CHILD/SPOUSAL AND MEDICAL SUPPORT NOTICE AND AGREEMENT

Assignment and Cooperation Requirements

You must assign to the county any rights you may have to child or spousal support payments while you are receiving Aid to Families with Dependent Children (AFDC) and any rights you may have to medical support to the state while you are receiving Medi-Cal. The receipt of an AFDC check and/or a Medi-Cal card will assign the past and present support rights of all persons for whom you are requesting AFDC and/or Medical Assistance. At your request, the county will provide information to you on the amount of support paid to the county by the absent parent(s)

You must cooperate with the County Welfare Department and the District Attorney:

- In identifying and locating any absent parent in your case;
- In establishing the paternity of any child in your case when necessary;
- In obtaining from any absent parent medical support payments and, if you receive AFDC, child/spousal support payments;
- By turning over to the county district attorney any medical support payments given to you on or after this date; and if you receive AFDC, any child/spousal support payments given to you on or after this date;
- By informing the county about medical coverage or payment for medical services paid by the absent parent on or after this date.

When requested to do so you must:

- Complete the Child Support Questionnaire (Form CA 2.1).
- Complete a statement (CS 870) under penalty of perjury. If you sign the form and you don't give all the facts or you give the wrong information, you could be fined and/or imprisoned.
- Agree to cooperate in the support enforcement process or to claim good cause for refusing to cooperate.
- Appear at the County Welfare Department or District Attorney's Office to sign papers or provide necessary information.

Benefits of Support Enforcement:

Your cooperation may be of value to you and your child(ren) because finding the absent parent and establishing paternity may give you and your child(ren) rights to future social security, veterans, or other benefits. The District Attorney will continue to help enforce support after you go off AFDC or Medi-Cal unless you make a request in writing to the District Attorney to stop.

You have the right:

- To claim Good Cause if you have an acceptable reason for refusing to cooperate in the support enforcement process. If you feel that cooperating would not be in the best interests of your child(ren), you may refuse to cooperate and claim Good Cause. The back of this form explains your right to claim Good Cause in more detail. If you think you might have Good Cause, ask your eligibility worker to explain it to you before signing below.

- To show you are cooperating by filling out and signing a statement (CS 870) under penalty of perjury that you have given all the facts you know about the absent parent(s).

Penalty Provision:

If you refuse to assign support rights, if you refuse or fail to turn over to the county any support given to you by the absent parent(s), or if you refuse to cooperate in the support enforcement process without Good Cause, the following will apply.

If you are an applicant/recipient of AFDC:

- You will be ineligible for AFDC, but your child(ren) may still be eligible. Their grant will go to another person called a protective payee who will pay the child(ren)'s living expenses, and
- Your case will be referred to the District Attorney.
- You will be ineligible for Medi-Cal benefits, but your child(ren) may still be eligible.

If you are an applicant/recipient of Medi-Cal Only:

- You will be ineligible for Medi-Cal benefits, but your child(ren) may still be eligible.

Agreement:

- ☐ I agree to cooperate with the County Welfare Department and the District Attorney as specified above.
- ☐ I claim Good Cause and refuse to cooperate at this time.
- ☐ I refuse to assign child/spousal support rights (AFDC).
- ☐ I refuse to assign medical support rights (AFDC and Medi-Cal only cases).

I understand my rights and responsibilities as described above, including the requirement that I assign support rights to the county. I also understand my right to claim Good Cause.

Signature of Applicant or Recipient _____ Date _____

I certify that I have notified the applicant or recipient of his or her rights and responsibilities by means of this notice and verbally as needed.

Eligibility Worker's Signature _____ Eligibility Worker Number _____ Date _____

YOUR RIGHT TO CLAIM GOOD CAUSE

The only reasons for claiming Good Cause

- Cooperation is expected to result in serious physical harm to the child(ren);
- Cooperation is expected to result in serious emotional harm to the child(ren);
- Cooperation is expected to result in physical harm to you which is so serious that it reduces your ability to care for the child(ren) adequately;
- Cooperation is expected to result in emotional harm to you which is so serious that it reduces your ability to care for the child(ren) adequately;
- The child(ren) were conceived due to incest or forcible rape;
- Court proceedings are going on for the adoption of the child(ren); or
- You are working with a social agency to help you decide whether to place the child(ren) for adoption and the counseling sessions have not gone on for more than three months.

How to Claim Good Cause

If you want to claim Good Cause, you must tell your eligibility worker. You can do this whenever you believe you have Good Cause not to cooperate. You must also complete and sign the Good Cause claim form which your eligibility worker will give to you.

If you claim Good Cause you must:

- Give the County Welfare Department evidence needed to determine if you have Good Cause for refusing to cooperate. (If your reason for claiming Good Cause is your fear of physical harm and it is impossible to obtain evidence, the County Welfare Department may still be able to make a Good Cause determination after investigating your claim.)
- Give the necessary evidence within 20 days of claiming Good Cause. The County Welfare Department will only give you more time when it decides that more than 20 days are required to get the evidence.

What is Acceptable Evidence?

The following are examples of acceptable evidence the County Welfare Department can use to determine if Good Cause exists. If you need help in getting a copy of any of the documents your eligibility worker will help you.

- Birth certificates, or medical or law enforcement records which indicate that the child was conceived due to incest or forcible rape;
- Court documents or other records which indicate that legal proceedings for adoption are pending in court;
- Records which indicate that the absent parent or alleged father might inflict physical or emotional harm on you or the child(ren);
- Medical records which indicate your or your child(ren)'s emotional health history and present health status; or written statements from mental health professionals giving a diagnosis or prognosis on your or your child(ren)'s emotional health.
- A written statement from a social agency confirming that you are being helped to decide whether to place the child for adoption; and,
- Sworn statements from people who know the circumstances of your Good Cause claim. These people could be friends, neighbors, clergymen, social workers and others.

The County Welfare Department Decides Your Claim

The County Welfare Department will:

- Decide your claim based on the evidence you give, or
- Conduct an investigation to verify and decide your claim. (You may be required to give information such as the absent parent or alleged father's name and address. The County Welfare Department will not contact the absent parent or alleged father without first telling you.)

District Attorney's Participation

The District Attorney may review the County Welfare Department's findings and the basis for a Good Cause determination in your case. If you request a hearing on the issue of Good Cause, the District Attorney may participate in that hearing.

If the County Welfare Department decides you have Good Cause for not cooperating, the District Attorney may try to establish paternity or collect support only if the County Welfare Department decides that this can be done without risk to you or your child(ren). This will not be done without first telling you.

The District Attorney will not pursue child support enforcement activities until the final determination regarding your Good Cause claim has been made by the County Welfare Department.

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE AND AGREEMENT FOR CHILD, SPOUSAL AND MEDICAL SUPPORT

Complete one form for each noncustodial parent or alleged father.

Assignment and Cooperation Rules

You must assign (give to) the county any rights you may have for:

- Any child or spousal support payments you get while receiving cash aid.
- Medical support you get while getting Medi-Cal.

The receipt of a cash aid payment and/or Medi-Cal Benefits Identification Card (BIC) will assign the past and present support rights of all persons for whom you are requesting cash aid and/or medical assistance. You will be sent facts on the amount of support the county gets from the noncustodial parent(s).

Cooperation

You must cooperate with the county and the Local Child Support Agency (LCSA) to:

- Identify and locate any noncustodial parent/alleged father in your case;
- Tell the county or LCSA any time you get facts about the noncustodial parent/alleged father, such as place of residence or work location;
- Agree to cooperate in the support enforcement process or to claim good cause for refusing to cooperate by completing this Notice and Agreement;
- Complete the Child Support Questionnaire (CW 2.1Q) for each noncustodial parent or alleged father;
- Establish paternity and get child and/or spousal support;
- Submit to genetic testing if paternity is in question;
- Obtain any other payments or property due any member of your assistance unit;
- Obtain medical support money from any noncustodial parent and, if you get cash aid, obtain child support money;
- Tell the county about medical coverage or money for medical services paid by the noncustodial parent and complete the Health Insurance Questionnaire form (DHS 6155);
- Give the LCSA any medical support money from any noncustodial parent, and any child/spousal support money you get;
- Appear at the county or LCSA office to sign papers or give required facts;
- Appear at hearings or in court when necessary;
- Fill out and sign an Attestation Statement, if asked by the LCSA. On this form you declare under penalty of perjury that you have given all the facts you know about the noncustodial parent/alleged father. If you sign the form and you do not report all the facts or give wrong facts, you can be fined or sent to jail/prison.

Benefits of Cooperation

Your cooperation can help you and your child(ren). Finding the noncustodial parent and establishing paternity may give you and your child(ren) rights to future social security, veterans, or other benefits. The LCSA will continue enforcement after you go off cash aid or Medi-Cal unless you make a request in writing to the LCSA to stop.

Good Cause for Not Cooperating

- Good cause is the right to refuse to cooperate because it is not in the best interests of you or your child(ren).
- You have the right to claim good cause for not cooperating if you have an acceptable reason for refusing to cooperate with the county and the LCSA.
- The back of this form gives you facts about good cause. If you want more facts about good cause and/or refusal to cooperate, ask your worker to explain them to you.

Penalty for Refusal to Cooperate

If you do not have good cause, there are penalties if you refuse to assign support rights, refuse or fail to give the county any support given to you by the noncustodial parent(s), or refuse to cooperate with the LCSA, including in determining paternity.

- **For cash aid applicants/recipients:**
  - If you refuse to assign support rights or refuse/fail to give the county any support given to you, you will not be eligible for cash aid or Medi-Cal. Your child(ren) may still be eligible for aid/benefits and your case will be referred to the LCSA.
  - If you refuse or fail to cooperate in the paternity or support enforcement process, your family's grant will be lowered by 25 percent until you cooperate and you may not get Medi-Cal. This penalty ends effective the first day of the month in which you do cooperate.
- **For applicants/beneficiaries of Medi-Cal Only:** You will not be eligible for Medi-Cal benefits, but your child(ren) may still be eligible.

Certification and Agreement:

- I understand my rights and responsibilities as written on this notice.
- I understand the rules for assigning support rights to the county.
- I also understand my right to claim good cause.

NAME OF NONCUSTODIAL PARENT/ALLEGED FATHER

☐ I agree to cooperate with the county and the LCSA as listed above.

☐ I claim good cause and refuse to cooperate at this time.

☐ I refuse to assign child/spousal support rights (cash aid).

☐ I refuse to assign medical support rights (cash aid and Medi-Cal).

Signature of Parent or Caretaker Relative, or Medi-Cal Applicant/Beneficiary	Date	Case Name	Case Number

I certify that I have notified the applicant, cash aid recipient, or Medi-Cal beneficiary of his/her rights and responsibilities by means of this notice and orally as needed.

County Worker's Signature	Worker's Number	Date

YOUR RIGHT TO CLAIM GOOD CAUSE

Reasons for Claiming Good Cause:

- Cooperation would increase the risk of physical, sexual, or emotional harm to the child(ren).
- Cooperation would increase the risk of domestic abuse for the parent or caretaker relative.
- The child(ren) was conceived due to incest or rape.
- Court proceedings are going on for the adoption of the child(ren).
- You are working with an adoption agency to help you decide whether to keep or place the child(ren) for adoption.
- You are cooperating in good faith but are not able to identify or help locate the noncustodial parent.
- You have other credible reasons why cooperation would not be in the best interest of the child(ren).

How to Claim Good Cause:

- If you want to claim good cause, you must tell your worker. You can do this whenever you believe you have good cause not to cooperate.
- You must also complete and sign the Good Cause Claim form which your worker will give you.
- If you claim good cause, you must:
  - Give the county proof that you have good cause for refusing to cooperate.
  - Give the proof to the county within 20 days of claiming good cause. The county will give you more time if it determines that you need more than 20 days to get your proof.
- If you are claiming good cause and it is not possible for you to get proof, tell the worker.

The Role of the County:

- The county reviews your Good Cause Claim and the proof you provide and decides whether you have good cause.
- The county investigates your facts.
- The county will tell you when you need to provide:
  - more proof to support your good cause claim, and/or
  - additional facts so that it will not be necessary to contact the noncustodial parent or alleged father.

What Is Acceptable Evidence to Claim Good Cause for Not Cooperating?

- Birth certificates, medical/mental health, rape crisis, domestic violence program, or police/sheriff records that show that the child(ren) was conceived due to incest or rape.
- Records that show you have asked for help with abuse toward you and/or the child(ren); or records that show evidence of abuse. These records can be from police/sheriff, governmental agency, or court records; facts from a domestic violence program or a professional from whom you have asked for help in dealing with abuse; physical evidence of abuse, or any other evidence that supports an exemption from the cooperation rules.
- Court documents or other records that show that a legal adoption is pending in court.
- A written statement from an adoption agency confirming that you are being helped to decide whether to keep or place your child(ren) up for adoption.
- Credible sworn statements under penalty of perjury about the history of abuse or the increased risk of abuse, from either you or other people who know about the reasons for your good cause claim for not cooperating.

The Role of the Local Child Support Agency (LCSA):

- If you request a hearing on the issue of good cause, the LCSA may take part in that hearing.
- The LCSA may try to establish paternity or collect child support if:
  - Establishing paternity or collecting child support will not increase risk of harm to you or the child(ren).
  - You do not have good cause for refusing to cooperate.
- After the county tells the LCSA that an applicant/recipient has claimed to be exempt from the cooperation rules, the LCSA will not pursue child support enforcement activities unless the applicant/recipient asks for these actions to begin or to begin again.

Current Form

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

SUPPORT QUESTIONNAIRE

Instructions:
You must answer ALL questions.
COMPLETE ONE FORM FOR EACH NONCUSTODIAL PARENT OR EACH UNMARRIED FATHER IN THE HOME.

Use ink. Print answer. Check Yes, No, or Unknown.
Use a separate piece of paper if you need more room.

FOR COUNTY USE ONLY	
CWD CASE NAME	LCSA CASE NAME
CWD CASE NUMBER	LCSA CASE NUMBER
CWD WORKER NAME/NO.	LCSA WORKER NAME/NO.
TELEPHONE NUMBER ( )	TELEPHONE NUMBER ( )

SECTION 1 - COMPLETE THE FOLLOWING ABOUT YOURSELF

NAME (FIRST, MIDDLE, LAST) | MAIDEN NAME | SOCIAL SECURITY NUMBER (SSN) | BIRTHDATE | BIRTH PLACE | RACE

HOME ADDRESS (STREET NUMBER AND NAME, APARTMENT NUMBER, IF ANY) | CITY | STATE | ZIP | TELEPHONE NUMBER ( )

YOUR RELATIONSHIP TO CHILDREN | YOUR RELATIONSHIP TO NONCUSTODIAL PARENT/UNMARRIED FATHER IN THE HOME ☐ Spouse ☐ Ex-Spouse ☐ Friend ☐ Other

SECTION 2 - COMPLETE THE FOLLOWING ABOUT THE NONCUSTODIAL PARENT OR UNMARRIED FATHER IN THE HOME

A. NAME (FIRST, MIDDLE, LAST) | SOCIAL SECURITY NUMBER (SSN) | ☐ MALE ☐ FEMALE | BIRTHDATE | BIRTH PLACE

LAST KNOWN ADDRESS (STREET NUMBER AND NAME, APARTMENT NUMBER, IF ANY) | HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR | RACE

CITY | STATE | ZIP | SCARS, BIRTHMARKS, TATTOOS, NICKNAMES, ETC.

WHEN WAS THIS ADDRESS CURRENT? | TELEPHONE NUMBER ( ) | WHEN DID YOU LAST HEAR FROM OR GET MAIL FROM THIS PARENT? | DOES THIS PARENT LIVE WITH YOU? ☐ YES ☐ NO

B. WHAT KIND OF INCOME DOES NONCUSTODIAL PARENT HAVE? ☐ Earnings ☐ Unemployment or Disability Insurance Benefits ☐ Social Security ☐ None ☐ Other

LAST KNOWN EMPLOYER | TELEPHONE NUMBER ( )

STREET ADDRESS | TYPE OF WORK

CITY | STATE | ZIP | UNION MEMBER? ☐ YES, UNION NAME ☐ NO ☐ UNKNOWN

WHEN DID THIS PARENT LAST WORK THERE? | UNION ADDRESS:

C. DOES THIS PARENT HAVE HEALTH INSURANCE FOR THE CHILDREN? ☐ YES ☐ NO ☐ UNKNOWN | WHO IS COVERED?

NAME OF INSURANCE | POLICY NUMBER | DATE OF COVERAGE

D. PARENTS ARE OR HAVE BEEN ☐ MARRIED DATE _____ WHERE _____ ☐ DIVORCED DATE _____ WHERE _____ ☐ SEPARATED ☐ NEVER MARRIED ☐ LIVING TOGETHER

E. IS THERE A COURT ORDER FOR SUPPORT? ☐ YES ☐ NO ☐ PENDING | AMOUNT ORDERED $ | HOW OFTEN? | DATE OF COURT ORDER | COURT ORDER NUMBER | LOCATION OF COURT (COUNTY & STATE)

HOW DOES THE PARENT PAY? ☐ TO YOU ☐ TO COUNTY ☐ PAYS HOUSEHOLD BILLS ☐ PAYROLL DEDUCTION ☐ OTHER | WHEN DID PARENT LAST PAY? | HOW MUCH? $

F. NAME OF A FRIEND OR RELATIVE OF NONCUSTODIAL PARENT | RELATIONSHIP TO NONCUSTODIAL PARENT | TELEPHONE NUMBER ( )

ADDRESS (NUMBER AND STREET) | CITY | STATE | ZIP

G. DOES THIS PARENT OWN ANY MOTOR VEHICLES? ☐ YES ☐ NO ☐ UNKNOWN | MAKE | MODEL | YEAR | LICENSE NO. | STATE

H. DOES THIS PARENT OWN A HOUSE, LAND, BUILDINGS, OR BANK ACCOUNTS? ☐ YES ☐ NO ☐ UNKNOWN | WHAT/WHERE

I. IS THIS PARENT CURRENTLY ON PROBATION OR PAROLE? ☐ YES ☐ NO ☐ UNKNOWN | WHAT COUNTY OR STATE?

J. HAS THIS PARENT EVER BEEN IN JAIL OR PRISON? ☐ YES ☐ NO ☐ UNKNOWN | IF YES, WHEN/WHERE?

K. HAS THIS PARENT EVER BEEN IN THE MILITARY? ☐ YES ☐ NO ☐ UNKNOWN | IF YES, WHEN/WHAT BRANCH?

L. ARE YOU ABLE TO IDENTIFY OR HELP LOCATE THE NONCUSTODIAL PARENT? ☐ YES ☐ NO

SECTION 3 - CHILDREN (IN YOUR HOME) OF THIS PARENT OR UNMARRIED FATHER

NAME OF CHILD	☐ M ☐ F	SSN	BIRTHDATE – –	BIRTHPLACE, CITY, STATE	PATERNITY DECLARATION: MFG ☐ ☐ YES ☐ NO ☐ UNK DATE SIGNED COUNTY
NAME OF CHILD	☐ M ☐ F	SSN	BIRTHDATE – –	BIRTHPLACE, CITY, STATE	MFG ☐ ☐ YES ☐ NO ☐ UNK DATE SIGNED COUNTY
NAME OF CHILD	☐ M ☐ F	SSN	BIRTHDATE – –	BIRTHPLACE, CITY, STATE	MFG ☐ ☐ YES ☐ NO ☐ UNK DATE SIGNED COUNTY
NAME OF CHILD	☐ M ☐ F	SSN	BIRTHDATE – –	BIRTHPLACE, CITY, STATE	MFG ☐ ☐ YES ☐ NO ☐ UNK DATE SIGNED COUNTY

SECTION 4 - SUPPORT ENFORCEMENT SERVICES (MEDI-CAL ONLY)

☐ I don't want other child support enforcement services.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES OF AMERICA AND THE STATE OF CALIFORNIA THAT THE INFORMATION IN THIS QUESTIONNAIRE IS TRUE, CORRECT AND COMPLETE.

