement, Form ABCD 820

The Reconciliation Statement is prepared from batch voucher controls as provided in MPP Handbook Section 25-230.3. It demonstrates on a total basis that each aid claim includes only amounts authorized to be paid. Adequate records are to be maintained in the county to support the figures included in the statement.

Only amounts authorized to be paid or warrants to be canceled and the persons counts included in these authorizations shall be included in Items 1 through 10 of the statement. If there is a difference between the amounts in Items 10 and 11, or between the persons count in Items 10 and 12, this difference shall be stated on Items 13 and/or 14 and shall be explained adequately either below Item 14 or on a separate sheet.

Proper procedure requires that the reconciliation control total be maintained and verified currently as authorizations are approved, resulting in predetermined totals controlling the amounts of aid to be paid and claimed each month. This procedures enables detection of under or overpayments before warrants are released. It also serves as a signal that there are errors in the aid claims which should be located and corrected, if possible, prior to transmittal of the claim to SDSS.

Those counties operating on the case data processing system are not required to submit a Reconciliation Statement.

.3 Aid Payrolls (Conta Rolls)

.31 The Form ABCD 801 is used to report payments, cancellations, abatements, adjustments, zero grants and repayments for the AFDC-FG&U, AFDC-FC, AAP, RCA, Time Eligible Refugee/Entrants on GA, Special Circumstances and repayments on the Adult Close-Out Claim.

.32 The Form AD 801A is used as a payroll (contra roll) for the Adoption Cost of Care Program. (See MPP Handbook Section 25-755.)

The original of these forms is required by SDSS. Copies retained by the county shall be exact duplicates.

The information required on SDSS prescribed payroll and contra roll forms is the minimum information required. Any special county forms shall contain all of the information required by the state forms in the same sequence. Any county substitute for the prescribed forms shall not be used by the county prior to specific written approval by Fiscal Policy and Procedure Bureau, SDSS.

25-730 FORMS USED IN AID CLAIMS (Continued) 25-730

.4 Integrated Payrolls

The Integrated Payroll is a listing of payroll and contra roll information in case number sequence with a net total, by case, by current month and prior months, of persons county and total aid paid. When the information on all of the payrolls and contra rolls for a program is merged and one listing is prepared, the term Fully Integrated Payroll is used to describe the listing.

Fully integrated payrolls are required for those counties having data processing equipment. Counties submitting separate integrated payrolls for FG and U are requested to combine these two categories in one fully integrated payroll.

.41 The following payroll and contra roll codes, if used on the Integrated Payroll for identification and accumulation purposes, may be used without definition of the codes on the payroll:

Main Payroll	1
Current Month Supplemental Payroll	2
Current Month Cancellation Contra Roll	3
Zero Grant	4
Prior Month Supplemental Payroll	5
Prior Month Cancellation Contra Roll	7
Abatements	8
Schedule of Adjustments	9
Repayments	10

.5 Integrated Payroll Summary

The Integrated Payroll Summary is an accumulation of totals by payroll and contra roll code and is required to support the totals carried forward to the Summary Reports.

Counties submitting a fully integrated AFDC payroll will prepare two separate integrated payroll summaries accumulating totals by aid program 30 for AFDC-FG cases and aid program 35 for AFDC-U cases. An integrated payroll summary combining FG and U totals is not necessary for SDSS.

.6 Integrated Payrolls and Payroll Summaries for Time Eligible Refugee/Entrants

When time eligible refugees/entrants are claimed on the AFDC-FG&U or AFDC-FC Programs, the following procedures apply:

25-730 FORMS USED IN AID CLAIMS (Continued) 25-730

.61 AFDC-FG&U Federal and Nonfederal Programs

All cases which include at least one time eligible refugee/entrant will be coded 30, 32, 33, or 35 as determined by the program for which they are eligible. Transactions for these cases must be claimed on a payroll separate from transactions for all other cases on that program. Each segment of the program must be combined and carried forward to the appropriate Summary Report. The separate payroll will be used to substantiate the additional federal funds claimed for time eligible refugees/entrants. (See MPP Handbook Sections 25-730.1.) On the Time Eligible Refugee/Entrant Payroll, the Date of Entry (DOE) must be shown for each time eligible refugee and the Date of Parole (DOP) shown for each time eligible entrant. (For instructions for Refugee Demonstration Project (RDP) see MPP Handbook Section 25-756.)