SIGNATURE ☛ | DATE

1st Copy – Local Child Support Agency 2nd Copy – County Welfare Department 3rd Copy – Applicant

Old Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT OF FACTS FOR AN ADDITIONAL PERSON

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

INSTRUCTIONS: Fill out this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper. Fill in the answers for all the questions about the benefits you are asking for. The "CA" for cash aid and "FS" for food stamps listed to the left side of each question tell you which questions are for which program.

If you get cash aid, and you want aid for the new person, this form must be filled out by either the adult caretaker relative who is now getting cash aid or the new person, unless the new person is a child.

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

PLEASE PRINT IN INK

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME

WORKER NUMBER

DATE RECEIVED

VERIFIED:	YES	NO
SSN		
FS ID		
Blind/Deaf/Disabled		
Residency		
DFA 285-C Comp.		
Referred to Cal-Learn		
CA 25 Completed		
CA 25 A Completed		
Referred to GAIN		
Citizen		
Eligible Non-citizen		
Sponsored		
SAVE		

Date of Entry to U.S. _____

Excluded HH Member Code _____

Work/Training/GAIN Code _____

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

CA FS (2) List new person in the home, including a newborn.

NAME (First Middle Last)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO

SOCIAL SECURITY NUMBER - -

BIRTHDATE - -

PREGNANT ☐ YES ☐ NO

IS HE/SHE A PARENT? ☐ YES ☐ NO

BIRTHPLACE (City/State/Country)

SEX (✓) ☐ M ☐ F

SCHOOL STATUS (✓)
- ☐ Has a High School Diploma
- ☐ Has a GED
- ☐ Currently Attending School
- ☐ Not Attending School (Explain):

MARITAL STATUS
☐ Married ☐ Never Married ☐ Separated
☐ Divorced ☐ Common Law ☐ Widowed

BLIND/DEAF/DISABLED ☐ YES ☐ NO

RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? ☐ YES ☐ NO
If "YES", explain relationship:

ANY OTHER NAME USED, BELOW: (Maiden, adoptive, etc.)

CA FS (3) Has he/she applied for or received benefits in the past, such as: cash aid, food stamps homeless assistance, Medi-Cal, Refugee Cash Assistance? ☐ YES ☐ NO
If "YES", explain:

WHEN	WHERE (County, State, or Country)	TYPE OF BENEFIT

CA (4) Is he/she a child under age 19? If "YES", complete below: ☐ YES ☐ NO

MOTHER'S NAME (✓) Lives in Home	FATHER'S NAME (✓) Lives in Home	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply)
☐ Yes ☐ No	☐ Yes ☐ No		☐ Absence ☐ Unemployment ☐ Incapacity ☐ Death

VERIFIED: Deprivation ☐ YES ☐ NO

CA FS (5) Has he/she been in the U.S. military service or the spouse, parent or child of a person who has been in the military service? If "YES", explain: ☐ YES ☐ NO

LIST NAME, BRANCH OF SERVICE, ETC.

HONORABLE DISCHARGE ☐ YES ☐ NO

CA 5 ☐ YES ☐ NO

Date Initiated _____

CA (6) Has he/she lived in California for the last 12 months in a row? Complete below: ☐ YES ☐ NO

LAST PLACE OF RESIDENCE (City, State)	DATE ARRIVED IN CALIFORNIA

Apply RFG: ☐ YES ☐ NO

State _____

RFG MAP _____

RFG Months _____

CA (7) Does he/she presently live in California and intend to continue living here? ☐ YES ☐ NO
If "NO", explain:

		COUNTY USE ONLY
CA FS (8) A. Is he/she a foster child(ren) living in the home?	☐ YES ☐ NO	☐ AFDC and FC Eligible/ CR Chooses: Child: ☐ AFDC ☐ FC CR: ☐ AFDC ☐ None
FS B. Do you want the foster child and their foster care income included in the Food Stamp case?	☐ YES ☐ NO	
CA FS (9) A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below:	☐ YES ☐ NO	VERIFIED: School Enrollment ☐ Yes ☐ No FS Eligible Student ☐ Yes ☐ No

NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING?
IF ENROLLED, CHECK (✔) STATUS ☐ Full time ☐ Half time ☐ Other (specify):			☐ YES ☐ NO

CA FS B. Complete below if he/she is enrolled in college or attending a similar educational institution.

TERM	TUITION/FEES PER TERM	BOOKS, EQUIPMENT, ETC., PER TERM
☐ Semester ☐ Year ☐ Quarter	$	$
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED
TRANSPORTATION COST PER WEEK $	AMOUNT PAID BY CARPOOL MEMBERS $	PUBLIC TRANSPORTATION (BUS, ETC.,) PER DAY $

VERIFIED: Expenses ☐ Yes ☐ No Financial Aid ☐ Yes ☐ No

CA FS (10) Has he/she had cash aid or food stamps stopped for a period of time or forever due to: non-cooperation during a quality control review, work or training sanctions, or due to welfare fraud or an Intentional Program Violation? If "YES", complete below:	☐ YES ☐ NO	

WHY	WHEN	WHAT COUNTY/STATE

CA FS (11) Is he/she hiding or running from the law for a felony, an attempted felony, or for a parole or probation violation?	☐ YES ☐ NO	
FS (12) Does he/she buy food and fix meals separately from others in the home?	☐ YES ☐ NO	Separate household eligible ☐ Yes ☐ No
FS (13) Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability?	☐ YES ☐ NO	Separate household eligible ☐ Yes ☐ No
FS (14) Does he/she pay you for meals and/or a room?	☐ YES ☐ NO	

CHECK (✔)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
☐ Meals ☐ Room ☐ Both	$		

Household Elects: BOARDER | HH MEMBER | ROOMER

FS (15) Does he/she get food from any of the following programs? • Communal dining facility for the elderly or disabled • Food distribution program operated by a Native American reservation • Other food program If "YES", complete below:	☐ YES ☐ NO	

NAME OF PROGRAM

CA FS (16) Is he/she working now or expecting to be working in the next two months? If "YES", complete below. Attach paystubs or other proof of earnings. (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form). ☐ YES ☐ NO

EMPLOYER NAME	SELF EMPLOYED	OCCUPATION	DAYS/HOURS WORKED PER MONTH
	☐ YES ☐ NO		

PAY DATE(S)	WAGES BEFORE DEDUCTIONS	TIPS OR COMMISSIONS
	$ per	☐ YES Amount $ ☐ NO

COUNTY USE ONLY

(✓) If Exempt
☐ CA
☐ FS Adult
☐ FS Child

FS S/E Farmer ☐ Yes ☐ No

Verification(s) on file: ☐ Yes ☐ No

CA FS (17) A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? If "YES", complete below: ☐ YES ☐ NO

NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID
		$
NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID
		$

Child Care Informing Given to Client:

Trustline Informing (CCP 2)	Health & Safety Certification (CCP 5)
☐ Yes ☐ No	☐ Yes ☐ No

Dependent Care Eligible

CA	FS
☐ Yes ☐ No	☐ Yes ☐ No

CA FS B. Does he/she get child care costs paid for them? Include costs paid by a relative or friend, Department of Education, Student Aid Block Grant, Cal-Learn, TCC, NET, GAIN, SCC, CAAP, etc. If "YES", complete below: ☐ YES ☐ NO

NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID
		$
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID
		$

CA FS (18) Has he/she stopped or refused work or training in the last 60 days? If "YES", complete below: ☐ YES ☐ NO

	YES	NO
Emp. Statement		
Good Cause Determ		
Voluntary Quit		

☐ CA: 30 days
☐ FS: 60 days

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM

Did this person get or expect to get wages or benefits this month? If "YES", complete below. ☐ YES ☐ NO

LAST PAYCHECK RECEIVED (DATE)	AMOUNT BEFOREDEDUCTIONS
	$
EXPECTED CHECK (DATE)	AMOUNT BEFOREDEDUCTIONS
	$

NUMBER OF HOURS OF WORK/TRAINING

Last Month_____

This Month_____

LAST DAY OF WORK/TRAINING	TIPS OR COMMISSIONS
	☐ YES Amount $ ☐ NO

REASON FOR LEAVING JOB/TRAINING

CA FS (19) Is he/she on strike? If "YES", complete below: ☐ YES ☐ NO

Striker Regs Apply

CA	FS
☐ Yes ☐ No	☐ Yes ☐ No

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM

NAME OF UNION

DATE WENT ON STRIKE

GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE

$

CA FS (20) Does he/she pay child or spousal support? If "YES", complete below: ☐ YES ☐ NO

NAME OF CHILD OR SPOUSE	AMOUNT PER MONTH	COURT ORDERED
	$	☐ YES ☐ NO

Court Order on File ☐ Yes ☐ No

Amount Ordered

$

CA FS (21) Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.? If "YES", complete below: ☐ YES ☐ NO

TYPE BENEFIT	AMOUNT	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	HOW OFTEN (Weekly, Monthly, Etc.)	DATE EXPECTED TO START AND STOP	(✓) If Exempt CA	(✓) If Exempt FS
		$				START:		
						STOP:		

CA FS (22) Does he/she own or is he/she buying any real estate, such as land and/or buildings anywhere, including outside the U.S.? ☐ YES ☐ NO
If "YES", complete below:

ESTIMATED AMOUNT OWED	TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	VALUE
			$	$

COUNTY USE ONLY
Home Exempt ☐ Yes ☐ No
Other Real Property
Market Value $_____
Amount Owed $_____
Net Value $_____
Lien Applicable ☐ Yes ☐ No

CA FS (23) A. Does he/she have any of the following resources? ☐ YES ☐ NO
If "YES" check (✓) each item and explain below:

RESOURCE	YES	NO	RESOURCE	YES	NO
Checks or Money (at home or elsewhere)			Trust Funds		
Checking/Savings/Credit Union Account			Stocks, Bonds, Certificates, IRAs, Retirement Funds		
Notes, Mortgages, Trust Deeds, Sales Contracts			Other (list below)		

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	(✓) If Exempt AFDC	FS
				$		
				$		

CA FS B. Does he/she get income from any of these resources, such as interest, dividends, etc.? ☐ YES ☐ NO
If "YES," list each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	$	
	$	

CA FS (24) Does he/she own, lease, or use any motor vehicles, such as a car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.? ☐ YES ☐ NO
If "YES", complete below:

NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED
☐ Leased				☐ Yes ☐ No	$	$

(✓) If Exempt Leased | Vehicle Valuation
☐ Exempt
☐ Leased

CA FS (25) Does he/she own or use personal property which cost at least $100 for each item or is now worth at least $100 each, such as: jewelry, equipment, instruments, livestock, etc.? Do not list clothing, wedding rings, rugs, furniture, appliances, or other household furnishings. ☐ YES ☐ NO
If "YES", complete below:

OWNER	NAME OF ITEM	DATE BOUGHT	PURCHASE PRICE OR CURRENT VALUE	BALANCE OWED
			$	$
			$	$

☐ Owned Jointly
☐ Owned Separately
Net Market Value
$ _____

CA FS (26) Has he/she sold, transferred or given away any real or personal property within the last 2 years for cash aid and within the last 3 months for food stamps? ☐ YES ☐ NO
If "YES", explain below:

Closed Bank Accounts:
☐ Food Stamps in last 3 months

CA (27) Does he/she have any of the following insurance coverage: life, burial, disability or mortgage? ☐ YES ☐ NO
If "YES", complete below:

NAME OF INSURANCE COMPANY	POLICY NUMBER	PREMIUM PAID BY (NAME)	AMOUNT PAID
			$

Total CSV
(1) _____
(2) _____
Total Countable Property:
Items 22-27
AFDC $ _____
FS $ _____

CA FS (28) Does he/she have health or hospitalization insurance, including insurance paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.? ☐ YES ☐ NO
If "YES", complete below:

NAME OF INSURANCE COMPANY	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
		$	

☐ Health Care Options Explanation Given
Referral _____
NA _____
☐ DHS 6155
☐ DFA 285-C
Medicare Gross Premium
$_____

CA (29) Did he/she get medical/ pregnancy treatment this month or in the three months before this month? ☐ YES ☐ NO
If "YES", complete below:

WANT MEDI-CAL NAME OF PERSON		FOR TREATMENT? YES	NO	WAS PAYMENT MADE FOR THOSE MONTHS? YES	NO

COUNTY USE ONLY

Retro Medi-Cal
Requested ☐ Yes ☐ No
Approved ☐ Yes ☐ No

CA (30) Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? ☐ YES ☐ NO
If "YES", complete below:

NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID
	$	
	$	

☐ DHS 6155

CA FS (31) Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? ☐ YES ☐ NO
If "YES", complete below:

TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

VERIFIED:
Higher/Lower MAP ☐ Yes ☐ No
Special Need ☐ Yes ☐ No
☐ DFA 285-C

CA FS (32) A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item YES or NO:

	YES	NO		YES	NO
Special diet--prescribed by a doctor			Very high use of utilities		
Special transportation need			Special laundry service		
Special telephone or other equipment			Other (specify):		
Housework (no one in the home can do it)					

If "YES", explain:

CA Special Need
☐ Yes ☐ No
Amount $_____
VERIFIED:
CA ☐ Yes ☐ No
FS ☐ Yes ☐ No
☐ DFA 285-C

CA FS B. Does he/she get In-Home Supportive Services (IHSS)? ☐ YES ☐ NO
If "YES", how much does he/she pay each month? $_____

☐ DFA 285-C

CA (33) The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility.
Check (✓) each item YES or NO.

	YES	NO
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention program (CHDP) for eligible members of your family under age 21.		
• Do you want more information about CHDP Services?		
• Do you want CHDP medical services?		
• Do you want CHDP dental services?		
• Do you need help making appointments or with transportation to CHDP Services?		
B. If anyone in the family is pregnant, you can get help finding a doctor, getting		
C. Is anyone in the family breastfeeding a child?		
If "YES", was the birth within the last 12 months?		
If "YES" checked to (33) B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.		
D. Do you or any family member want free or low-cost family planning services ? If "YES", call your health care plan or regular doctor.		
Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.		

☐ CHDP Brochure and Explanation Given
Date: _____
☐ Referral

☐ Pregnant
☐ Parent or Guardian of child under 5
☐ Breastfeeding
☐ Postpartum
☐ WIC referral

☐ Family Planning Information Given
☐ Referred Date _____

CERTIFICATION

I understand the disqualification and/or welfare fraud penalties I will get if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

I understand that:

- If I do not follow cash aid rules, my cash aid can be stopped for 6 months for the first violation, 12 months for the second, and forever for the third. And I may also be fined up to $5,000 and/or sent to jail/prison for 3 years.
- If I give false or incomplete facts, I may be fined or sent to jail or prison if I am found guilty of committing perjury.
- If I file more than one application for cash aid so I can get cash aid in more than one case at the same time, or give the county false proof for an ineligible child or for a child that does not exist, my cash aid can be stopped for 2 years, 4 years, or forever.
- If I do not follow food stamp rules, my food stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
  - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation;
  - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second;
  - I traded or sold food stamps that were worth $500 or more, my food stamps can be stopped forever;
  - I gave the county false identity or residence information so I can get food stamps in more than one case at the same time, my food stamps can be stopped for 10 years.

I also understand that:

- I must apply for and keep any available health coverage if no cost is involved; if I don't, my Medi-Cal will be denied or stopped.
- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, etc.
- A Social Security Number (SSN) is required by law and will be matched with other records to be sure that I am not getting aid in more than one case, or in another county or state.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution, may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law for a felony or attempted felony, or is in violation of their parole or probation cannot get food stamps.

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

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

EW SIGNATURE	DATE

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT OF FACTS FOR AN ADDITIONAL PERSON

(Supplemental Application for CalFresh and Request for Cash Aid)

INSTRUCTIONS: Fill out this form to tell us about a new person in the home. If you need more space to answer the questions, attach another sheet of paper. Fill in the answers for all the questions about the benefits you are asking for. The "CA" for cash aid and "CF" for CalFresh listed to the left side of each question tell you which questions are for which program.

If you get cash aid, and you want aid for the new person, this form must be filled out by either the adult caretaker relative who is now getting cash aid or the new person, unless the new person is a child.

For CalFresh households, which do not get cash aid or do not want cash aid for the new person, this form may be completed by a household member, an authorized representative or the new person.

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME

WORKER NUMBER

DATE RECEIVED

PLEASE PRINT IN INK

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

CA CF (2) List new person in the home, including a newborn.

NAME (First Middle Last)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO

SOCIAL SECURITY NUMBER - -

BIRTHDATE - -

PREGNANT ☐ YES ☐ NO

IS HE/SHE A PARENT? ☐ YES ☐ NO

BIRTHPLACE (City/State/Country)

SEX (✓) ☐ M ☐ F

SCHOOL STATUS (✓)
- ☐ Has a High School Diploma
- ☐ Has a GED
- ☐ Currently Attending School
- ☐ Not Attending School (Explain):

MARITAL STATUS ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed

BLIND/DEAF/DISABLED ☐ YES ☐ NO

RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? ☐ YES ☐ NO
If "YES", explain relationship:

ANY OTHER NAME USED: (Maiden, adoptive, etc.)

TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ CalFresh

VERIFIED:	YES	NO
SSN		
CF ID		
Blind/Deaf/Disabled		
Residency		
DFA 285-C Comp.		
CW 25 Completed		
QR 25 A Completed		
Referred to WTW		
Citizen		
Eligible Non-citizen		
Sponsored		
SAVE		

Date of Entry to U.S._____

Excluded HH Member Code _____

Work/Training/WTW Code _____

CA CF (3) Has he/she applied for or received benefits in the past, such as: cash aid, CalFresh, homeless assistance, Medi-Cal, Refugee Cash Assistance? ☐ YES ☐ NO
If "YES", explain:

WHEN	WHERE (County, State, or Country)	TYPE OF BENEFIT

CA (4) Is he/she a child under age 19? If "YES", complete below: ☐ YES ☐ NO

PARENT OR CARETAKER RELATIVE'S NAME (✓) Lives in Home	OTHER PARENT'S NAME (✓) Lives in Home	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply)
☐ Yes ☐ No	☐ Yes ☐ No		☐ Absence ☐ Unemployment ☐ Incapacity ☐ Death

VERIFIED: Deprivation ☐ YES ☐ NO

CA (5) CF Has he/she been in the U.S. military service or the spouse, parent or child of a person who has been in the military service? If "YES", explain: ☐ YES ☐ NO

LIST NAME, BRANCH OF SERVICE, ETC.

HONORABLE DISCHARGE ☐ YES ☐ NO

CW 5 ☐ YES ☐ NO

Date Initiated _____

CA (6) Does he/she presently live in California and intend to continue living here? ☐ YES ☐ NO
If "NO", explain:

COUNTY USE ONLY

7A: ☐ Request dependency order
7B: CA and FC Elig/CR Chooses:
Child: ☐ CA ☐ FC
CR: ☐ CA ☐ None
☐ Kin-GAP
7C: ☐ Medi-Cal
☐ Fee for Service

CA CF (7) Is he/she a foster child living in the home? ☐ YES ☐ NO

A. Was the child placed in your home under a dependency order from the court? ☐ YES ☐ NO
B. Do you want the foster child and foster care income counted on the CalFresh case? ☐ YES ☐ NO
C. Is the child enrolled in a health care plan? ☐ YES ☐ NO

CA CF (8) A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: ☐ YES ☐ NO

NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING?
IF ENROLLED, CHECK (✔) STATUS ☐ Full time ☐ Half time ☐ Other (specify):			☐ YES ☐ NO

VERIFIED:
School Enrollment ☐ Yes ☐ No
CF Eligible Student ☐ Yes ☐ No

CA CF B. Complete below if he/she is enrolled in college or attending a similar educational institution.

TERM	TUITION/FEES PER TERM	BOOKS, EQUIPMENT, ETC., PER TERM
☐ Semester ☐ Year ☐ Quarter	$	$
ROUND TRIP PER DAY TO SCHOOL/CHILD CARE (MILES)	DAYS ATTENDING PER WEEK	TRANSPORTATION USED
TRANSPORTATION COST PER WEEK $	AMOUNT PAID BY CARPOOL MEMBERS $	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY $

VERIFIED:
Expenses ☐ Yes ☐ No
Financial Aid ☐ Yes ☐ No

CA CF (9) Has he/she had cash aid or CalFresh stopped for a period of time or forever due to: non-cooperation during a quality control review, work or training sanctions, or due to welfare fraud or an Intentional Program Violation? If "YES", complete below: ☐ YES ☐ NO

WHY	WHEN	WHAT COUNTY/STATE

CA CF (10) **Is any member of the household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime?** If "YES", give name of the person: ☐ YES ☐ NO

CA CF (11) **Has any member of the household been found by a court of law to be in violation of probation or parole?** If "YES", give name of the person: ☐ YES ☐ NO

CA CF (12) Has any member of the household been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s)? Give facts for cash aid, for convictions on or after 1/1/98; and for CalFresh, for crimes and convictions after 8/22/96. If "YES", complete below: ☐ YES ☐ NO

NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED

CF (13) Does he/she regularly buy food and fix meals separately from others in the home? ☐ YES ☐ NO

Separate household eligible ☐ Yes ☐ No

CF (14) Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? ☐ YES ☐ NO

Separate household eligible ☐ Yes ☐ No

CF (15) Does he/she pay you for meals and/or a room? ☐ YES ☐ NO

CHECK (✔)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY
☐ Meals ☐ Room ☐ Both	$		

Household Elects

BOARDER	HH MEMBER	ROOMER

CF (16) Does he/she get food from any of the following programs? ☐ YES ☐ NO

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

If "YES", complete below:

NAME OF PROGRAM

CA CF (17) Is he/she working now or expecting to be working in the future? ☐ YES ☐ NO
If "YES", complete below. Attach paystubs or other proof of earnings. If job hasn't started what is the anticipated start date? _____
(Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form).

EMPLOYER NAME	SELF EMPLOYED	OCCUPATION	DAYS/HOURS WORKED PER MONTH
	☐ YES ☐ NO		

PAY DATE(S)	WAGES BEFORE DEDUCTIONS	TIPS OR COMMISSIONS
	$ per	☐ YES Amount $ ☐ NO

Will this income continue? ☐ YES ☐ NO If "NO", explain any changes here:

COUNTY USE ONLY

(✓) if Exempt
☐ CA
☐ CF Adult
☐ CF Child

CF S/E Farmer ☐ Yes ☐ No

Verification(s) on file: ☐ Yes ☐ No

CA CF (18) A. Does he/she pay someone to care for a child, disabled adult or other dependent so he/she can go to work or training or look for a job? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID
		$
NAME OF PERSON WHO RECEIVES CARE	NAME OF PERSON WHO GIVES CARE	MONTHLY AMOUNT PAID
		$

Child Care Informing Given to Client:

Trustline Informing (CCP 2)	Health & Safety Certification (CCP 5)
☐ Yes ☐ No	☐ Yes ☐ No

Dependent Care Eligible

CA	CF
☐ Yes ☐ No	☐ Yes ☐ No

CA CF B. Does he/she get child care costs paid for them? ☐ YES ☐ NO
Include costs paid by a relative or friend, Department of Education, Student Aid, Block Grant, Cal-Learn,TCC, NET, WTW, SCC, CAAP, etc.
If "YES", complete below:

NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID
		$
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID
		$

CA CF (19) Has he/she stopped or refused work or training in the last 60 days? ☐ YES ☐ NO
If "YES", complete below:

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM

Did this person get or expect to get wages or benefits this month? ☐ YES ☐ NO
If "YES", complete below.

LAST PAYCHECK RECEIVED (DATE)	AMOUNT BEFORE DEDUCTIONS
	$
EXPECTED CHECK (DATE)	AMOUNT BEFORE DEDUCTIONS
	$
LAST DAY OF WORK/TRAINING	TIPS OR COMMISSIONS
	☐ YES Amount $ ☐ NO

REASON FOR LEAVING JOB/TRAINING

NUMBER OF HOURS OF WORK/TRAINING
Last Month_____
This Month_____

	YES	NO
Emp. Statement		
Good Cause Determ		
Voluntary Quit		

☐ CA: 30 days
☐ CF: 60 days

CA CF (20) Is he/she on strike? ☐ YES ☐ NO
If "YES", complete below:

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM

NAME OF UNION

DATE WENT ON STRIKE

GROSS MONTHLY INCOME EARNED FROM THIS JOB BEFORE THE STRIKE
$

Striker Regs Apply

CA	CF
☐ Yes ☐ No	☐ Yes ☐ No

CF (21) Does he/she pay child or spousal support? ☐ YES ☐ NO
If "YES", complete below:

NAME OF CHILD OR SPOUSE	AMOUNT PER MONTH	COURT ORDERED
	$	☐ YES ☐ NO

Court Order on File ☐ Yes ☐ No
Amount Ordered
$

CA CF (22) Has he/she applied for or received any other benefits in the last 12 months, such as: Social Security, Unemployment/Disability Insurance, Cash Aid, Child/Spousal Support, Veterans Benefits, Free Housing, Free Utilities, etc.? ☐ YES ☐ NO
If "YES", complete below:

TYPE BENEFIT	AMOUNT	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	HOW OFTEN (Weekly, Monthly,Etc.)	DATE EXPECTED TO START AND STOP	(✓) if Exempt CA	(✓) if Exempt CF
	$					START:		
						STOP:		

Will this income continue? ☐ YES ☐ NO If "NO", explain any changes here:

CA CF (23) Does he/she own or is he/she buying any real estate, such as land and/or buildings anywhere, including outside the U.S.? ☐ YES ☐ NO

If "YES", complete below:

TYPE (LAND, HOUSE, APARTMENT, ETC.)	USE (HOME, RENTAL, ETC.)	ADDRESS OR LOCATION	ESTIMATED VALUE	AMOUNT OWED
			$	$

COUNTY USE ONLY

Home Exempt ☐ Yes ☐ No

Other Real Property

Market Value $_____

Amount Owed $_____

Net Value $_____

Lien Applicable ☐ Yes ☐ No

CA CF (24) A. Does he/she have any of the following resources? ☐ YES ☐ NO

If "YES" check (✓) each item and explain below:

RESOURCE	YES	NO	RESOURCE	YES	NO
Checks or Money (at home or elsewhere)			Trust Funds		
Checking/Savings/Credit Union Account			Stocks, Bonds, Certificates, IRAs, Retirement Funds		
Notes, Mortgages, Trust Deeds, Sales Contracts			Other (list below)		

TYPE OF RESOURCE	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE	(✓) if Exempt CA	CF
				$		
				$		

CA CF B. Does he/she get income from any of these resources, such as interest, dividends, etc.? ☐ YES ☐ NO

If "YES," list each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	$	
	$	

CA CF (25) Does he/she own, lease, or use any motor vehicles, such as a car, truck, boat, trailer, van, mobile home, off-road vehicle (ATVs), motorcycle, seadoos, jetskis, etc.? ☐ YES ☐ NO

If "YES", complete below:

NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED
☐ Leased				☐ Yes ☐ No	$	$

(✓) If Exempt Leased ☐ Exempt ☐ Leased

Vehicle Valuation

CA CF (26) Does he/she own or use personal property which cost at least $100 for each item or is now worth at least $100 each, such as: jewelry, equipment, instruments, livestock, etc.? Do **not** list clothing, wedding rings, rugs, furniture, appliances, or other household furnishings. ☐ YES ☐ NO

If "YES", complete below:

OWNER	NAME OF ITEM	DATE BOUGHT	PURCHASE PRICE OR CURRENT VALUE	BALANCE OWED
			$	$
			$	$

☐ Owned Jointly

☐ Owned Separately

Net Market Value

$ _____

CA CF (27) Has he/she sold, transferred or given away any real or personal property within the last 2 years for cash aid and within the last 3 months for CalFresh? ☐ YES ☐ NO

If "YES", explain below:

Closed Bank Accounts:

☐ CalFresh in last 3 months

CA (28) Does he/she have any of the following insurance coverage: life, burial, disability or mortgage? ☐ YES ☐ NO

If "YES", complete below:

NAME OF INSURANCE COMPANY	POLICY NUMBER	PREMIUM PAID BY (NAME)	AMOUNT PAID
			$

Total CSV

(1) _____

(2) _____

Total Countable Property:

Items 22-27

CA $ _____

CF $ _____

CA CF (29) Does he/she have health or hospitalization insurance, including insurance paid for by an employer or absent parent, such as: Blue Cross, Kaiser, CHAMPUS, Medicare, etc.? ☐ YES ☐ NO

If "YES", complete below:

NAME OF INSURANCE COMPANY	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID
		$	

☐ Health Care Options Explanation Given

Referral _____

NA _____

☐ DHS 6155

☐ DFA 285-C

Medicare Gross Premium

$_____

		COUNTY USE ONLY
CA (30) Did he/she get medical/ pregnancy treatment this month or in the three months before this month? If "YES", complete below:	☐ YES ☐ NO	Retro Medi-Cal Requested ☐ Yes ☐ No Approved ☐ Yes ☐ No

NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	WAS PAYMENT MADE FOR TREATMENT?		WANT MEDI-CAL FOR THOSE MONTHS?	
		YES	NO	YES	NO

CA (31) Does he/she have any health insurance available from a parent, employer or absent parent, which has not been applied for? If "YES", complete below:	☐ YES ☐ NO	☐ DHS 6155

NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID
	$	
	$	

CA (32) CF Does he/she have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? If "YES", complete below:	☐ YES ☐ NO	VERIFIED: Higher/Lower MAP ☐ Yes ☐ No Special Need ☐ Yes ☐ No ☐ DFA 285-C

TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

CA (33) CF A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item YES or NO:

	YES	NO		YES	NO
Special diet--prescribed by a doctor			Very high use of utilities		
Special transportation need			Special laundry service		
Special telephone or other equipment			Other (specify):		
Housework (no one in the home can do it)					

If "YES", explain:

CA Special Need ☐ Yes ☐ No
Amount $_____
VERIFIED:
CA ☐ Yes ☐ No
CF ☐ Yes ☐ No
☐ DFA 285-C

CA CF B. Does he/she get In-Home Supportive Services (IHSS)? If "YES", how much does he/she pay each month? $_____	☐ YES ☐ NO	☐ DFA 285-C

	YES	NO	
CA (34) The following services are available. Answers to these questions for yourself or anyone in the family will not affect your eligibility. Check (✓) each item YES or NO.			☐ CHDP Brochure and Explanation Given Date: _____
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention program (CHDP) for eligible members of your family under age 21.			☐ Referral
• Do you want more information about CHDP Services?			
• Do you want CHDP medical services?			
• Do you want CHDP dental services?			
• Do you need help making appointments or with transportation to CHDP Services?			
B. If anyone in the family is pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?			
C. Is anyone in the family breastfeeding a child?			☐ Pregnant ☐ Parent or Guardian of child under 5
If "YES", was the birth within the last 12 months?			
If you checked "YES" to (34) B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.			☐ Breastfeeding ☐ Postpartum ☐ WIC referral
D. Do you or any family member want free or low-cost family planning services ? If "YES", call your health care plan or regular doctor.			
Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.			☐ Family Planning Information Given ☐ Referred Date _____

CERTIFICATION

I understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and CalFresh, records will be matched with law enforcement agencies for arrest warrants.
- All facts I gave, including benefit and income facts, may be reviewed and checked out by county, state, and federal personnel, and if I gave wrong facts, my cash aid, CalFresh, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the U.S. Citizenship and Immigration Services (USCIS) to verify immigration status and the facts the county gets from USCIS may affect my eligibility for cash aid, CalFresh and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident alien (LPR), (b) an amnesty alien with a valid and current I-688, or (c) an alien permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the USCIS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The CalFresh household, any adult member of a CalFresh household (even if he/she moves out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime <u>or</u> has been found by a court of law to be in violation of their probation or parole cannot get cash aid or CalFresh.
- Anyone who has committed and been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s) since August 22, 1996, cannot get CalFresh or if convicted on or after January 1, 1998, cannot get cash aid.
- For cash aid, the county will require that I and certain household members be fingerprint and photo imaged. Benefits may be denied or stopped if we do not cooperate.

I also understand that:

I will get disqualification and/or welfare fraud penalties if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, CalFresh, and Medi-Cal.

For cash aid:

- If I on purpose do not follow cash aid rules, I may be fined up to $10,000 and/or sent to jail/prison for 3 years. And my cash aid can be stopped:
  - For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
  - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
  - For conviction of felony thefts to get aid: 2 years for theft of amounts under $2,000; 5 years for amounts of $2,000 through $4,999.99; and forever for amounts of $5,000 or more.
  - For giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county false proof for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing: forever.

For CalFresh:

- If on purpose I do not follow CalFresh rules, my CalFresh benefits will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
  - I traded or sold CalFresh benefits for firearms, ammunition, or explosives, my CalFresh can be stopped forever for the first violation.
  - I traded or sold CalFresh benefits for controlled substances, my CalFresh can be stopped for 24 months for the first violation and forever for the second.
  - I traded or sold CalFresh benefits that were worth $500 or more, my CalFresh can be stopped forever.
  - I filed two or more applications for CalFresh at the same time and gave the county false identity or residence information, my CalFresh can be stopped for 10 years.

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

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT CALFRESH HOUSEHOLD MEMBER OR CALFRESH AUTHORIZED REPRESENTATIVE)

SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

Old Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT OF FACTS TO ADD A CHILD(REN) UNDER AGE 16

(Supplemental application and request for Cash Aid and/or Food Stamps)

INSTRUCTIONS:

Fill out this form for a new child(ren) in the home and sign the certification section. If you need more space, attach another sheet of paper.

If you get Cash Aid, and you want aid for the new child(ren), this form must be filled out by the parent or adult caretaker relative.