.62 AFDC-FC Federal and Nonfederal Programs

All cases which are time eligible refugee/entrant cases will be coded 40 or 42 as determined by the program for which they are eligible. The requirements for separate payrolls and DOE and DOP as specified in MPP Handbook Section 25-730.61 for the AFDC-FG and U Programs are applicable to the AFDC-FC Federal and Nonfederal Programs.

EXCEPTION: For those counties whose claiming system (computer or manual) cannot supply the DOE/DOP on the Time Eligible Payrolls, a separate listing per program providing the dates will be acceptable. For those counties whose computer system requires that time eligible cases remain intermingled with all other cases on the program, a select run of the time eligible cases with an accompanying Integrated Payroll Summary is acceptable.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS 25-740

The payrolls and contra rolls are reports of payments made, warrants canceled, abatements received, adjustments processed, and repayments received during the months.

EXCEPTION: When a services plan to resolve money management problems includes use of vendor payments (AFDC only), and a trust fund method as provided by MPP Handbook Section 25-362 is used, the total aid authorized is claimed in the month of payment to the trust fund regardless of the date the payments are made from the trust fund.

NOTE: References below to alternate pay period are applicable in only those counties having an approved alternate payment system. (See MPP Section 44-305.3.)

.1 Main Payroll (Master Payroll Payments)

These are payments of the continuing aid grant.

Totals are included as gross expenditures on the Summary Report of Assistance Expenditures, Line 1.

.2 Current Month Supplemental Payroll

These are payments for the current month or current alternate pay period made after the master payroll for the month is prepared. Included are initial payments, reissuances of warrants canceled and increases.

Depending on the reason for the supplemental payments, persons counts may or may not need to be reported in the persons count columns.

Totals are included as gross expenditures on the Summary Report of Assistance Expenditures, Line 2.

.3 Current Month Cancellation Contra Roll

Current cancellations are warrants canceled in the current month which were issued during the current month for either the current month or some prior month(s) or of the current or prior alternate pay period.

Persons count as reported when the warrant was claimed must be canceled with the cancellation of the warrant except in the following circumstances:

.31 When the warrant is canceled and a warrant is issued in lieu in the same month and the same persons count applies, or

.32 When a warrant (main or supplemental, with which persons count was reported) is canceled and a supplemental warrant for the same month or alternate pay period remains in effect, or

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued) 25-740

.33 In AFDC when only the first warrant is canceled and the same persons count extends to the second warrant.

Totals are included as reduction of gross expenditures on the Summary Report of Assistance Expenditures, Line 3.

.4 Zero Grants

There are currently three types of zero grant cases. Persons counts for two types of zero grant cases are claimed on Line 4 of the Summary Report (thus impacting the federal financial participation ratio) and persons counts for the third type of zero grant cases are not claimed on the Summary Report and, therefore, do not impact the federal financial participation ratio. All three types of zero grant case are claimed as Code 4 on computer printed payrolls. On manually prepared payrolls, separate listings for each type of zero grant case are required. (For further general information, see MPP Handbook Section 25-740.44 below.)

Adjustments for persons previously omitted or erroneously reported are made on the zero grant list or zero grant code, not on the Schedule of Adjustment or the adjustment code.

.41 Zero Grant-Overpayment Adjustment

These AFDC-FG&U cases are eligible for a cash grant for the current month or current alternate pay period because the net nonexempt income does not exceed the Maximum Aid Payment (MAP) available for the number of persons included in the AU. However, the grant for the current month or alternate pay period has been reduced to zero to adjust for a prior overpayment.

This is in lieu of discontinuance followed by a restoration action, in order to retain eligibility status for medical assistance, and to simplify authorization procedures. The federal and nonfederal persons counts are carried forward to Line 4 of the Summary Report, thus impacting the federal participation ratio.

.42 Zero Grant - Payment Less than $10

These AFDC-FG&U cases are eligible for a cash grant because the MAP for the AU is greater than net nonexempt income, but because the difference is less than $10, no payment is made for the month or the alternate pay period. Such cases shall be considered to have received payment for all other purposes, including payment of special needs. Persons counts for the cases are claimed on Line 4 of the Summary Report; there, do impact the federal financial participation ratio.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued) 25-740

In those instances where the AU was eligible to a grant in excess of $10 but an overpayment adjustment decreased the amount of the payment to less than $10, a payment is made in the amount less than $10.

.43 Zero Basic Grant

These cases are eligible for payment of special need but not basic need because the net nonexempt income is equal to, or exceeds, the MAP available but does not exceed the Minimum Basic Standard of Adequate Care (MBSAC) based on the size of the AU. For any month or alternate pay period for which no special need payment is made, persons count is shown on the payroll but identified as NG (Nongrant).