For Food Stamp households which don't get or don't want to get Cash Aid, this form must be filled out by an adult household member or authorized representative.

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME AND NUMBER

DATE RECEIVED

1. Parent's or Caretaker Relative's Name | **Phone** ( )

CHILD(REN) NEED AID DUE TO PARENT'S (✓) BELOW FOR EACH CHILD: DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

A CHILD'S NAME (FIRST, MIDDLE, LAST) | MOTHER'S NAME | SFU | AU | FS Non-HH/Excluded Member Code

SOCIAL SECURITY NUMBER — — | SEX(✓) ☐ M ☐ F | FATHER'S NAME | MFG Child? ☐ Yes ☐ No

BIRTHPLACE (CITY/STATE/COUNTRY) | BIRTHDATE | BLIND, DEAF, OR DISABLED? ☐ YES ☐ NO | Work Registration/Exemption

GAIN Status FS

TYPE OF AID REQUESTED: ☐ Cash Aid ☐ Food Stamps ☐ None | CITIZENSHIP/IMMIGRATION STATUS CHECK (✓) ☐ U.S. Citizen/National ☐ Undocumented | Verified: ☐ SSN ☐ Age

RELATIONSHIP TO APPLICANT/CARETAKER RELATIVE | Lawful alien: ☐ Sponsored ☐ Refugee ☐ Other | ☐ Deprivation ☐ Citizen/Immigr. ☐ Blind/Deaf/Disabled ☐ SAVE

B CHILD'S NAME (FIRST, MIDDLE, LAST) | MOTHER'S NAME | SFU | AU | FS Non-HH/Excluded Member Code

SOCIAL SECURITY NUMBER — — | SEX(✓) ☐ M ☐ F | FATHER'S NAME | MFG Child? ☐ Yes ☐ No

BIRTHPLACE (CITY/STATE/COUNTRY) | BIRTHDATE | BLIND, DEAF, OR DISABLED? ☐ YES ☐ NO | Work Registration/Exemption

GAIN Status FS

TYPE OF AID REQUESTED: ☐ Cash Aid ☐ Food Stamps ☐ None | CITIZENSHIP/IMMIGRATION STATUS CHECK (✓) ☐ U.S. Citizen/National ☐ Undocumented | Verified: ☐ SSN ☐ Age

RELATIONSHIP TO APPLICANT/CARETAKER RELATIVE | Lawful alien: ☐ Sponsored ☐ Refugee ☐ Other | ☐ Deprivation ☐ Citizen/Immigr. ☐ Blind/Deaf/Disabled ☐ SAVE

2. Did the child(ren) get cash aid or food stamps this month? ☐ YES ☐ NO

IF "YES", complete below:

☐ Verification provided

TYPE OF AID	WHERE (County, State)
Child A ☐ Cash Aid ☐ Food Stamps	
Child B ☐ Cash Aid ☐ Food Stamps	

3. Does the child(ren) get or expect to get any other income, such as: Earnings, SSI, Social Security Benefits, Child Support, Veterans Benefits, etc. ☐ YES ☐ NO

IF "YES", complete below:

☐ Verification provided

WHO	WHAT	AMOUNT (Before Deductions, If Any)	WHEN	HOW OFTEN	Income: Unearned	Income: Earned	(✓) If exempt: CA	FS: Adult	Child
		$							
		$							

4. Is the child(ren) pregnant or a teen parent? ☐ YES ☐ NO

IF "YES", complete below:

Verified:
☐ Referred to Cal-Learn
☐ Referred to GAIN

NAME | AGE | CHECK (✓) STATUS ☐ Pregnant ☐ Teen Parent

SCHOOL STATUS, CHECK (✓) STATUS

☐ High School Diploma ☐ GED ☐ Not Attending School (explain):

☐ Currently Attending School ☐ Other (explain):

* The Social Security Act [Section 402(a)(25)] and the Food Stamp Act of 1977 (as amended by Public Law 97-98) say that you must give the county the Social Security Number (SSN) for anyone applying for Cash Aid and Food Stamps. If you refuse to give anyone's SSN or proof of application for his/her SSN, you won't be able to get aid for that person. SSNs are matched against records from tax, welfare, employment and the Social Security Administration for help determining eligibility and benefit levels. And SSNs are used to confirm income and resources; to prove the identify of a person(s); to be sure a person isn't getting aid in more than one case, in another county or state; to help the county make changes; and for program reviews and audits.

5. Does the child(ren) own any property or have resources, such as: cash, land, bank accounts, trust funds, savings bonds, or other items? ☐ YES ☐ NO

IF "YES", complete below:

WHO	TYPE OF RESOURCE	ACCOUNT/POLICY NUMBER	NAME, ADDRESS, OF BANK, ETC.	CURRENT VALUE
				$
				$

COUNTY USE ONLY

☐ Verification provided

(✓) Check if exempt

☐ CA ☐ FS

☐ CA ☐ FS

6. Does the child(ren) have health insurance, such as Blue Cross, Kaiser, Champus, etc., which is paid for by a parent or parent's employer? ☐ YES ☐ NO

IF "YES", list insurance coverage:

Child A	Child B

☐ Verification provided

Health Coverage Code:
A:_____
B:_____

7. A. If you can get cash aid, eligible members of your family under age 21 may be able to get some health examinations through the Child Health Disability Prevention Program (CHDP).

- Do you want more facts about CHDP services? ☐ YES ☐ NO
- Do you want free CHDP medical or dental services? ☐ YES ☐ NO
- Do you need help making appointments or getting to the doctor or dentist? ☐ YES ☐ NO

B. Do you want facts about non-discrimination, alcohol/drug counseling, past medical expenses, and other special needs? ☐ YES ☐ NO

C. Does anyone who is pregnant need to find a doctor, get medical transportation, and/or other help? ☐ YES ☐ NO

D. Is anyone breastfeeding a child? ☐ YES ☐ NO

IF **"YES"**, was the birth within the last three months? ☐ YES ☐ NO

E. Do you want to get facts or services from a Family Planning Clinic to help you plan your family size and prevent unplanned pregnancies? ☐ YES ☐ NO

☐ CHDP brochure and explanation given
☐ Referred
☐ Date:

☐ Other services referral

☐ Pregnant ☐ Parent or Guardian of child under 5.

☐ Breastfeeding ☐ Postpartum
☐ WIC referral

☐ Family Planning info given
☐ Date Referred:

CERTIFICATION

I understand that

- if I give wrong facts or fail to report all facts or situations on purpose that affect my eligibility and aid payments, I may be fined, jailed/imprisoned, or both. I can be fined up to $10,000 for cash aid and $250,000 for food stamps. I can be sent to jail/prison for 5 years for cash aid and 20 years for food stamps. And benefits for cash aid and food stamps can be stopped for six months, twelve months, or forever.
- my case can be picked for reviews to prove eligibility and that I must cooperate fully with county, state and federal personnel in any quality control review.
- the facts I give will be checked out by local, state and federal personnel.
- the county will send facts to the Immigration and Naturalization Service (INS) for proof of immigration status.
- the facts the county gets from INS may affect eligibility for cash aid and food stamps.
- the facts I give will be checked with tax, welfare, employment agencies and the Social Security Administration to prove the child(ren)'s eligibility for cash aid or food stamps and that I am getting the right amount of cash aid or food stamps.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this Statement of Facts is true, correct and complete.

WHO MUST SIGN THIS FORM: **For Cash Aid,** you and your aided spouse or the other parent of an aided child living in the home.
For Food Stamps, an adult household member or authorized representative.

SIGNATURE OF CARETAKER RELATIVE AND/OR ADULT FOOD STAMP HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE	DATE SIGNED
SIGNATURE OF CASH AIDED SPOUSE OR OTHER PARENT OF CASH AIDED CHILDREN (IF LIVING IN THE HOME)	DATE SIGNED
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE SIGNED

COUNTY USE ONLY

☐ INELIGIBLE (Reason)

☐ ELIGIBLE	Eligibility Conditions Met - Date:	Authorization Date:	Effective Date of Aid:
Signature of Eligibility Worker	Date	Signature of Supervisor	Date

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT OF FACTS TO ADD A CHILD UNDER AGE 16

(Supplemental Application and Request for Cash Aid and/or CalFresh)

INSTRUCTIONS:
Fill out this form for a new child in the home and sign the Certification section.
If you need more space, attach another sheet of paper. Use one form for each child.

If you get Cash Aid, and you want aid for the new child, this form must be filled out by the parent or California domestic partner or adult caretaker relative.

For CalFresh households which do not get or want to get Cash Aid, this form must be filled out by an adult household member or authorized representative.

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME AND NUMBER

DATE RECEIVED

1. Parent's or Caretaker Relative's Name | **Phone** ( )

CHILD NEEDS AID DUE TO PARENT'S (✔) BELOW: DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

2. Give us all the facts for this child.

CHILD'S NAME (FIRST, MIDDLE, LAST) | PARENT OR CARETAKER RELATIVE'S NAME

SOCIAL SECURITY NUMBER | SEX (✔) ☐ M ☐ F | OTHER PARENT'S NAME

BIRTHPLACE (CITY/STATE/COUNTRY) | BIRTHDATE (MONTH, DAY, YEAR) | BLIND, DEAF, OR DISABLED ☐ YES ☐ NO

TYPE OF AID REQUESTED (✔) ☐ Cash Aid ☐ CalFresh | CITIZEN/NONCITIZEN STATUS (✔) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IF CHILD IS UNDER AGE 6, ARE IMMUNIZATION SHOTS UP TO DATE? ☐ YES ☐ NO ☐ Not under age 6

AU | Non-AU | MFG Child ☐ Yes ☐ No | CF Non-HH Excl. Member Code:

Work Registration/Exemption Codes:

WtW: | CF:

VERIF: ☐ SSN ☐ Blind/Deaf/Disabled ☐ Citizen ☐ SAVE ☐ Eligible Noncitizen ☐ Immun.

Alien Reg. No. | D.O.E.

3. Is the child a foster child? ☐ YES ☐ NO
A. Was the child placed in your home under a dependency order from the court? ☐ YES ☐ NO
B. Do you want the foster child and foster care income counted on the CalFresh case? ☐ YES ☐ NO
C. Is the child enrolled in a health care plan? ☐ YES ☐ NO

3A. ☐ Request dependency order
3B. ☐ CA and FC Elig/CR Chooses:
Child: ☐ CA ☐ FC
CR: ☐ CA ☐ None ☐ Kin-GAP
3C. ☐ Medi-Cal ☐ Fee for Service

4. Did the child get cash aid or CalFresh this month? ☐ YES ☐ NO
If **"YES"**, complete below:

TYPE OF AID	WHERE (County, State)
☐ Cash Aid ☐ CalFresh	

☐ Verification provided

5. Does the child get or expect to get any income, such as: Earnings, Supplemental Security Income/State Supplementary Payment (SSI/SSP), Social Security Benefits, Child Support, Foster Care Payment, Veterans Benefits, etc. If **"YES"**, complete below: ☐ YES ☐ NO

TYPE OF INCOME	AMOUNT (Before Deductions, if any)	WHEN	HOW OFTEN
	$		

Will this income continue? ☐ YES ☐ NO If "NO", explain any known changes:

☐ Verification provided
☐ FC Income Counted on CF Case ☐ YES ☐ NO
☐ CA Eligible for Higher MAP

Income		(✔) if exempt	
Unearned	Earned	CA	CF

6. A. Complete below if you want cash aid for this child and the child is between ages 6 to 16. Does he/she attend school regularly? ☐ YES ☐ NO ☐ Not Age 6-16
If **"NO"**, explain why he/she does not attend regularly:

B. Is the child pregnant or a teen parent? ☐ YES ☐ NO
If **"YES"**, Check (✔) status: ☐ Pregnant ☐ Teen Parent

SCHOOL STATUS, CHECK (✔)
☐ Has a High School Diploma ☐ Has a GED ☐ Not Attending School (explain):
☐ Currently Attending School ☐ Other (explain):

C. Has the child received a cash bonus or sanction, or help with child care, transportation, etc, from the Cal-Learn Program? ☐ YES ☐ NO
If **"YES"**, complete below:

WHERE (COUNTY)	DATE(S) RECEIVED

Verified:
☐ Referred to Cal-Learn Program
☐ CW 25
☐ QR 25A

CW 5 ☐ YES ☐ NO
Date Initiated _____

7. Has the parent(s) of this child been in the United States (U.S.) military? ☐ YES ☐ NO
If **"YES"**, complete below:

NAME OF PARENT	PARENT A U.S. CITIZEN	BRANCH OF SERVICE	DATES OF SERVICE	HONORABLE DISCHARGE
	☐ YES ☐ NO			☐ YES ☐ NO

CF: Honorable Discharge ☐ YES ☐ NO

8. Complete below if you want CalFresh for this child and the child is <u>not a citizen of the U.S.</u>

A. How many years total has this child and/or his/her parents lived in the U.S.?

B. <u>While living in the U.S.</u>, in how many of the years did this child and/or the child's parents earn money by working in the U.S.?

C. <u>While living outside the U.S.</u>, how many total years did this child and/or the child's parents work in the U.S. or for a U.S. company?

		COUNTY USE ONLY
9. Does the child own any property or have resources, such as: cash, land, bank accounts, trust funds, savings bonds, Native American per capita payments or trust funds, or other items? If **"YES"**, complete below:	☐ YES ☐ NO	☐ Verification provided ☐ CA Restricted Account (✔) Check if exempt ☐ CA ☐ CF

TYPE OF RESOURCE	ACCOUNT/POLICY NUMBER	NAME, ADDRESS OF BANK, ETC.	CURRENT VALUE
			$

10. Does the child have Medicare or health insurance, such as Blue Cross, Kaiser, CHAMPUS, etc., which is paid for by a parent or parent's employer? If **"YES"**, list insurance coverage:	☐ YES ☐ NO	☐ Verification provided Health Coverage Code:
11. Has the child been charged as an adult with a felony, and if so, is the child hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for that felony crime or attempted felony crime?	☐ YES ☐ NO	
12. Has the child been found by a court of law to be in violation of probation or parole?	☐ YES ☐ NO	
13. Has the child been convicted as an adult of a drug-related felony for possession, use, or distribution of a controlled substance(s)? If **"YES"**, give facts for cash aid, for convictions on or after 1/1/98; and for CalFresh, for crimes and convictions after 8/22/96.	☐ YES ☐ NO	

DATE CONVICTED	DATE CRIME COMMITTED

	YES	NO
14. A. If you can get cash aid, eligible members of your family under age 21 may be able to get some health examinations through the Child Health and Disability Prevention Program (CHDP).		
• Do you want more facts about CHDP services?		
• Do you want free CHDP medical or dental services?		
• Do you need help making appointments or getting to the doctor or dentist?		
B. Do you want more facts about immunization services?		
C. Do you want facts about non-discrimination, alcohol/drug counseling, past medical expenses, and other special needs?		
D. Does anyone who is pregnant need to find a doctor, get medical transportation, and/or other help?		
E. Is anyone breastfeeding a child?		
If **"YES"**, was the birth within the last 12 months?		
F. Do you want to get facts or services from a Family Planning Clinic to help you plan your family size and prevent unplanned pregnancies?		

COUNTY USE ONLY:
- ☐ CHDP brochure and explanation given
  - ☐ CHDP Referral
  - ☐ Date:
- ☐ Referred for Immunization
- ☐ Other services referral
- ☐ Pregnant
- ☐ Parent or Guardian of child under 5
- ☐ Breastfeeding ☐ Postpartum
- ☐ WIC referral
- ☐ Family Planning info given
  Date Referred:

CERTIFICATION

I understand that:

- **If I give wrong facts or fail to report all facts or situations on purpose that affect my eligibility and aid payments, I may be fined, jailed/imprisoned, or both. I can be fined up to $10,000 for cash aid and $250,000 for CalFresh. I can be sent to jail/prison for up to 3 years for cash aid and 20 years for CalFresh. And benefits for cash aid and CalFresh can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years, 20 years or forever; and for Refugee Cash Assistance, 3 months and 6 months.**
- My case can be picked for reviews to prove eligibility; and I must cooperate fully with county, state, and federal personnel in any quality control review.
- The facts I give will be checked out by local, state, and federal personnel.
- The county will send facts to the U.S. Citizenship and Immigration Services (USCIS) for proof of immigration status.
- The facts the county gets from USCIS may affect eligibility for cash aid and CalFresh.
- The facts I give will be checked with tax, welfare, employment agencies, school districts, and the Social Security Administration to prove the child's eligibility for cash aid and/or CalFresh and to prove that I am getting the right amount of cash aid or CalFresh. And the social security number will be matched with law enforcement agency records for arrest warrants.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this Statement of Facts is true, correct, and complete.

WHO MUST SIGN THIS FORM: **For Cash Aid,** you and your aided spouse, Registered Domestic Partner, or the other parent (of cash aided children), if living in the home.
For CalFresh, an adult household member or authorized representative.

SIGNATURE OF CARETAKER RELATIVE AND/OR ADULT CALFRESH HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE	DATE
SIGNATURE OF CASH-AIDED SPOUSE OR DOMESTIC PARTNER OR OTHER PARENT (OF CASH-AIDED CHILD) IF LIVING IN THE HOME	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

COUNTY USE ONLY

☐ INELIGIBLE (Reason)				IMMUNIZATION ☐ Informing (CW 101 / TEMP CW 101A) Regs Met: ☐ YES ☐ NO
☐ ELIGIBLE	Eligibility Conditions Met - Date:	Authorization Date:	Effective Date of Aid:	
Signature of County Worker		Date	Signature of Supervisor	Date

Current Form

COUNTY OF

CARETAKER RELATIVE AGREEMENT

The County will use this agreement to decide which adult can get cash aid with the children. This agreement is not meant to change any other custody agreement you have for the children.

We understand that only one Caretaker Relative can get cash aid along with the children.