The persons counts are not carried forward to the Summary Report and, therefore, do not impact the federal financial participation ratio.

.44 Aid Suspended for One Month

This type of case is not classified as a zero grant but is addressed here because of similarity.

A case is suspended, rather than terminated, when income or other circumstances in the corresponding budget month appear to result in ineligibility for only one month. The case is automatically restored to aid payment status the following month. No money payment nor persons counts are claimed for such cases on the payroll. It is preferred that the case identification number and case name not be shown on the payroll. If the county decides, based upon their system's capabilities, that it is not feasible to remove the case record from the master file for only one month, then such case is coded "S" on the payroll.

.5 Prior Month Supplemental Payroll

These are payments for a prior month(s) or a prior alternate pay period(s) made during the current month.

Payments for prior months or for prior alternate pay periods will be grouped on the payroll according to month or period in state number order under each month or period.

If one warrant is issued covering more than one prior month or prior alternate pay period for a given case, the total warrant amount need not be shown, but the amount paid for each individual month or prior alternate pay period shall be reported separately.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued) 25-740

Depending on the reasons for the supplemental payment, persons counts may or may not need to be reported in the persons count columns.

Totals are included as gross expenditures on the Summary Report of Assistance Expenditures, Line 5.

.7 Prior Months Cancellation Contra Roll

Prior cancellations are warrants canceled in the current month which were issued and claimed in some prior month.

Prior cancellations are reported by grant month or alternate pay period in state number order on contra rolls as originally reported. If the originally reported persons count, and/or amount of aid have been changed by abatement or adjustment, the cancellation of the warrant may necessitate a reversing adjustment, applying the abatement to another month or another alternate pay period, or possible return of the abatement.

If the cancellation of the warrant with persons count does not cancel the total aid paid for the month or alternate pay period, an adjustment to add persons count may be necessary.

Totals are included as a reduction of gross expenditures on the Summary Report of Assistance Expenditures, Line 7.

.8 Abatements

An abatement is any cash payment (other than child support) received from or in behalf of any individual or family during a month or alternate pay period that the individual or family is in receipt of aid. For abatement reporting purposes, an individual is considered in receipt of assistance if the grant has been reduced to zero because of a previous overpayment, or if there has been no payment of assistance because the amount the AU would receive is less than $10.

Types of abatements include:

(a) Current income (i.e., monthly Social Security (SS) or veteran's benefits normally payable in the month of receipt when made payable to the welfare department and deposited to the welfare fund).

(b) Current cash adjustment (collection of an overpayment in lieu of a grant adjustment).

(c) A voluntary contribution made by a relative having no legal obligation to contribute.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued) 25-740

(d) Recovery of interim assistance payments made in behalf of a nonfederal FC child determined eligible for Supplemental Security Income/State Supplemental Program (SSI/SSP).

When the requirements of MPP Section 46-337 are met, interim assistance payments made in behalf of a nonfederal FC child determined eligible for SSI/SSP are deducted from the initial SSI/SSP payment received by the county. It is necessary that the amount of FC funds recovered be reported as an abatement on a current AFDC-FC claim.

Abatements applicable to two or more months or two or more alternate pay periods will be broken down and reported by amount for each month or alternate pay period.

When the full amount claimed for any month or alternate pay period is entirely abated, enter the persons count in the appropriate column. In AFDC, If there was an overpayment because one or more of the family group was ineligible to aid, a persons count is reported (unless previously correct) although the abatement covers only that portion of the total aid overpaid.

Column 11 of the ABCD 801 shall be used to report either the deposit permit number or receipt number. Counties preparing integrated payrolls shall report the required number in the "Warrant Number" column of the payroll.

The date of receipt by the County Welfare Department (CWD) shall be reported in Column 12 of the ABCD 801 or in the "Issue Date" column of the integrated payroll.

Totals are included as a reduction of gross expenditures on the Summary Report of Assistance Expenditures, Line 8.

.81 Erroneous Abatements

Amounts collected from recipients of aid on an erroneous assumption that an overpayment occurred, or an amount collected in excess of the amount receivable, are reported as follows:

.811 If an abatement later determined to be erroneous has already been reported on a claim, and such abatement is returned, the county shall report the return on a current claim. It is reported as:

(a) A supplemental payment for a prior month(s), or

(b) A debit item on the Abatement Contra Roll.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued) 25-740

.812 When a persons count has been deducted when reporting an abatement later determined to be erroneous, the return of the abatement restores the persons count and the count is reported as originally claimed. The rule regarding federal participation in retroactive payments does not apply since the return of an erroneous abatement is an adjustment.