We agree that _____ is the person who provides the care and control and is the Caretaker Relative for the following children:

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
	/		/
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
	/		/
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
	/		/

SIGNATURE OR MARK OF APPLICANT	DATE	PRINT NAME IN FULL
SIGNATURE OR MARK OF APPLICANT	DATE	PRINT NAME IN FULL

SIGNATURE OF WITNESS TO MARK(S)

COUNTY USE ONLY

CASE NAME	CASE NUMBER
CASE NAME	CASE NUMBER

This agreement is to be used only when a caretaker relative is to be chosen under MPP 82-808.413(c).

Old Form

SENIOR PARENT STATEMENT OF FACTS

(Supplement to the SAWS 2)

CASE NAME	
CASE NUMBER	

The rules say that when a minor parent (up to age 18) applies for cash aid, we must count the income of the senior parent(s) living in the same home. We will figure how much of this income will be counted.

INSTRUCTIONS:

- Fill in this form and return it. Answer all of the questions about your parent(s) who lives with you.
- If we do not get a complete form, your cash aid and cash-based Medi-Cal may be **changed or stopped.**
- If you have questions, ask your worker.

1. Does your parent(s) get income, money, or benefits, such as: earnings; government benefits like Social Security, Unemployment/Disability Benefits (UIB/DIB), Supplemental Security Income/State Supplementary Payment (SSI/SSP), worker's compensation; railroad retirement, veterans or other private or government disability retirement; interest or dividends from stocks, bonds, savings accounts; child/spousal support; training payments; strike benefits; cash, gifts, loans, grants, scholarships; tax refunds; Earned Income Tax Credit (EITC); gambling/lottery winnings; rental income, rental assistance; free housing/utilities/clothing or food; insurance or legal settlements; etc.? ☐ YES ☐ NO

NAME	SOURCE	AMOUNT RECEIVED	HOW OFTEN
		$	
NAME	SOURCE	AMOUNT RECEIVED	HOW OFTEN
		$	

2. Does your parent(s) support other persons living in the home and claim as Federal tax dependents? If YES, list name of person(s) and relationship. ☐ YES ☐ NO

NAME	RELATIONSHIP	NAME	RELATIONSHIP

3. Does your parent(s) support anyone not living in the home and claim or could claim that person as a Federal tax dependent? If YES, give name of person(s), amount paid and ATTACH proof. ☐ YES ☐ NO

NAME	AMOUNT PAID	NAME	AMOUNT PAID
	$		$

4. Does your parent(s) make child and/or spousal support payments for anyone not living in the home? If YES, give name of person(s), amount paid and ATTACH proof. ☐ YES ☐ NO

NAME	AMOUNT PAID	NAME	AMOUNT PAID
	$		$

CERTIFICATION

- I understand that if on purpose I do not report all facts, or give wrong information to get aid, I can be legally prosecuted. I can be charged with committing a serious crime if I get more than $400 in aid that I am not supposed to get. And my cash aid can be stopped for a period of time. I may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.
- I understand that failing to report information or true facts can result in legal prosecution with penalties of a fine, imprisonment or both.
- I understand that I must call my worker to report any unexpected changes which may affect my eligibility for or the amount of my Cash Aid within 5 days of the change. If I am unsure about needing to report any changes, I must contact my worker.
- I understand that the facts I report may result in my benefits being denied, lowered or stopped.
- I understand that I have the right to request a State Hearing on any proposed action by the County Welfare Department.
- I declare under penalty of perjury under the laws of the State of California that the information contained in this report is true and correct.
- I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and are complete for the entire report month.

YOU MUST SIGN AND DATE THIS REPORT OR IT WILL BE INCOMPLETE

SIGNATURE OF CASH AIDED MINOR PARENT

DATE SIGNED

COUNTY USE ONLY

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

SENIOR PARENT STATEMENT OF FACTS

(Supplement to the SAWS 2)

CASE NAME	
CASE NUMBER	

The rules say that when a minor parent (up to age 18) applies for cash aid, we must count the income of the senior parent(s) living in the same home. We will figure how much of this income will be counted.

INSTRUCTIONS:

- Fill in this form and return it. Answer all of the questions about your parent(s) who lives with you.
- If we do not get a complete form, your cash aid and cash-based Medi-Cal may be **changed or stopped.**
- If you have questions, ask your worker.

1. Does your parent(s) get income, money, or benefits, such as: earnings; government benefits like Social Security, Unemployment/Disability Benefits (UIB/DIB), Supplemental Security Income/State Supplementary Payment (SSI/SSP), worker's compensation; railroad retirement, veterans or other private or government disability retirement; interest or dividends from stocks, bonds, savings accounts; child/spousal support; training payments; strike benefits; cash, gifts, loans, grants, scholarships; tax refunds; Earned Income Tax Credit (EITC); gambling/lottery winnings; rental income, rental assistance; free housing/utilities/clothing or food; insurance or legal settlements; etc.? ☐ YES ☐ NO

NAME	SOURCE	AMOUNT RECEIVED	HOW OFTEN
		$	
NAME	SOURCE	AMOUNT RECEIVED	HOW OFTEN
		$	

2. Does your parent(s) support other persons living in the home and claim them as Federal tax dependents? If YES, list name of person(s) and relationship. ☐ YES ☐ NO

NAME	RELATIONSHIP	NAME	RELATIONSHIP

3. Does your parent(s) support anyone not living in the home and claim or could claim that person as a Federal tax dependent? If YES, give name of person(s), amount paid and ATTACH proof. ☐ YES ☐ NO

NAME	AMOUNT PAID	NAME	AMOUNT PAID
	$		$

CERTIFICATION

- I understand that if on purpose I do not report all facts, or give wrong information to get aid, I can be legally prosecuted. I can be charged with committing a serious crime if I get more than $400 in aid that I am not supposed to get. And my cash aid can be stopped for a period of time. I may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.
- I understand that failing to report information or true facts can result in legal prosecution with penalties of a fine, imprisonment or both.
- I understand that I must call my worker to report any unexpected changes which may affect my eligibility for or the amount of my Cash Aid within 5 days of the change. If I am unsure about needing to report any changes, I must contact my worker.
- I understand that the facts I report may result in my benefits being denied, lowered or stopped.
- I understand that I have the right to request a State Hearing on any proposed action by the County Welfare Department.
- I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and are complete for the entire report month.

YOU MUST SIGN AND DATE THIS REPORT OR IT WILL BE INCOMPLETE

SIGNATURE OF CASH AIDED MINOR PARENT ☛ DATE SIGNED

COUNTY USE ONLY

Current Form

PAYEE AGREEMENT FOR MINOR PARENT

COUNTY USE ONLY
CASE NAME:
CASE NUMBER:
WORKER NAME:

If you do not return this form by_____ you will not get cash aid.

SECTION A: PREGNANT OR PARENTING MINOR AGREEMENT

I understand that any cash aid I am eligible to get for myself or dependent child(ren) will be paid to my parent, legal guardian, or other adult relative, with whom I live. I give permission to give this agreement to the person named below.

NAME OF PROPOSED PAYEE		RELATIONSHIP
NAME OF MINOR	SIGNATURE OF MINOR	DATE

SECTION B: PAYEE RESPONSIBILITIES

The above-named minor has applied for California Work Opportunity and Responsibility to Kids (CalWORKs) for him/herself and/or his/her dependent child(ren). The minor has named you to serve as payee and receive cash aid payments. Payee responsibilities are listed below:

- I understand the payments I get for the person(s) in this case are to be used for their support. If I willfully and knowingly receive or use any part of the payment for any reason other than to support them, state law says I may be prosecuted for committing a misdemeanor.
- I understand that I am responsible to make sure the minor is given all information sent to me by the county for the minor such as quarterly report forms, notices of action and informing notices. It is the minor's responsibility to complete any necessary forms by the due date.
- I understand that if the minor moves out of my home, I should notify the county within 5 days and any payments received after the minor moves out should be returned to the county.
- I understand that if I do not agree to become the payee it does not affect the eligibility of the minor and/or his/her dependent child(ren).

SECTION C: PAYEE CERTIFICATION

Please check (✔) one of the boxes below:

☐ **I understand the above facts and agree to act as the payee for the minor listed above.**
☐ **I refuse to act as the payee for the minor listed above.**

PROPOSED PAYEE	PHONE NUMBER	DATE

"New" Form

PAYEE AGREEMENT FOR MINOR PARENT

COUNTY USE ONLY
CASE NAME:
CASE NUMBER:
WORKER NAME:

If you do not return this form by_____ you will not get cash aid.

SECTION A: PREGNANT OR PARENTING MINOR AGREEMENT

I understand that any cash aid I am eligible to get for myself or dependent child(ren) will be paid to my parent, legal guardian, or other adult relative, with whom I live. I give permission to give this agreement to the person named below.

NAME OF PROPOSED PAYEE	RELATIONSHIP
SIGNATURE OF MINOR	DATE

SECTION B: PAYEE RESPONSIBILITIES

The above-named minor has applied for California Work Opportunity and Responsibility to Kids (CalWORKs) for him/herself and/or his/her dependent child(ren). The minor has named you to serve as payee and receive cash aid payments. Payee responsibilities are listed below:

- I understand the payments I get for the person(s) in this case are to be used for their support. If I willfully and knowingly receive or use any part of the payment for any reason other than to support them, state law says I may be prosecuted for committing a misdemeanor.
- I understand that I am responsible to make sure the minor is given all information sent to me by the county for the minor such as annual and semi-annual report forms, notices of action and informing notices. It is the minor's responsibility to complete any necessary forms by the due date.
- I understand that if the minor moves out of my home, I should notify the county within 5 days and any payments received after the minor moves out should be returned to the county.
- I understand that if I do not agree to become the payee it does not affect the eligibility of the minor and/or his/her dependent child(ren).

SECTION C: PAYEE CERTIFICATION

Please check (✔) one of the boxes below:

☐ **I understand the above facts and agree to act as the payee for the minor listed above.**

☐ **I refuse to act as the payee for the minor listed above.**

PROPOSED PAYEE	PHONE NUMBER	DATE

Current Form

APPLICANT TEST

CASE NAME	CASE NUMBER	CW NAME	DATE

- Determine whose needs to consider in the MBSAC size and select the corresponding MBSAC amount.
- Use a best estimate of countable income from AU members (including penalized AU members), certain non-AU members and sanctioned/excluded members.
- Deduct $90 from the gross earned income of each family member whose earnings are used on the QR 29.
- Compare the family's total countable income to the MBSAC plus special needs to determine financial eligibility.

MONTH AND YEAR _____

1. NUMBER OF FAMILY MEMBERS WHOSE NEEDS ARE CONSIDERED IN MBSAC		
2. CORRESPONDING MBSAC FOR FAMILY SIZE IN #1 ABOVE	$	
3. RECURRING SPECIAL NEEDS	+	
4. TOTAL GROSS INCOME LIMIT	=	
5. GROSS EARNINGS COMPUTATION		
a. Gross Earnings (Person 1)	$	
b. Disregard	-	90
c. SUBTOTAL	=	
d. Gross Earnings (Person 2)	$	
e. Disregard	-	90
f. SUBTOTAL	=	
g. Gross Earnings (Person 3)	$	
h. Disregard	-	90
i. SUBTOTAL	=	
j. TOTAL (Line 5c, 5f and 5i)	$	
6. SOCIAL SECURITY BENEFITS	+	
7. V.A. BENEFITS	+	
8. UIB	+	
9. CHILD/SPOUSAL SUPPORT RECEIVED (Less CSSD)	+	
10. UA CONTRIBUTION (From CW 71)	+	
11. UNEARNED IN-KIND (Total received)	+	
12. ALL DISABILITY INCOME	+	
13. OTHER (Specify)	+	
14. TOTAL COUNTABLE INCOME (Line 5j through Line 13)	=	

15. Is total countable income (Line 14) less than the total gross income limit (Line 4)?

☐ YES; eligible, complete QR 30.

☐ NO; ineligible.

SELF-EMPLOYMENT INCOME CALCULATION

EARNINGS FROM SELF-EMPLOYMENT	PERSON 1 Line 5a	PERSON 2 Line 5d
Gross earnings from self employment	$	$
Expenses ☐ Actual ☐ 40%	-	-
Net self-employment income (Include in line 5 for appropriate person)	$	$

"New" Form

APPLICANT TEST

CASE NAME	CASE NUMBER	CASE WORKER NAME	DATE

- Determine whose needs to consider in the MBSAC size and select the corresponding MBSAC amount.
- Use a best estimate of countable income from AU members (including penalized AU members), certain non-AU members and sanctioned/excluded members.
- Deduct $90 from the gross earned income of each family member whose earnings are used on the CW 29.
- Compare the family's total countable income to the MBSAC plus special needs to determine financial eligibility.

MONTH AND YEAR _____

1.	NUMBER OF FAMILY MEMBERS WHOSE NEEDS ARE CONSIDERED IN MBSAC	
2.	CORRESPONDING MBSAC FOR FAMILY SIZE IN #1 ABOVE	$
3.	RECURRING SPECIAL NEEDS	+
4.	TOTAL GROSS INCOME LIMIT	=
5.	GROSS EARNINGS COMPUTATION	
a.	Gross Earnings (Person 1)	$
b.	Disregard	- 90
c.	SUBTOTAL	=
d.	Gross Earnings (Person 2)	$
e.	Disregard	- 90
f.	SUBTOTAL	=
g.	Gross Earnings (Person 3)	$
h.	Disregard	- 90
i.	SUBTOTAL	=
j.	TOTAL (Line 5c, 5f and 5i)	$
6.	SOCIAL SECURITY BENEFITS	+
7.	V.A. BENEFITS	+
8.	UIB	+
9.	CHILD/SPOUSAL SUPPORT RECEIVED (Less CSSD)	+
10.	UA CONTRIBUTION (From CW 71)	+
11.	UNEARNED IN-KIND (Total received)	+
12.	ALL DISABILITY INCOME	+
13.	OTHER (Specify)	+
14.	TOTAL COUNTABLE INCOME (Line 5j through Line 13)	=

15. Is total countable income (Line 14) less than the total gross income limit (Line 4)?

☐ YES; eligible, complete CW 30.

☐ NO; ineligible.

SELF-EMPLOYMENT INCOME CALCULATION

EARNINGS FROM SELF-EMPLOYMENT	PERSON 1 Line 5a	PERSON 2 Line 5d
Gross earnings from self employment	$	$
Expenses ☐ Actual ☐ 40%	-	-
Net self-employment income (Include in line 5 for appropriate person)	$	$

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CalWORKs BUDGET WORKSHEET

Use the worksheet on the back of the QR 30 to calculate average income for the quarter.

CASE NAME:	CASE NUMBER:
DATA MONTH_____ ☐ STANDARD MAP	PAYMENT QUARTER_____ ☐ EXEMPT MAP
WORKER NAME:	
WORKER #:	DATE:

NAME	Check (✓) One (A) AU (non MFG and non-penalized)	(B) Penalized AU	(C) non-AU (if income counted or ineligible non citizen)	(D) MFG	(E) SANCTIONED

SECTION A: DISABILITY BASED INCOME (DBI)

1.	Total Average DBI of A, B, C, D, E	$
2.	Minus $225 DBI disregard (If #1 is $225 or more) or	-
3.	Minus DBI disregard (If #1 is less than $225)	-
4.	DBI Remainder (#1 - #2)	-
5.	Unused DBI disregard ($225 - #3)	-

SECTION B: EARNED INCOME (EI)

1.	Average monthly earnings from Self-Employment of A, B, C, D, E	$
2.	Minus Self-Employment expenses Actual ☐ or 40% ☐	-
3.	Subtotal	=
4.	Other EI of A, B, C, D, E, (From income worksheet)	$
5.	Total Gross EI (#3 + #4)	=
6.	Unused DBI Disregard (Section A, #5 or $112, whichever is less)	-
7.	Subtotal	=
8.	50% EI Disregard (#7 divided by 2)	=
9.	Subtotal: Net Nonexempt Income (#7 - #8)	=
10.	Nonexempt DBI (Section A, #4)	+
11.	Other Nonexempt Income of A, B, C, D, E including child/spousal support for C, E (but not A, B, D)	+
12.	Subtotal: Net Nonexempt income for grant computation (#9 + #10 + #11)	$
13.	Child/Spousal Support for A, B (but not C, D, E)	=
14.	Minus child/spousal support disregard (up to $50)	-
15.	Total Countable child/spousal support (#13 - #14)	=
16.	Value of Income in Kind	=
17.	Total Net Nonexempt Income (#12 + #15 + #16)	$
18.	MAP for A & C + special needs for A, C, D	=
19.	Family meets recipient test if #17 is less than #18 If yes, then continue with Grant Computation	☐ YES ☐ NO

SECTION C: GRANT COMPUTATION

18.	Maximum Aid Payment for _____ Family Member (A & C).	$
	a. Net nonexempt income (enter amount from line 11 or 15).	-
	b. Special needs other than HA, (A, C, D)	+
	c. Potential Grant	$
19.	Maximum Aid Payment for _____ persons. (A)	$
	a. Special Need other than HA (A & D).	+
	b. Subtotal	$
	c. Aid Payment (lesser of 18c or 19b).	$
20.	Proration figure	
	Date:_____	X
21.	Prorated Aid Payment	$
22.	Other adjustments imposed upon the AU:	
	a. Child Support non-co-op (25% of Aid Payment)	-
	b. Overpayment adjustment	-
	c. Other penalties	-
	d. School bonus	+
23.	Adjusted Aid Payment	$

SECTION D: BUDGET RECOMPUTATION

24.	Actual Cash Aid Paid	$
	a. Adjusted Aid Payment (amount from line 23).	$
	b. Subtotal	=
25.	Overpayment Amount (line 24b)	$
26.	Underpayment if line 23 is greater than line 24.	$

QR INCOME WORKSHEET

CASE NAME:	CASE NUMBER:

MONTH 1: _____

PERSON #	DBI, U or E	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	TOTAL	MINUS SELF - EMPLOYMENT EXPENSES*	DIVIDE BY	CONVERSION FACTOR *	AVERAGE	INCOME IN KIND***	TOTALS

*Deduct either 40% or Actual expenses **BI-WEEKLY = 2.167, WEEKLY = 4.33 ***See MPP 44-115

MONTH 2: _____

PERSON #	DBI, U or E	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	TOTAL	MINUS SELF - EMPLOYMENT EXPENSES*	DIVIDE BY	CONVERSION FACTOR *	AVERAGE	INCOME IN KIND***	TOTALS

*Deduct either 40% or Actual expenses **BI-WEEKLY = 2.167, WEEKLY = 4.33 ***See MPP 44-115

MONTH 3: _____

PERSON #	DBI, U or E	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	TOTAL	MINUS SELF - EMPLOYMENT EXPENSES*	DIVIDE BY	CONVERSION FACTOR *	AVERAGE	INCOME IN KIND***	TOTALS

*Deduct either 40% or Actual expenses **BI-WEEKLY = 2.167, WEEKLY = 4.33 ***See MPP 44-115

	MONTH 1	MONTH 2	MONTH 3	QUARTER TOTAL	DIVIDE BY	AVERAGE MONTHLY GROSS INCOME
DBI						DBI =
U						U =
E						E =

*Bi-Weekly = x 2.167, Weekly = 4.33

"New" Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CalWORKs BUDGET WORKSHEET

Use the worksheet on the back of the CW 30 to calculate income for the payment period.