.9 Schedule of Adjustments

Claim adjustments are reported on the Schedule of Adjustments and usually result from discovery that claiming error has been made affecting amount claimed, participation status, and/or persons count. Adjustment may increase or decrease the amount claimable.

EXCEPTION: Adjustment of zero grants, abatements and repayments are made on the respective rolls or payroll codes rather than on the Schedule of Adjustments or adjustment payroll code.

Specific authorizing action for the adjustment may or may not be necessary depending on the reason for the adjustment.

.91 To correct an item authorized correctly but claimed incorrectly, no additional authorizing action is necessary. The county must develop some system to get such adjustment data from the point of discovery to the Schedule of Adjustments.

.92 To change an item authorized correctly and claimed correctly, but on which subsequent information indicates need for change in such authorization, additional authorizing action is necessary and the county's normal Forms 278L-M procedures (or other approved procedures) apply.

Claim adjustments include (but are not limited to) the following types of transactions:

(a) Correction of an item reported incorrectly on a current or prior claim (e.g., amount claimed in excess of warrant amount issued);

(b) Change in financial participation (e.g., federal to nonfederal);

(c) Addition of an item omitted in error (e.g., person added to the AU and grant increased accordingly; additional persons count not claimed);

(d) Deletion of persons count and total of aid paid when county began aid prior to the date specified in MPP Section 44-317.

25-740 TYPE OF PAYROLLS AND CONTRA ROLLS (Continued) 25-740

(e) Deletion of an unauthorized payment claimed and any persons count claimed with the unauthorized payment.

(f) Deletion of persons counts erroneously claimed when the amount claimed as authorized is not affected.

(g) Repealed by Manual Letter No. FMC-90-04, effective 12/1/90.

In reporting the item to be corrected, the net increase and/or decrease of persons count and total aid paid is reported in a single line entry.

The totals (persons counts and total aid paid) are included on the Summary Report of Assistance Expenditures, Line 9.

.10 Repayments

A repayment is the recoupment of assistance from or in behalf of a former recipient of assistance. This may be recovery of an overpayment or a voluntary repayment or contribution when there is no legal obligation to repay.

Repayments may be integrated or reported on a separate Repayment Contra Roll. Report only the case number, name, amount and receipt number. The receipt number may be placed in the "Warrant Number" column. The month and year are left blank. No persons counts are involved since the single percentage takes in all factors of federal, state and county sharing.

.101 Erroneous Repayments

Amounts collected from recipients on an erroneous assumption that an overpayment occurred, or amounts collected in excess of the amount receivable are reported as debit items on the Repayment Contra Roll or on the repayment code when returned.

Adjustment of repayment items are made on the Repayment Contra Roll or in the repayment payroll code, not on the Schedule of Adjustments or the adjustment code.

25-750 REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS 25-750

County payments of aid shall be listed in state case number order on aid payrolls unless otherwise provided in this chapter. On the FC payrolls, cases may be listed alphabetically by payee. If the alphabetical arrangements are used and there is more than one case with the same payee, they shall be listed in state case number order under the name of each payee.

Allow double space between line items.

EXCEPTION: On integrated payrolls, single space the information for each case and triple space between cases.

All pages in a payroll or contra roll shall be numbered consecutively and shall carry individual totals by page for persons count and warrant amount columns. Page totals shall be added and the grand totals inserted on the last page of each payroll or contra roll.

Page totals are not required on integrated payrolls, but grand totals of persons county and total aid paid columns are required.

NOTE: Special instructions for specific programs are to be found in other sections of this chapter.

On all payrolls and contra rolls, the following information shall be provided in the appropriate headings and columns:

.1 The Name of the County Filing the Claim

.2 The Month and Year of the Claim

.3 The Type of Payroll or Contra Roll (see Section 25-740)

.4 State Case Number or Other Required Identification Number

.5 Payee Name

.51 All Programs

In all programs, show the payee name as it appears on the authorization document. If the county mechanical equipment makes it advisable, the given initial only need be shown. The name of each child and the amount for each child in an AU need not be separately reported. See .52 below for exceptions.