CASE NAME:	CASE NUMBER:
DATA MONTH_____ ☐ STANDARD MAP	PAYMENT PERIOD_____ ☐ EXEMPT MAP
WORKER NAME:	
WORKER #:	DATE:

NAME	Check (✓) One (A) AU (non MFG and non-penalized)	(B) Penalized AU	(C) non-AU (if income counted or ineligible non citizen)	(D) MFG	(E) SANCTIONED

SELF-EMPLOYMENT INCOME CALCULATION

EARNINGS FROM SELF-EMPLOYMENT	PERSON 1	PERSON 2
Gross earnings from self employment	$	$
Expenses ☐ Actual ☐ 40%	-	-
Net self-employment income (Include in Section a, line 4)	$	$

SECTION A: RECIPIENT FINANCIAL ELIGIBILITY AND NET NON-EXEMPT INCOME COMPUTATION

1.	Total disability-based unearned income of A, B, C, D, E.	$
2.	Minus $225 disability-based income disregard.	-225
3.	Subtotal nonexempt disability-based income. (If positive amount, enter amount on line 9. If negative amount, enter amount on line 5).	=
4.	Gross averaged earned income of A, B, C, D, E. (From income worksheet)	$
5.	Remainder of $225 income disregard, if any. (Enter negative amount from line 3).	-
6.	Subtotal earned income (line 4 minus line 5).	=
7.	50% earned income disregard. (Total on line 6 divided by 2).	-
8.	Subtotal net nonexempt earned income. (Line 6 minus line 7).	=
9.	Nonexempt disability-based unearned income. (Enter positive amount from line 3).	+
10.	Other nonexempt income of A, B, C, D, E including child/spousal support for C, E (but not A, B, D).	+
11.	Total net nonexempt income for grant computation (line 8 + 9 + 10)	=
12.	Child/Spousal support for A, B, (not C, D, E).	$
13.	Minus child/spousal support disregard (up to $50 per AU).	-
14.	Total countable child/spousal support	=
15.	Total net nonexempt income for recipient test (line 11 + 14).	=
16.	MAP for A & C + special needs for A, C, D.	$
17.	Family meets recipient test (if line 15 is less than line 16). If Yes, continue with grant computation.	☐ Yes ☐ No

SECTION B: GRANT COMPUTATION

18.	Maximum Aid Payment for _____ Family Member (A & C).	$
	a. Net nonexempt income (enter amount from line 11 or 15).	-
	b. Special needs other than HA, (A, C, D)	+
	c. Potential Grant	$
19.	Maximum Aid Payment for _____ persons. (A)	$
	a. Special Need other than HA (A & D).	+
	b. Subtotal	$
	c. Aid Payment (lesser of 18c or 19b).	$
20.	Proration figure	
	Date:_____	X
21.	Prorated Aid Payment	$
22.	Other adjustments imposed upon the AU:	
	a. Child Support non-co-op (25% of Aid Payment)	-
	b. Overpayment adjustment	-
	c. Cal-Learn penalties	-
	d. Cal-Learn bonus	+
23.	Adjusted Aid Payment	$

SECTION C: BUDGET RECOMPUTATION

24.	Actual Cash Aid Paid	$
	a. Adjusted Aid Payment (amount from line 23).	$
	b. Subtotal	=
25.	Overpayment Amount (line 24b)	$
26.	Underpayment if line 23 is greater than line 24.	$

CW INCOME WORKSHEET

MONTH OF: _____

CASE NAME:	CASE NUMBER:

PERSON #	DBI, U or E	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	TOTAL	MINUS SELF - EMPLOYMENT EXPENSES*	DIVIDE BY**	CONVERSION FACTOR ***	MONTHLY AMOUNT	INCOME IN KIND ****	TOTALS

* Deduct either 40% or Actual expenses

** Divide by number of payments in the month

*** BI-Weekly = x 2.167, Weekly = x 4.33

**** See MPP 44-115

MONTHLY INCOME:

	MONTH OF	MONTHLY GROSS INCOME*
DBI		DBI =
U		U =
E		E =

*Apply the disregards to each type of monthly gross income to calculate the total net, non-exempt income for the month. Use that amount to calculate the grant for each month of the payment period unless a change in actual or anticipated income is reported.

Current Form

STATE OF CALIFORNIA — HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT OF FACTS - HOMELESS ASSISTANCE

Important Information

- If you have no place to stay or have received a pay rent or quit notice from your landlord, you may be able to get Homeless Assistance payments **once in a lifetime**, unless your homelessness is due to an exception. To get Homeless Assistance, you cannot have more than $100 in resources and you must either be eligible for CalWORKs or appear to be eligible for CalWORKs.
- Exceptions to the once-in-a-lifetime rule are homelessness due to: domestic violence, physical or mental illness, or uninhabitability of the home. These exceptions are limited to once every 12 months. Homelessness that is directly caused by a State or Federal declared natural disaster is also an exception.
- If you received a pay rent or quit notice you may be able to get Homeless Assistance payments for up to two months of back rent.
- If you have no place to stay, you must be looking for permanent housing to get Homeless Assistance for Temporary Shelter (TS). If you find someplace to live, you may get money for permanent housing.
- You may get TS payments for up to 16 days in a row. The first day starts when you get the first TS payment. If you stay anywhere for free, or somewhere other than a shelter or business which rents rooms, you can't get a TS payment, but the days count as part of the 16 days.
- To get TS payments you must rent from a person or place that is in the business of renting property.
- At the end of the 16 days, TS will stop. You will never be able to get TS again, unless you have an exception, even if you have not used up all the TS benefits.
- You will be asked to prove that your payments were spent on shelter. If you can't, future payments will go to a shelter, landlord or others for you.

Instructions: Print all answers in ink. If you need help, ask your worker.

1. Name of Caretaker Relative (first, middle, last)

Message Phone | A Social Security Number - - | B Date of Birth Mo.____ Day ____ Yr. ____

2. What is your current or last address?

Number, Street | City | State | Zip

3. Do you get Cash Aid? ☐ YES ☐ NO

If "YES," in which county:

4. Did you get Homeless Assistance from any county at any time? ☐ YES ☐ NO

If "YES," complete:

Which county: When:

5. Does anyone in your home get income from a job or training program or any other source? ☐ YES ☐ NO

If "YES", list all income and who gets it below:

6. List all liquid resources you own (include cash, checks, savings or checking accounts, credit union accounts, etc.). List each item and give its value.

7. If you get Homeless Assistance, you may have the payment made out to you or given directly to a shelter, landlord or other for you. Check (✓) below to tell us how you want the payment made:

☐ To Yourself ☐ To a Landlord ☐ To a Shelter ☐ Other (explain):

If you do not have a permanent home, fill out questions 8 through 12. If you are asking for back rent, skip to questions 13 through 17.

8. Explain where you are staying now.

9. How long have you been there?

10. Do you pay for staying there?

If "YES," how much?

11. Explain why you have no place to live.

12. Are you seeking permanent housing? ☐ YES ☐ NO

Explain:

COUNTY USE ONLY

DATE RECEIVED

C	CO	Aid Code	Case Number	AU

D Case Name (Last, First)

E Date HA Authorized

Mo. ____ Day ____ Yr. ____

F Type of HA (check)

☐ Temporary ☐ Permanent

☐ TV ☐ PV

☐ TM ☐ PM

☐ TU ☐ PU

☐ TD ☐ PD

Start Date:____ Start Date:____

Disposition:

☐ Shelter arranged prior to TS

☐ Vendor payment issued

☐ HA denied

Worker:

Total resource value:

13. What day did you get a pay rent or quit notice?

14. How many months of back rent do you owe?

15. How much is your monthly rent?

16. Why didn't you pay your rent?

17. Why is your Landlord evicting you?

CERTIFICATION

I understand that:

- Homeless Assistance Temporary Shelter (TS) and Permanent Housing (PH) payments are limited to once in a lifetime, unless I have a verified exception.
- There is a limit on how much Homeless Assistance I can get.
- I am required to give my Social Security Number, which will be used to check identity and verify that I am not getting aid in more than one case, one county, or one state.

I understand that I must **provide proof** that:

- I am homeless; or I have received a notice to pay rent or quit.
- I am homeless due to an exception, if I have already gotten homeless assistance.
- I used the TS payment for housing, and that if I cannot, I must have my homeless assistance payments made out or given to a shelter, landlord or to others for me.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this Statement of Facts - Homeless Assistance is true and correct.

SIGNATURE OF CARETAKER RELATIVE DATE

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REFERRAL TO LOCAL CHILD SUPPORT AGENCY (LCSA)

(Complete one form for each Noncustodial Parent or Alleged Father)

DATE OF REFERRAL

☐ TO LCSA REPRESENTATIVE

CASE NAME

AID TYPE/CASE NUMBER

☐ FROM CWD REPRESENTATIVE CW # PHONE

APPLICANT/RECIPIENT NAME (LAST, FIRST, MIDDLE)

RELATIONSHIP TO CHILD(REN)

MINOR PARENT'S NAME (IF DIFFERENT FROM APPLICANT/RECIPIENT)

A. This case is referred to you because:

☐ Action is necessary to obtain:
  ☐ financial support ☐ medical support ☐ paternity
☐ Recipient is receiving direct support payments. Action needed to transfer payments to county.
☐ Good Cause has been (see CW 51 attached):
  ☐ claimed ☐ granted ☐ denied
☐ Other (see comments)

B. The following information applies to this case:

☐ CA 2.1(Q) Questionnaire is attached.
☐ Noncustodial parent has health insurance coverage. A copy of the DHS 6155 is attached.
☐ Medi-Cal eligibility has not been determined.
☐ Previously sanctioned/penalized; now agrees to cooperate/assign support rights.
☐ Child no longer resides with recipient.
☐ Medi-Cal Only
☐ CS 909, Declaration of Paternity, is attached.
☐ Other (see comments)
☐ Lamb Case (minor parent not eligible as a dependent child: Family Code 4000)

C. Applicant/recipient has not agreed to:

☐ Assign:
  ☐ financial support rights ☐ medical support rights
☐ Cooperate in:
  ☐ obtaining financial support ☐ obtaining medical support and/or
  ☐ establishing paternity
☐ Forward support payments.

D. Penalty/Sanction

☐ Penalty has been applied due to non-cooperation.
☐ Sanction has been applied for refusal to assign rights.

☐ TO CWD REPRESENTATIVE CW #

☐ FROM LCSA REPRESENTATIVE PHONE

☐ Applicant/recipient has cooperated with the law.
☐ Applicant/recipient has not cooperated with the law:
  ☐ Did not appear and/or provide verbal, written or documentary information
  ☐ Rescheduled appointment on _____ ☐ kept ☐ failed
  ☐ Refuses to appear as a witness at court or other hearing
  ☐ Refuses to transmit child support payment(s) received directly from the noncustodial parent
☐ Other (see comments)
☐ This is a notice of renewed cooperation.
☐ Paternity ☐ has ☐ has not been established.
☐ Support order established.
☐ CS 909, Declaration of Paternity, is attached.
☐ Other (see comments)

E. TYPE OF APPLICATION

☐ NEW ☐ REAPPLICATION ☐ ADD A CHILD ☐ ICT ☐ RENEWAL

NONCUSTODIAL PARENT'S OR ALLEGED FATHER'S NAME

CHILD SUPPORT FILE NUMBER

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

F. ☐ APPLICANT PREVIOUSLY RECEIVED AID

SPECIFY TYPE: ☐ CASH AID ☐ MEDI-CAL ONLY ☐ TMC

PLACE (CITY, COUNTY, STATE)

DATE LAST RECEIVED

G. ☐ INTER-COUNTY TRANSFER/INTERSTATE TRANSFER

FROM (COUNTY/STATE)

PRIOR COUNTY'S CHILD SUPPORT FILE NUMBER (IF KNOWN)

H. ☐ CASH AID

APPROVAL DATE

ONGOING CASH AID AMOUNT

$

DISCONTINUANCE DATE

REASON/CODE FOR DISCONTINUANCE

I. ☐ MEDI-CAL ONLY

DATE MEDI-CAL BEGINS/CONTINUES

DATE DISCONTINUED

REASON FOR DISCONTINUANCE

Comments:

REMINDER FOR TEENS TURNING 18 YEARS OLD

Give this notice right away to your child who will be turning 18 years old within the next 60 days.

If you are 18 years old and don't have children and/or are not pregnant

You can still get cash aid as part of your parent/caretaker's case after your 18th birthday ONLY if you:

- Are a full-time student in high school, or in a vocational or technical training program, and are expected to finish school/program before reaching 19 years old, or
- Are a full-time student in high school, or in a vocational or technical training program, and have been or are considered disabled, and meet the disability criteria pursuant to the CalWORKs regulations, or
- Are a foster child living with an approved relative and are completing high school or an equivalency program, enrolling in post-secondary or vocational school, participating in a program or activity that promotes or removes barriers to employment, employed at least 80 hours per month, or unable to participate in school or employment due to a documented medical condition.

Call your county worker right away if you think you meet any of these situations. If you are eligible to stay on cash aid, you may need to have a fingerprint and photo image taken by the county.

If you are 18 years old and have a child of your own and/or are pregnant

1. You can continue to get cash aid as part of your parent/caretaker's case after your 18th birthday ONLY if you:

- Are a full-time student in high school, or in a vocational or technical training program, and are expected to finish school/program before reaching 19 years old, or
- Are a full-time student in high school, or in a vocational or technical training program, and have been or are considered disabled, and meet the disability criteria pursuant to the CalWORKs regulations, or
- Are a foster child living with an approved relative and are completing high school or an equivalency program, enrolling in post-secondary or vocational school, participating in a program or activity that promotes or removes barriers to employment, employed at least 80 hours per month, or unable to participate in school or employment due to a documented medical condition.

- OR -

2. You can choose to start your own case. Call your county worker right away if you want to start your own case. Here are some things you need to know before starting your own case:

- You do NOT have to move out of your parent/caretaker's home to be in your own case.
- Your time limits for getting cash aid will start.
- As the head of your case, YOU must report all changes to your county worker each Quarter.
- If you start your own case, your parent or caretaker may get less cash aid or if you are the only child their cash aid may be stopped.
- As of July 1, 2011, if you are pregnant and don't have other children, you will not be able to get cash aid until your third trimester. If you were granted cash aid prior to your third trimester before July 1, 2011, you will be eligible to continue to receive aid.
- If the Maximum Family Grant (MFG) rule was applied to your child while you were a dependent minor parent, your child can be counted in your cash aid payment when you are in your own case.

If you are under your own case or are a part of your parent/caretaker's case, to be eligible to stay on cash aid, you may need to have a fingerprint and photo image taken by the county. If you have questions about whether you should start your own case, call the county welfare office or local legal services office.

"New" Form

REMINDER FOR TEENS TURNING 18 YEARS OLD

Give this notice right away to your child who will be turning 18 years old within the next 60 days.

If you are 18 years old and don't have children and/or are not pregnant

You can still get cash aid as part of your parent/caretaker's case after your 18th birthday ONLY if you:

- Are a full-time student in high school, or in a vocational or technical training program, and are expected to finish school/program before reaching 19 years old, or
- Are a full-time student in high school, or in a vocational or technical training program, and have been or are considered disabled, and meet the disability criteria pursuant to the CalWORKs regulations, or
- Are a foster child living with an approved relative and are completing high school or an equivalency program, enrolling in post-secondary or vocational school, participating in a program or activity that promotes or removes barriers to employment, employed at least 80 hours per month, or unable to participate in school or employment due to a documented medical condition.

Call your county worker right away if you think you meet any of these situations. If you are eligible to stay on cash aid, you may need to have a fingerprint and photo image taken by the county.

If you are 18 years old and have a child of your own and/or are pregnant

1. You can continue to get cash aid as part of your parent/caretaker's case after your 18th birthday ONLY if you:

- Are a full-time student in high school, or in a vocational or technical training program, and are expected to finish school/program before reaching 19 years old, or
- Are a full-time student in high school, or in a vocational or technical training program, and have been or are considered disabled, and meet the disability criteria pursuant to the CalWORKs regulations, or
- Are a foster child living with an approved relative and are completing high school or an equivalency program, enrolling in post-secondary or vocational school, participating in a program or activity that promotes or removes barriers to employment, employed at least 80 hours per month, or unable to participate in school or employment due to a documented medical condition.
- If you are 18 years old and pregnant, and don't have other children, you may be able to get cash aid once your pregnancy is verified, if you are not otherwise eligible for the Cal-Learn program.

- OR -

2. You can choose to start your own case. Call your county worker right away if you want to start your own case. Here are some things you need to know before starting your own case:

- You do NOT have to move out of your parent/caretaker's home to be in your own case.
- Your time limits for getting cash aid will start.
- As the head of your case, YOU must report all changes to your county worker.
- If you start your own case, your parent or caretaker may get less cash aid or if you are the only child their cash aid may be stopped.
- If you are 18 years old and pregnant, and don't have other children, you may be able to get cash aid once your pregnancy is verified, if you are not otherwise eligible for the Cal-Learn program.
- If the Maximum Family Grant (MFG) rule was applied to your child while you were a dependent minor parent, your child can be counted in your cash aid payment when you are in your own case.