.52 Payee Codes

25-750 REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS (Continued) 25-750

.521 If a guardian or conservator has been appointed, show the name of the payee and note on the payroll that the payee is other than the recipient. Suggested codes:

(a)	If the GUARDIAN is the payee	GN
(b)	If the CONSERVATOR is the payee	CN

.522 When the services plan to resolve money management problems includes use of a protective payment or vendor payments, show the name of the payee and note on the payroll that the payee is other than the recipient. Suggested codes:

(a)	If a SUBSTITUTE PAYEE is the payee	SP
(b)	If a VENDOR PAYMENT is made directly to an individual or agency supplying goods or services to the family	VP

NOTE: See MPP Handbook Section 25-360.

.6 Payment Codes on Payrolls

The following must be identified on payrolls. If the suggested codes are used, no definition of the codes is needed on the payroll. These codes may be substituted by county codes upon approval by SDSS if the county's payroll defines the codes used.

(a)	Immediate Need Payments	EA
(b)*	Payments containing an amount for Special Needs (AFDC, RCA, ECA)	SN
(c)	Warrants reissued after voiding because of being outstanding over six months from the date issued	VR
(d)	An AFDC case (federal and/or nonfederal) RDP or GA case which includes one or more time eligible refugees	IR/OR

NOTE: It is no longer necessary, for fiscal purposes, to identify time eligible refugees from Cambodia, Loas and Vietnam from all other time eligible refugees.

* When applicable, identify cancellations, abatements and adjustments as well as payments (including supplemental).

25-750 REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS (Continued) 25-750

(e)	An AFDC case (federal and/or nonfederal) RDP or GA case which includes one or more time eligible entrants	CH
(f)	Time eligible refugee/entrant children in receipt of FC (federal or nonfederal)	FC
(g)	Unaccompanied refugee entrant minors in receipt of RCA	UM
(h)	Unaccompanied refugee entrant minors in receipt of ECA	EM
(i)	Expenditures for burial expense made for time eligible refugees/entrants on AFDC-FG&U, FC, RDP, RCA and ECA	BE
(j)	Adoption Assistance Program cases - Nonfederal	N

NOTE: These are cases which became eligible on or after October 1, 1982. This coding is not to be used for the old AAC cases which are also identified with the 04 aid code.

(k)	Adoption Assistance Program payments in excess of the Foster Family Home Rate	A
(l)	AFDC-FG&U case suspended for only one payment month because of income or other circumstances in the budget month	S
(m)	Foster Care payments made to Home Finding Agencies	HF
(n)	Foster Care payments which includes a clothing allowance	CE
(o)	Foster Care payments which include Social Worker Activity and/or Nonfederal Other amounts	E

(p) Special Circumstances

Each payment made for Special Circumstances shall be code by the type of Special Circumstance granted. These codes are as follows:

FE Furniture and Equipment

25-750 REQUIRED INFORMATION ON PAYROLLS AND/OR CONTRA ROLLS 25-750
(Continued)

FC Clothing

ME Necessary Moving Expenses

HR Required Housing Repairs

US Unmet Shelter Needs

HM Home Modification

PF Payment to Prevent Foreclosure

.7 The Grant Month

.8 The Persons Counts

The Persons Counts for individuals eligible to aid segregated as to federal adults, federal children, nonfederal adults, and nonfederal children. In AFDC, FG and U, the persons count is reported with the first warrant for the month and when applicable, with supplemental warrants.

NOTE: As it is no longer necessary to capture essential persons count on the claim in a separate column, the persons count for an essential person is claimed as a federal persons count.

.9 The Warrant Amount

In AFDC, FG and U, include special need in the warrant amount when applicable. The first and second warrants are listed together on the payroll in date sequence and totaled (except on payrolls prepared by addressograph or typewriters).

.10 The Warrant Number

.11 The Warrant Date

The Warrant Date is placed in Column 12 of the ABCD 801; however, if all warrant numbers on a given roll or page carry the same date, the date may be indicated at the beginning of the roll or top of the page rather than individually for each warrant.

.12 The Authorization Date

The Authorization Date, which may be used as an additional control, is also placed in Column 12 of the ABCD 801. On the Zero Grant List include only Items .1 through .4 above, the payee name, the Nongrant payment code, when applicable, and Items 7 and 8. (See MPP Handbook Section 25-740.4.)

25-752 SPECIAL CIRCUMSTANCES CLAIMING INSTRUCTIONS 25-752

This program provides for payments for expenditures incurred by SSP recipients for special circumstances as defined in MPP Section 46-400. Special circumstances payments are claimed monthly on the Summary Report, Form FC 800.

Nonintegrated payrolls and contra rolls should be separated into three sets according to expenditures made for aged, blind, and disabled recipients. For those counties submitting an integrated payroll all transactions should be integrated; however, it will necessary to prepare three separate integrated summaries by aged, blind and disabled categories. If a county's computer system will not accommodate preparation of the special circumstances payrolls and contra rolls if aid categories 10, 20 and 60 are used, aid codes 12, 22, and 62 may be used for special circumstances payments.