If you are under your own case or are a part of your parent/caretaker's case, to be eligible to stay on cash aid, you may need to have a fingerprint and photo image taken by the county. If you have questions about whether you should start your own case, call the county welfare office or local legal services office.

Current Form

REPORTING CHANGES FOR CASH AID AND FOOD STAMPS

CASE NAME:
CASE NUMBER:
WORKER:
WORKER NUMBER:

If you receive Cash Aid, what you MUST report even when it is not your report month.

Anytime your family's combined gross monthly income, both earned and unearned, is more than the Income Reporting Threshold (IRT) for your family size, you must report this information to the County within ten (10) days. You can report this information to the County by calling your worker or reporting it in writing.

Your family size is _____ your IRT is $ _____.

The County will let you know each time your IRT changes.

Gross income means the amount of your income before any deductions, such as taxes, Social Security and retirement contributions, overpayment collections, wage garnishments or attachments, etc.

Failure to report when your income is more than the IRT limit for your family's size may result in your benefits being overpaid. Any overpaid benefits caused by your failure to report **MUST** be repaid. You may also be subject to fraud charges/penalties if you do not report required information to the County.

How to figure your family's gross income.

Each month, add all of your family's income both earned and unearned (wages or earnings, salary, disability income, unemployment, public benefits, etc.). If the total is more than the amount shown on this letter, you must report this income to the County. Families that only have unearned income or that only get Food Stamps will not be required to report income except on the Quarterly Report form.

If you receive Cash Aid, you MUST also report this information even when it is not your report month.

- Anyone in your household who has been convicted of a drug-related felony for possession, use or distribution of a controlled substance(s), has become a fleeing felon or is in violation of a condition of probation or parole and you have not already reported it.
- Anytime you have an address change, you must report your new address to the County.

If you receive Food Stamps, you MUST report this information even when it is not your report month.

- If you are an Able Bodied Adult Without Dependents (ABAWD) Food Stamp recipient, you must report anytime the number of hours you work or are in training drop to less than 20 hours a week or 80 hours a month.
- Anytime you have an address change, you must report your new address to the County.

Voluntarily reporting information

You may report changes to the County anytime you think the change will result in your Cash Aid or Food Stamp benefits going up. For example.

- Your income stops or goes down;
- Someone who has income has moved out of your home;
- Someone moves into your home and has no income;
- Your minor child becomes pregnant and is eligible for Cal-Learn services;
- CalWORKs special needs that you or someone in your household may have such as, pregnancy special needs, a special diet prescribed by a doctor, etc;
- The birth of a child;
- For Food Stamps: Anyone in your household who is disabled or age 60 or older may report new medical costs that are not currently being used to figure your Food Stamp benefits.

At anytime, you can also ask the County to discontinue your entire case or any individual person who leaves the home or is not required to be in the assistance unit. You can also ask the County to stop other benefits, such as: Medi-Cal or Food Stamps. Receiving Medi-Cal and/or Food Stamps only will not count against your Cash Aid time limits.

"New" Form

REPORTING CHANGES FOR CASH AID AND CALFRESH

CASE NAME:	
CASE NUMBER:	
WORKER NUMBER:	

Because you get Cash Aid or CalFresh (formerly called Food Stamps), you must report within 10 days when your TOTAL income reaches a certain level. You must report anytime your household's total monthly income is more than your current Income Reporting Threshold (IRT).

Your family size is	_____
Your current income is	$_____
Your IRT is	$_____

How to report?

If your total income is over the IRT amount listed above, you must report this to the County **within 10 days**. You can report this information to the County by calling the county or reporting it in writing.

By "total monthly income" we mean:

- ⇨ Any money you get (both earned **and unearned**).
- ⇨ The amount *before* any deductions are taken out. (Examples of deductions are: taxes, Social Security or other retirement contributions, garnishments, etc.)

What will happen?

- ⇨ Your benefits may be lowered or stopped based on income over your IRT.
- ⇨ Your IRT may change when your income changes or when someone moves in or out of your home.
- ⇨ The County will let you know in writing each time your IRT changes.
- ⇨ You also need to report on your SAR 7 all income you get during the Report Month, even if you already reported that money.

Penalty for not reporting

If you do not report when your income is more than your household's IRT limit you may get more benefits than you should. You **must** repay any extra benefits you get based on income you do not report. If you do not report on purpose to try to get more benefits, this is fraud, and you may be charged with a crime.

If you get Cash Aid, you MUST ALSO report the things below within 10 days of when they happen:

1. Anytime someone joins, or is in your household, who has a conviction for a drug related felony *that was not reported before.*
2. Anytime someone joins, or is in your household, who is in violation of a condition of probation or parole.
3. Anytime someone joins, or is in your household, who is running from the law.
4. Anytime you have an address change.

If you get CalFresh, you MUST ALSO report the things below within 10 days of when they happen:

1. Anytime you have an address change.
2. If you are an Able Bodied Adult Without Dependents (ABAWD), you must report any time your work or training hours drop to *less* than 20 hours a week or 80 hours a month.

Voluntarily reporting information

You may also voluntarily report changes to the County anytime. *Reporting some changes may get you more benefits.* For example:

- Your income stops or goes down.
- Someone with income moves out of your home.
- Someone without income moves into your home.
- Someone in the house becomes pregnant.
- Someone on cash aid has a special need, such as: a pregnancy, a special diet prescribed by a doctor, household emergency, etc.
- The birth of a child.
- For CalFresh, if someone disabled or age 60 or older has new or higher out of pocket medical costs.

Current Form

MID-QUARTER STATUS REPORT

For Cash Aid and Food Stamps

RECIPIENT'S NAME:	CASE NUMBER (IF KNOWN):

Use this form to report mandatory or voluntary changes that have occurred since your last Quarterly Report (QR 7/SAWS QR 7).

If you are reporting income information, please provide proof, such as, pay stubs; copies of checks; letters from agencies, etc.

If you are reporting changes in expenses, please provide proof, such as, receipts; canceled checks, paid invoices; etc.

If you are reporting an address change, please provide proof of expenses such as, a copy of your new rental agreement or lease; rent receipt for your new address; copies of utility deposits; etc.

MANDATORY INFORMATION

If you receive Cash Aid, report the information marked CA. if you receive Food Stamps, report the information marked FS. The change of address and voluntary information sections are for all households/assistance units.

CA ☐ My combined household income is more than the limit for my household size.
In the month of _____ , the total combined income for my household is $ _____.

CA ☐ Someone in my household is a convicted drug felon.
Name of person _____
Date of felony conviction _____

CA ☐ Someone in my household is running from the law to avoid a felony conviction; running from the law, to avoid custody or confinement after a felony conviction; or is in violation of probation or parole.
Name of person_____

CA/FS ☐ I have moved, changed my phone number or have a new mailing address.
New home address _____
_____
New mailing address (if different from your home address) _____
New phone number (_____)_____

☐ I receive free rent at this new address.
☐ My rent amount is $ _____ per month.
☐ I share the rent (explain)

☐ I receive free utilities at this new address.
☐ My utilities are $_____ per month.
I have: ☐ Heating ☐ Cooling
☐ Water ☐ Sewer
☐ Garbage ☐ Telephone
☐ Other

See other side

MANDATORY INFORMATION - continued

FS ☐ Complete this section to report reduced work or training hours for Able-Bodied Adults without Dependents (ABAWDs):

The number of hours worked or in training dropped below 20 hours a week or 80 hours a month to _____ hours per week or _____ hours per month.

Name of person(s)_____

Relationship to you _____

Explain what happened_____

_____

Date of change _____

VOLUNTARY INFORMATION (All households/Assistance Units)

I would like to report the following information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CERTIFICATION

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. And, I may be charged with committing a felony if more than $400 in cash aid and/or food stamps is wrongly paid out.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW:	**For Cash Aid:** you, your aided spouse or CA Domestic Partner and the other parent (of cash aided children) if living in the home. **For Food Stamps:** the head of household, household member or the household's authorized representative.

Signature or Mark	Date Signed	Home Phone	Contact Phone

Signature of Spouse or CA Domestic Partner or other Parent of Cash Aided Children	Date Signed	Signature of Witness to Mark, interpreter or other person completing form	Date Signed

"New" Form

MID-PERIOD STATUS REPORT

For Cash Aid and CalFresh

RECIPIENT'S NAME:	CASE NUMBER (IF KNOWN):

Use this form to report mandatory or voluntary changes that have occurred since you last reported.

If you are reporting income information, please provide proof, such as: pay stubs; copies of checks; letters from agencies; etc.

If you are reporting changes in expenses, please provide proof, such as: receipts; canceled checks; paid invoices; etc.

If you are reporting an address change, please provide proof of expenses such as: a copy of your new rental agreement or lease; rent receipt for your new address; copies of utility deposits; etc.

MANDATORY INFORMATION

If you get Cash Aid, report the information marked CA. If you get CalFresh, report the information marked CF. Sections marked CA/CF are for all households/assistance units.

CA/CF ☐ My combined household income is more than the limit for my household size.
In the month of _____ , the total combined income for my household is $ _____.

CA ☐ Someone in my household was convicted of a felony drug charge.
Name of person _____
Date of felony conviction _____

CA ☐ Someone in my household is hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime.
Name of person_____

CA ☐ Someone in my household has been found by a court of law to be in violation of probation or parole.
Name of person_____

CA ☐ I have moved, changed my phone number or have a new mailing address.
New home address _____
_____
New mailing address (if different from your home address) _____
New phone number (_____)_____

☐ I get free rent at this new address.
☐ My rent amount is $ _____ per month.
☐ I share the rent; my share is $_____.
☐ I became homeless.

☐ I get free utilities at this new address.
☐ My utilities are $_____ per month.
I have: ☐ Heating ☐ Cooling ☐ Water ☐ Sewer ☐ Garbage ☐ Telephone ☐ Other

See other side

MANDATORY INFORMATION - continued

CF ☐ Fill out this section to report reduced work or training hours for Able-Bodied Adults without Dependents (ABAWDs). (ABAWDs are adults between 19 and 50 who are not caring for minor children.)

The number of hours worked or in training dropped below 20 hours a week or 80 hours a month to _____ hours per week or _____ hours per month.

Name of person(s)_____

Relationship to you _____

Explain what happened_____

_____

Date of change _____

VOLUNTARY INFORMATION (All households/Assistance Units)

I would like to report the following information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CERTIFICATION

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be charged with a crime. And, I may be charged with committing a felony if more than $950 in cash aid and/or CalFresh is wrongly paid out.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW:	**For Cash Aid:** you and your aided spouse, Registered Domestic Partner, or the other parent (of cash aided children), if living in the home. **For CalFresh:** the head of household, household member or the household's authorized representative.

Signature or Mark	Date Signed	Home Phone	Contact Phone

Signature of Spouse, Registered Domestic Partner or other Parent of Cash Aided Children	Date Signed	Signature of Witness to Mark, interpreter or other person completing form	Date Signed

Current Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

ELIGIBILITY/STATUS REPORT

WORK PAYS IN SO MANY WAYS

PLEASE SIGN THE FORM AFTER _____ 1ST AND RETURN IT BY THE 5TH OF THE MONTH.
SUBMIT MONTH

NEED HELP? CALL YOUR WORKER.

Worker Name:

Worker Phone:

BAR CODE:

Please Stop My Benefits For: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal at the end of this month. Sign and date the last page. Return the form to your worker. You can reapply at any time.

PART 1: Please tell us what happened in _____ _____
REPORT MONTH YEAR

1. **Did you or anyone get any income or money from any source this MONTH?** If "YES", list below and **ATTACH PROOF.** ☐ **YES** ☐ **NO**

Earnings: Babysitting, interest or dividends, rental income, salary, self-employment, sick pay, tips, vacation pay, etc. **Any Government Benefits:** State Disability Indemnity (SDI), Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), other government disability or retirement, rental assistance, unemployment, veteran's retirement, Worker's Compensation (UIB), etc. **Other Benefits:** Child/spousal support, insurance or legal settlements, other private disability or retirement, railroad retirement, strike benefits, etc. **Other:** Cash, gifts, loans, scholarships, etc. **Income In-Kind:** Such as earned housing, free housing/utilities/clothing/food, etc.

Who got the income?	From?	Gross amount	$	$	$	$	$
		Date received					
Who got the income?	From?	Gross amount	$	$	$	$	$
		Date received					
Who got the income?	From?	Gross amount	$	$	$	$	$
		Date received					

1a. Number of hours worked or in training in this MONTH:

Who worked?	Where?	Total Hours	Who worked?	Where?	Total Hours
Who trained?	Where?	Total Hours	Who trained?	Where?	Total Hours

1b. If the income or money reported above will change in the next three months after the SUBMIT MONTH, please explain and **ATTACH PROOF.**

Name of person	Source of income or money	Why will it change?	How much will you get?		
			First Month	Second Month	Third Month
			$	$	$
			$	$	$

Questions 2, 3, 4, and 5 may help you get more Food Stamps

2. **Medical Costs: Did anyone who gets Food Stamps and is disabled or 60 years or older pay medical costs?** If "YES", list the amount paid below and **ATTACH PROOF** of payment. ☐ **YES** ☐ **NO**

Who paid?	Who gets care?	Amount
		$

3. **Dependent Care: Did anyone who gets Food Stamps pay for the care of a child, disabled person, or other dependent while working, seeking work, or attending school or training?** If "YES", list the amount paid below and **ATTACH PROOF** of payment. ☐ **YES** ☐ **NO**

Who paid?	Who gets care?	Amount
		$

COUNTY USE SECTION

4. Child Support: Did anyone who gets Food Stamps pay court-ordered child support? ☐ YES ☐ NO
If "YES", list the amount paid below and **ATTACH PROOF** of payment.

Who paid?	Amount $	Who paid?	Amount $

5. If the information in Question 2, 3, or 4 will change in the next three months after the SUBMIT MONTH, check the box(es) below, please explain and **ATTACH PROOF.**

Medical Costs ☐	Who pays ?	Amount $	Who gets care?	What changed?	When will it change?
Dependent Care ☐	Who pays?	Amount $	Who gets care?	What changed?	When will it change?
Court-Ordered Child Support ☐	Who pays?	Amount $	For whom?	Attach new court order	When will it change?

PART 2: What Has Happened *SINCE* Your Last Report?

6. Did anyone get, buy, sell, trade, or give away any property [land, home, cars, bank accounts, money payments (such as: lottery or casino winnings, retroactive social security, tax refunds), other]? If "YES", list all items below and **ATTACH PROOF.** ☐ YES ☐ NO

Who owns, sold, traded, or gave away?	Type of Property	When?	Value $	☐ Bought ☐ Sold ☐ Won ☐ Gift Received ☐ Traded ☐ Gave Away

Checking Account ☐ Opened ☐ Closed Balance $ | Savings Account ☐ Opened ☐ Closed Balance $

7. Has anyone moved into or out of your home, or did you move in with someone else? ☐ YES ☐ NO
If "YES", complete below.

Full name of person	Relationship to you	Moved in or out?	When?

8. Has anyone in your family been convicted of a drug related felony for possession, use, or distribution; avoiding or running from any felony prosecution, custody, or confinement; or in violation of probation or parole? ☐ YES ☐ NO
If "YES", name: Where convicted? Date of conviction:

9. Have any of the following or any other changes happened to anyone in your home? ☐ YES ☐ NO
If "YES", check the box(es) below and **ATTACH PROOF.**

- ☐ **Family Change** (Married, divorced, separated, registered a California Domestic Partnership (DP), have a non-California DP, ended a DP, became pregnant, had a baby, or no longer pregnant?)
- ☐ **Disability** (Became disabled or recovered from a disability or major illness?)
- ☐ **Work** (Started or stopped working, refused a job or training, number of hours worked or in training went up or down, or went out on strike?)
- ☐ **Immigration** (Citizenship or immigration status change, or got a new card, form, or letter from USCIS (INS)?)
- ☐ **Insurance** (Started, stopped, or changed health, dental, or life insurance benefits, including MEDICARE?)
- ☐ **Custody** (Any change in the amount of time you care for/have custody of your children?)
- ☐ **In-Home Supportive Services** (Started or stopped getting services?)
- ☐ **School Attendance**
  - **For Cash Aid Only - Student age 6 - 18** stopped or started attending school regularly?
  - **Age 16 or older student** started or stopped school/college? (You may be able to claim costs for books, school transportation, etc.)

☐ **Other**_____

If you checked "YES" for any of these, please fill out below. Attach a separate sheet of paper if needed:

Name of person(s)	Relationship to you	What happened?	When

ADDRESS CHANGE

Fill in this section **ONLY** if you have moved or have a new mailing address. If you are getting Food Stamps, you may be asked to provide proof of your new shelter costs.

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

Date Moved	NEW Mailing Address (If different from Home Address)	City	State	Zip Code

Do you have housing costs at this new address? ☐ YES ☐ NO If yes, how much? $_____

Do you have to pay heating/cooling costs separate from your housing cost? ☐ YES ☐ NO If yes, how much? $_____

CERTIFICATION - FRAUD WARNING

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I may also be charged with committing a felony if more than $400 in Cash Aid, and/or Food Stamps is wrongly paid out as a result of such an action. I have received a copy of the Instructions and Penalties for the Eligibility/Status Report for Cash Aid and Food Stamps.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE MONTH THIS REPORT IS FOR OR IT WILL BE CONSIDERED INCOMPLETE. I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW: **For Cash Aid**: you and your aided spouse, domestic partner, and the other parent (of cash-aided children) if living in the home. **For Food Stamps**: the head of household, a responsible household member, or the household's authorized representative.