The payroll will be prepared on Form ABCD 801, or equivalent form, and in Social Security Number (SSN) order unless the county's system cannot accommodate the nine-digit SSN. Additional information required includes:

.1 The recipient's name.

.2 Coding for type of need provided. (See MPP Handbook Section 25-750(p).)

.3 Total aid paid.

.4 Warrant number.

25-753 REIMBURSEMENT FOR FUNERAL COSTS FOR CHILDREN IN FOSTER FAMILY HOME PLACEMENT 25-753

State funds are available for reimbursement of funeral costs for children who had been placed in foster family homes. (MPP Section 11-405.2 and MPP Handbook Section 25-320(1)). The payment is made to the foster parent(s) or upon request of the foster parent(s), the county shall authorize payment be made to the funeral home and burial plot provider. When death of the foster child is due to the foster parent's alleged criminal negligence or other alleged criminal action, the county shall authorize payments be made to the funeral home and burial plot provider.

If the child had been a federally eligible foster care child, reimbursement is claimed on the Summary Report of Assistance Expenditures - Federal Children in Foster Care, Form CA 800 FC(Fed), Line 20, Columns B and D. If the child had been nonfederally eligible, the costs are claimed on the Summary Report of Assistance Expenditures - Nonfederal Children in Foster Care, Form CA 800A FC(Nonfed), Line 18, Columns B and C. These costs must be substantiated by a separate payroll (Form ABCD 801 or the county's equivalent form) submitted with the monthly AFDC-FC payrolls. Required information includes the case number for the child, the payee name, the warrant amount, the warrant number and warrant date.

25-754 ADOPTION ASSISTANCE PROGRAM CLAIMING INSTRUCTIONS 25-754

Payments made for a child who has been determined to be federally eligible for the AAP in accordance with MPP Section 45-802.12 shall be claimed on the Summary Report of Assistance Expenditures - AAP/Federal, Form AB 800A. Provision is made in Lines 13A and 14A of the Summary Report to allow federal participation in only that rate which would be available if the child were in a family foster home. State participation shall supplement the remainder of the payment.

Payments for adoption cases which do not meet the AAP federal eligibility standards are claimed on the Summary Report of Assistance Expenditures - AAP/Nonfederal (Includes Aid for the Adoption of Children - AAC) Form AD 800 B. (See MPP Handbook Section 25-525.)

25-755 CLAIMS FOR ADOPTION COST OF CARE 25-755

Reimbursement from state funds is available to each county, including licensed county adoption agencies, for the full cost of care of any child placed under the custody of the CWD pursuant to Section 226c of the Civil Code, from the effective date of the court commitment until the date of placement for adoption, or until another permanent plan is made for the child.

.1 Claimable Costs

Cost of care is defined as the cost to the county of goods, facilities, and services incurred to meet the needs of children placed under the custody of the CWD, including housing, food, clothing, medical, dental, nursing or psychiatric services, and other personal needs. Claimable costs do not include expenditures incurred prior to the date of the court commitment to the SDSS or county adoption agency under Section 226c of the Civil Code, nor expenditures incurred subsequent to placement for adoption, nor after another permanent plan is made for the child by SDSS or county adoption agency. Expenditures incurred, but not disbursed, cannot be allowed.

If the child is not eligible for the AFDC-FC Program, the payment to the provider shall be claimed directly on the Adoption Cost of Care Claim. If the child is eligible for AFDC-FC, payment for such child shall be made through the AFDC-FC Program in the same manner as any other foster care provider payment. The AFDC-FC claiming mechanism provides the normal federal, state and county participation in the aid payment. That part of the payment which is determined as county share (any amount not reimbursed by federal or state funds) must then be claimed in Column 5 of the Form AD 801A (Claim-Adoption Cost of Care under Welfare and Institutions Code Section 16106) and summarized on the Form AD 800 (Certification-Adoption Cost of Care Subvention). All other applicable information on both forms must be completed as instructed on the forms.

The adoption cost of care claim shall include all children for whom care was given during the months in the calendar quarter covered by the claim.

EXCEPTION: If payment for cost of care is made in a quarter subsequent to that in which the care was given, the date of disbursement governs the quarter for which the claim is filed.

25-756 REFUGEE DEMONSTRATION PROJECT (RDP) 25-756

Effective July 1, 1985 a three-year statewide Refugee Demonstration Project (RDP) was implemented in California. All counties in which there are SDSS funded or Targeted Assistance refugee employment/training programs must participate in the RDP. (See MPP Section 69-200.)

Effective July 1, 1985 refugee cases which were currently aided on AFDC-FG/U and in which the relative caretaker or the principal earner had at least 12 months of time eligibility remaining were required to participate in the RDP. The county welfare departments (CWDs) were required to transfer these cases from the AFDC-FG/U Program to the RDP Program. The transfer period was designated as July 1, 1985 through September 30, 1985 with instructions that one-third of the caseload should be transferred per month.

Effective July 1, 1985 all refugee applicant cases which would otherwise be aided on the AFDC-FG/U Program and in which the relative caretaker or the principal earner has at least six months of the time eligibility remaining are also required to participate in the RDP and must, therefore, be aided in the RDP.

When the relative caretaker or the principal earner time expires (36 months after date of entry) the AU must be discontinued from RDP. A determination must be made if the AU is eligible for another aid program.

The claiming of RDP expenditures must be separately identified from AFDC-FG/U expenditures. Each RDP reporting system (FG/U) must provide separate payrolls. Separate summaries of the integrated payroll are required for those counties submitting an integrated computer payroll; i.e., one for the FG component and one for the U component. Aid Codes 77 (RDP-FG) and 78 (RDP-U) are used for identifying cases aided under the RDP. The expenditures for the separate components are claimed on separate Forms CA 800 RDP, Summary Report of Assistance Expenditures, Refugee Demonstration Project (RDP).

Assistance payments for time-eligible persons in RDP cases are 100 percent federally funded. The nonfederal share of assistance payments for time-expired persons in RDP cases is funded at the 89.2/10.8 percent state/county rate.

25-758 CLAIMING INSTRUCTIONS FOR RETROACTIVE BENEFITS 25-758

The following simplified procedures may be used when claiming retroactive payments made to comply with court judgments (see MPP Division 50).

Retroactive payments may be authorized by a single line entry on the ABCD 278L (or substitute authorizing document) and paid in one warrant. The months covered in the amount authorized will be identified on the authorizing document. The minimum information needed on the Aid Payroll is case number, name, persons county (when applicable), grant amount and warrant number.

A list of court-ordered retroactive assistance payments must be included with the appropriate monthly assistance claim for any month in which such payments are made. The list may be handwritten, typed or computer generated and must be attached to the front of the payroll. The information on the list must include the case name, case number and payment amount of the court-ordered retroactive payment(s). In addition, each payment must be identified as to the pertinent court case.

25-759 REPATRIATE PROGRAM CLAIMING INSTRUCTIONS 25-759

The Repatriate Program consists of a program for the needy and a program for the mentally ill.

The purpose of the Repatriate Program for the Needy is to help U.S. citizens and their dependents who are certified as eligible by the Department of State, at the point of their return to the U.S. and for a temporary period thereafter, and to enable them to utilize other resources for maintenance as soon as possible. The purpose of the Repatriate Program for the Mentally Ill is to help U.S. citizens/nationals who are certified as eligible by the Department of State at the point of their return to the U.S. and thereafter with necessary assistance, care and treatment for a temporary period and to make arrangements for the transfer of responsibility for such persons for continued care and treatment.

State standards for the program of Aid to Families with Dependent Children (AFDC) shall be used in determining the amount of financial assistance needed by individuals or families. When aid is needed for resettlement or in the place of residence, financial assistance for initial, one-time services may exceed the AFDC standard. (Prior approval should first be obtained through SDSS.)

Form SSA-3955, Expenditure Statement and Claim for Reimbursement shall be used to report and claim expenditures on each repatriate case, unless or until the volume and nature of the cases is such that group reporting is indicated. Claims are to be submitted in quadruplicate as soon as possible after the end of each month but not later than 15 days after the close of the month. A copy of a receipt or bill shall be attached to the SSA-3955 for unusual expenses such as medical bills. County agency records shall contain sufficient information to support the validity of each claim. The completed copies of Form SSA-3955 shall be sent to the SDSS, Disaster Response Services Bureau, MS 19-43, 744 P Street, Sacramento, CA 95814.

Reimbursement for assistance provided by the county agency under the Repatriate Program for the Needy is available for costs identified in MPP 68-104.2.

Reimbursement for assistance provided by the county agency under the Repatriate Program for the Mentally Ill is available for costs identified in MPP 68-106.

Identifiable administrative costs incurred by the county agency in providing assistance to eligible persons under both programs are also reimbursable and are to be claimed in the space designated "Other" on the SSA-3955. An explanation fully describing the administrative costs is to be attached to the SSA-3955.

25-760 ASSEMBLING OF CLAIMS 25-760

.1 Number of Copies Required

Only the original of each required document and each payroll or portion of a payroll must be submitted.

.2 Method of Compiling Claims

.21 General

The claim shall be assembled in the following order: a. on top and fastened at the top with an ACCO type fastener:

(a) Summary Report of Assistance Expenditures

(b) Reconciliation Statement

(c) Main Payroll

(d) Current Month Supplemental Payroll

(e) Current Month Cancellation Contra Roll

(f) Zero Grant Lists

(g) Prior Months Supplemental Payment

(h) Prior Months Cancellation Contra Roll

(i) Abatement Contra Roll

(j) Schedule of Adjustments

(k) Repayment Contra Roll

(l) Protective Backing Sheet

NOTE: There are additional required documents for specific claims. As an example, under certain circumstances, some counties must submit a Form Number DFA 844 with each Report of Expenditures for AFDC-FG and AFDC-U. This form is utilized to claim the nonfederal share of expenditures for time eligible refugees/entrants. Any such required document(s) should be assembled directly behind the Report of Expenditures.

.22 Exception for AFDC Claims

Counties preparing payrolls on typewriter or addressograph will assemble the FG and U payrolls separately in the order prescribed in c. through k. above and the entire claim will then be assembled as follows:

Summary Report of Assistance Expenditures - FG

Summary Report of Assistance Expenditures - U

Reconciliation Statement(s)

FG Payrolls

U Payrolls

Protective Backing Sheet

25-770 TRANSMITTAL OF CLAIMS 25-770

All aid claims filed with SDSS shall be forwarded by the counties so as to be received not later than the 8th working day of the month immediately following the month or quarter of claim. The ability of SDSS to prepare quarterly statements of expenditure for the federal government within the required deadline, which is necessary to assure timely monthly advances of federal monies to the counties, depends upon prompt transmittal of county claims.

All claims shall be addressed to SDSS, 744 P Street, Sacramento, California 95814, Attention: Claims Audit and Control, MS 8-300.

Each claim shall be transmitted completely at one time.

Statistical reports and material for other divisions or bureaus of SDSS shall not be packaged with aid claims.

25-775 SUBMISSION OF ASSISTANCE PAYROLLS ON MICROFICHE 25-775

Those counties which have the capacity and wish to submit assistance payrolls on microfiche in lieu of computer printout for integrated payrolls may do so, provided advance notice is given to the Assistance Fiscal Policy Unit of the Fiscal Policy and Procedures Bureau. Claims submitted on microfiche must be submitted in accordance with the following specifications:

(a) Reduction: 48 x is preferred; 42 x is acceptable.

(b) Line per frame: Standard 56 lines; triple spacing should be used between case entries, per MPP Handbook Section 25-750.

(c) Fiche Sequence:

(1) Each program is to begin a new fiche.

(2) Each fiche should be numbered consecutively, as specified in the index information.

(d) Format:

(1) All information currently displayed on the printout must be on the microfiche. This includes page totals, end of payroll totals, code key, and statistical reports.

(2) Summary Report pages should appear at the end of the payroll.

25-775 SUBMISSION OF ASSISTANCE PAYROLLS ON MICROFICHE (Continued) 25-775

(e) Index System:

(1) Eye - readable title line across the top of each fiche containing:

(A) County number

(B) First case number appearing on fiche.

(C) Program identifier

(D) Month/year of report

(E) Fiche number in sequential order for the entire claim

(2) The final frame of each fiche should contain an index showing the first case number on each frame. Each number should be cross-referenced to the appropriate frame by use of an alpha-numeric grid index, i.e., A-1, B-1, etc. Each frame would be likewise identified.

(f) Accessibility to Audit: Microfiche viewers must be made available to state and federal auditors. In addition, the county should have access to a reader-printer in the event that a hard-copy document is required for audit purposes.

(g) Quality Control: A monitoring process should be developed to assure that the tape which generates the microfiche contains all program input; also that the microfiche produced is legible quality and that it contains all information from the tape.

(h) Submittal: One microfiche copy should be submitted to SDSS. Follow the instructions contained in MPP Handbook Section 25-770.

(i) Retention of microfiche records: Follow instructions contained in MPP Handbook Section 25-602.

(j) Destruction of microfiche records: Follow instructions contained in MPP Handbook Section 25-210.8.