SIGNATURE OR MARK	DATE SIGNED	HOME PHONE	CONTACT/CELL PHONE
		( )	( )

SIGNATURE OF SPOUSE, DOMESTIC PARTNER, OR OTHER PARENT OF CASH AIDED CHILD(REN)	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE SIGNED

"New" Form

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

REPORT MONTH

ELIGIBILITY STATUS REPORT

TO KEEP YOUR BENEFITS COMING ON TIME, PLEASE SIGN THE FORM AFTER _____ 1st AND RETURN IT BY _____5th
SUBMIT MONTH SUBMIT MONTH

_____
CASE NUMBER HERE

NEED HELP? *(County Specific instructions w/county url)*

Worker Name:

[DIST. ID HERE]

Worker Phone:

County:

Street address:

City, State, Zip Code

BAR CODE:

Check the box if you would like to STOP getting any of the following: ☐ **STOP my CalWORKs** ☐ **STOP my CalFresh** ☐ **STOP my Medi-Cal**

1. **Has anyone moved into or out of your home (including newborns) or did you move in with someone else since you last reported?** ☐ Yes ☐ No (If Yes, complete the section below)

Date of Move (mm/dd/yy)	Name (First, Middle, Last)	Date Of Birth	Relationship To You	Regularly Purchase And Prepare Food Together?
☐ In ☐ Out / /		/ /		☐ YES ☐ NO
☐ In ☐ Out / /		/ /		☐ YES ☐ NO
☐ In ☐ Out / /		/ /		☐ YES ☐ NO

2. **Have there been any changes to your address since you last reported?** ☐ Yes ☐ No (If Yes, complete the section below)

New Address:_____ Date Moved: _____

Mailing Address (if different than above)_____

3. **If you have moved or have new/changed housing costs since you last reported please fill out the section below:**

Your rent or mortgage per month now?	If paid separately, your property taxes and home insurance per month now?
$	$

Do you have utility costs that are not included in your rent or mortgage payment? If so, check which ones:
☐ Phone ☐ Trash ☐ Water ☐ Electric/Gas ☐ Other heating or cooling costs

4. **Is anyone in your home:**
   A. **A felon whose conviction was drug-related?**
   B. **Running from the law?**
   C. **In violation of probation or parole?**
   ☐ Yes ☐ No (If Yes, complete the section below)

Name Of Person	A, B, or C From Above	Where Did The Arrest Or Conviction Happen?	Date of Arrest And/Or Conviction

5. **Medical Costs: Did anyone who gets CalFresh and is 60 years old or older, or disabled, have a change in medical costs?**
   ☐ Yes ☐ No (If Yes, complete the section below)

Who had the change?	Amount:
	$

6. **Child Support: Did anyone who gets CalFresh have a change in the amount of child support they have to pay since they last reported?** ☐ Yes ☐ No If Yes, what was the amount paid in the **Report Month? $**_____.
   Who paid support?_____
   <u>If Yes, Attach proof</u>.
7. **Dependent or Child Care: Did anyone who gets CalFresh and either works, is looking for work, or is going to school have a change in dependent care or child care costs since they last reported?**
   ☐ Yes ☐ No If Yes, what was the amount paid in the **Report Month? $**_____
   Who paid: _____ **List child/children:** _____
8. **Did anyone: Get, buy sell, trade or give away any property, land, homes, cars, bank accounts, money, payments (such as lottery/casino winnings, prior social security), or other property items since last reported?**
   ☐ Yes ☐ No (If Yes, complete the section below. If you need more space, attach a separate piece of paper).

Who?	Type of Property?	When?	Amount:	☐ Bought ☐ Sold ☐ Gave Away ☐ Spent ☐ Got as a gift ☐ Traded ☐ Won ☐ Other

9. Did anyone get income from employment in the Report Month? ☐ Yes ☐ No (If Yes, complete the section below and **attach proof**). The **Report Month** is listed at the top of the first page. List each job for each person who works. If you need more space attach a separate piece of paper. Examples include babysitting, salary, self-employment, sick pay, tips. etc.

	Job #1	Job #2	Job #3
Name of person who got income:			
Source of income:	Self-employed, check here ☐	Self-employed, check here ☐	Self-employed, check here ☐
How often paid:	☐ Weekly ☐ Biweekly ☐ Other ☐ Monthly ☐ Twice monthly	☐ Weekly ☐ Biweekly ☐ Other ☐ Monthly ☐ Twice monthly	☐ Weekly ☐ Biweekly ☐ Other ☐ Monthly ☐ Twice monthly
Gross amount they got, list here:	$ $ $ $ $ $	$ $ $ $ $ $	$ $ $ $ $ $
Hours worked per month:			
Will this income continue?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Will there be any changes to your job or income in the next six months? Examples: Stopping, starting, increase or decrease of income, changes in hours, quitting a job or going on strike, change in how often you are paid. ☐ Yes ☐ No (If Yes, explain): Use a separate piece of paper if needed:

10. Did anyone get money from any other source in the Report Month: ☐ Yes ☐ No (If Yes, complete the section below and **attach proof.**) The **Report Month** is listed at the top of the first page.
Examples include: Social Security, Unemployment Compensation, Veteran's Benefits, State Disability Insurance (SDI), Child/Spousal Support, Worker's Compensation, Loans/Gifts, Earned/Unearned Housing, Utilities, Food, etc.

Name	Source of income	One time payment or monthly	How much
			$
			$
			$

Will there be any changes to this income in the next six months? ☐ Yes ☐ No
Explain here:

11. Have any of the following happened to anyone in your home since you last reported? ☐ Yes ☐ No
(If yes, check below and attach proof):

- ☐ Family Change (Married, divorced, separated, entered into a California Registered Domestic Partnership (RDP), have a non-California Domestic Partnership (DP), ended a DP or RDP, became pregnant, or is no longer pregnant?)
- ☐ Job/Employment (Start, stop, quit a job, started a business or went on strike?)
- ☐ Disability (Became disabled or recovered from a disability or major illness?)
- ☐ Immigration (Citizenship or immigration status change, or got a new card, form, or letter from USCIS (INS)?)
- ☐ Insurance (Started, stopped, or changed health, dental, or life insurance benefits, including MEDICARE?)
- ☐ Custody (Any change in the amount of time you care for/have custody of your children?)
- ☐ In-Home Support Services (Started or stopped getting services?)
- ☐ School Attendance
  *For Cash Aid Only- Student age 6-18 stopped or started attending school regularly?
  *For Age 16 or older student- started or stopped school/college? (You may be able to claim costs for books, school transportation, etc.)
- ☐ Someone paid for all of my housing, food, clothing or utility costs. (please explain) _____
- ☐ Other_____

Please read carefully, sign, and date.

By signing this form:

- I understand and certify, under penalty of perjury, that all my answers on this report are correct and complete to the best of my knowledge.
- I understand the penalties for fraud are as follows: I may be sent to prison for up to 20 years and fined up to $250,000, I may have to pay back benefits if I was not eligible to them, the first time I break the rules on purpose I will not be able to get CalFresh for one year, the second time two years, and after the third time I will not be able to get CalFresh again.
- I understand and agree to give copies of all documents needed to complete my semi-annual report.
- I understand that in some instances, I may be asked to give consent to the County to make whatever contacts are necessary to determine eligibility.

CERTIFICATION - FRAUD WARNING

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I may also be charged with committing a felony if more than $950 in Cash Aid, and/or CalFresh is wrongly paid out as a result of such an action. I have received a copy of the Instructions and Penalties for the Eligibility/Status Report for Cash Aid and CalFresh.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE.
I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW:	**For Cash Aid**: You and your aided spouse, domestic partner, and the other parent (of cash-aided children) if living in the home. **For CalFresh**: The head of household, a responsible household member, or the household's authorized representative.

SIGNATURE OR MARK	DATE SIGNED	HOME PHONE	CONTACT/CELL PHONE
		( )	( )

SIGNATURE OF SPOUSE, REGISTERED DOMESTIC PARTNER, OR OTHER PARENT OF CASH AIDED CHILD(REN)	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE SIGNED

Current Form

STATE OF CALIFORNIA- HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

HOW TO FILL OUT YOUR QR 7 QUARTERLY ELIGIBILITY/STATUS REPORT

For Cash Aid and Food Stamps

- Save this notice to help you fill out your QR 7 (Quarterly Eligibility/Status Report) if you need help filling out your report, tell your worker.
- If you do not send in a complete report including, but not limited to, answering all questions on the QR 7 and attaching proof when we ask for it, your benefits may be delayed, changed, or stopped. **Attach a separate sheet of paper if needed.**
- Changes that may affect your eligibility for Cash Aid or Food Stamps that you are required to report, must be reported within 10 days.
- Facts you report may result in your benefits going up, down, or being stopped.

INSTRUCTIONS

HOW OFTEN YOU MUST COMPLETE THE QR 7

For Cash Aid and Food Stamps you must turn in a complete QR 7 once every quarter (every three months). The County will tell you when you are supposed to turn in your completed QR 7.

REPORTING FOR PEOPLE WHO ARE LIVING IN YOUR HOME

If your family gets Cash Aid (no Food Stamps), report facts for:

- All children-natural, adopted, and stepchildren.
- All parents-natural, adoptive, and stepparent.
- Other aided relatives of the child.
- Yourself and your spouse or registered domestic partner.
- Anyone who is temporarily absent from the home.

If your family gets Cash Aid and Food Stamps you must also report facts for:

- All related adults.
- Others who buy and prepare food with you.

If your family gets Food Stamps only, you must report facts for:

- All children.
- All related adults.
- Others who buy and prepare food with you.

REQUEST TO STOP BENEFITS

- If you ask to have your Cash Aid stopped, your Medi-Cal may also be stopped or changed. You may not be eligible for Medi-Cal or you may have to pay a share of cost of it.
- On the QR 7, complete the request to stop benefits section only if you want to stop any of your benefits. Check the benefits you want stopped and sign and date the QR 7. If you only want to stop some of your benefits and keep others, you must fill out the rest of the QR 7.
- You can also request to stop your benefits by calling your worker.

FACTS YOU MUST REPORT FOR EACH QUESTION

Part 1: Questions 1 (except for question 1b) through 4 are about what happened in the report month.

Question number:

1 Any earnings, training allowances, or other money anyone got. Such as wages, vacation pay, cash bonuses, In-Home Supportive Services (IHSS) pay, child or spousal support; Social Security; Supplemental Security Income/State Supplementary payment (SSI/SSP); Unemployment/Disability Insurance; worker's compensation; any other type of disability or retirement; lottery winnings; insurance or legal settlements; rental income or assistance; free housing/utilities/clothing/food; or anything else. List the name of the person(s) who got the money, where they got the money from, the date the person(s) actually got the money, and the gross amount they got (this means the amount before any taxes or deductions). Attach proof such as, check stubs, copies of checks or statements from the employer, award letters from the agency you got the money from, etc. If self-employed, and you want to claim actual expenses, list all business expenses on a separate sheet of paper. Attach proof such as, receipts or paid invoices, etc. If you want to figure your business costs by using the standard 40 percent deduction of your verified income, you do not need to list your business expenses.

1a List the name of anyone who worked or trained, where, and the total hours for the month.

1b Any income or money you expect will change in the next three months after the submit month. List the name of the person whose income or money will change, the source, why it will change, and the total gross amount for each month. Attach proof.

2 If anyone who gets Food Stamps and is disabled or 60 years or older paid medical costs, list the name of the person who paid it, who got the medical care, and the amount they paid. Attach proof of payment.

3 If anyone who gets Food Stamps paid for the care of a child, disabled person, or other dependent while working, looking for work, or while they were in school or training during the report month, list the name of the person who paid it, who received the care, and the amount they paid. Attach proof of payment.

4 If anyone who gets Food Stamps paid court-ordered child support, list the name of the person who paid it and the amount they paid. Attach proof of payment.

5 If the expenses in Questions 2, 3, and 4 will change in the next three months after the submit month, list the medical expenses for someone who is age 60 or older; child/dependent care; and child support. List the name of the person who paid it, the amount they paid, who received the care or the child who got the support, what changed, and when will it change. Attach proof of payment.

Part 2: Questions 6 through 9 are about what has happened since your last quarterly report.

6 Anyone who got, bought, sold, trade, or gave away any of the following property: land, home, cars, bank accounts, money payments (lottery or casino winnings, retroactive social security, tax refunds), etc. List who owns or owned the property, the type of property, when it changed, the value of the property, and what happened. Attach proof.

7 Anyone who moved into or out of your home or if you moved in with someone else. This includes; newborns; people who are temporarily absent from your home; anyone who died, entered or left a hospital or institution (including a penal institution), etc. List the name of the person who moved in or who you moved in with, their relationship to you, what happened, and the date it happened.

8 Anyone in your home who has been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s) or who is avoiding or running from the law to avoid felony prosecution, custody, or confinement or is in violation of probation or parole. List the name of the person, where they were convicted, and date they were convicted. If you have previously reported the information to the County on a past quarterly report, you do not need to report the same information each quarter.

9 Other facts that could change your eligibility or the amount of your benefits: marriage, divorce, separation, a California Domestic Partnership (DP), other state DP, ended a DP, became pregnant, had a baby, no longer pregnant; became disabled or recovered from a disability/major illness; starting or stopped working, refused a job or training, hours worked or trained changed, went on strike; citizenship or immigration status changed or got new documentation from USCIS; started, stopped, or changed health, MEDICARE, dental, or life insurance benefits; any change in time of care or custody of your children; started or stopped getting In-Home Supportive Services; student ages 6 - 18 stopped or started attending school regularly; student ages 16 or older stopped or started attending school/college.

SEE OTHER SIDE FOR MORE INFORMATION

ADDRESS CHANGE

Give us the facts about any changes in your address or phone number. If you are getting Food Stamps you may be asked to give proof of new housing costs like rent and utilities. If your housing costs increased because of the move be sure to list the new amounts.

WHO MUST SIGN THE QR 7

- **For Cash Aid:** You and your aided spouse, registered domestic partner, and the other parent of the aided child(ren) if they live in your home.
- **For Food Stamps:** The head of household, an adult household member or the household's Authorized Representative.
- **And:** Any other person who fills out the report, an interpreter or the witness to your mark.

WHAT WE MEAN WHEN WE SAY

AVOIDING OR RUNNING FROM THE LAW TO AVOID PROSECUTION, CUSTODY OR CONFINEMENT: A person is considered avoiding or running from the law if an arrest warrant has been issued and the person knew or should have known from the facts that the law was looking for them.

CASH AID: CalWORKs (California Work Opportunity and Responsibility to Kids) and Refugee Cash Assistance.

CONTROLLED SUBSTANCE: Any drug whose availability is restricted by federal or state law, including but not limited to, narcotics, stimulants, depressants, hallucinogens and marijuana.

COMPLETE QR 7: A QR 7 is "complete" only when:

- All of the YES/NO questions are answered, and
- All of the information is filled in, and
- All of the proof is attached when the form asks for it, and
- All of the required signatures are on the form, and
- The form is signed and dated after the last day of the report month.

COURT ORDERED CHILD SUPPORT: The payment a legal document or court of law says you must make to a person for a child who is not in your home. Include payments made by a stepparent.

GROSS AMOUNT: The amount of your paycheck before deductions are taken out for taxes, social security, etc.

IN VIOLATION OF PROBATION OR PAROLE: Probation or parole was revoked or an arrest warrant was issued. The original crime for which probation or parole was ordered could be for a felony or misdemeanor.

REPORT MONTH: The month shown in Part 1 of the QR 7.

SUBMIT MONTH: The month shown in the header at the top of the QR 7.

CERTIFICATION SECTION

- You must sign the QR 7 "under penalty of perjury." This means that you swear under oath that the facts you give us are true, correct and complete.
- Perjury and fraud are crimes punishable by law.

PENALTIES FOR CASH AID WELFARE FRAUD: If on purpose you do not follow Cash Aid rules, your Cash Aid can be lowered for a period of time and you may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.

Your Cash Aid can be stopped:

- For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second offense, or forever for the third.
- For submitting one or more application to get aid in more than one case for the same time period: 2 years for the first conviction, 4 years for the second, and forever for the third.
- For conviction of felony fraud to get aid: 2 years for theft of amounts under $2,000; 5 years for amounts of $2,000 through $4,999.00; and forever for amounts of $5,000 or more.
- Forever: for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county wrong facts for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing.

PENALTIES FOR FOOD STAMP FRAUD: If you purposely do not follow Food Stamp rules, your Food Stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to $250,000 and/or sent to jail/prison for 20 years.

- **If you are found guilty in any court of law or administrative hearing because:**
- You traded or sold Food Stamps for firearms, ammunition, or explosives, your Food Stamps can be stopped forever for the first violation.
- You traded or sold Food Stamps for controlled substances, your Food Stamps can be stopped for 24 months for the first violation and forever for the second.
- You traded or sold Food Stamps that were worth $500 or more, your Food Stamps can be stopped forever.
- You gave the county false identify or residence information, so you can get Food Stamps in more than one case at the same time, your Food Stamps can be stopped for 10 years.

DO NOT FORGET:

- **If your report is late, not complete or not turned in, your benefits may be late, changed or stopped.**
- **If your report is not complete when you turn it in, you will be asked to complete it again.**
- **If you sign and date your report before the last day of the report month, you will be asked to sign and date it again.**
- **If you are not sure how to report, what to report or what proof you need to send in, ask your worker.**
- **If your Cash Aid stops, you may still be eligible for Food Stamp benefits even if you are now employed.**
- **If your Cash Aid stops, you may still be eligible for no-cost or low-cost health coverage under Medi-Cal.**

"New" Form

HOW TO FILL OUT YOUR SAR 7 SEMI-ANNUAL ELIGIBILITY/STATUS REPORT

For Cash Aid and CalFresh (Food Stamp) Benefits

Save this form to help you fill out your SAR 7 (Semi-Annual Eligibility/Status Report). If you need help filling out your report, **call the County**.

- If you do not send in a complete report, your benefits may be delayed, changed, or stopped, or cause an overpayment that you will have to pay back. You must answer all the questions, and attach proof when we ask for it.
- **Attach a separate sheet of paper if needed.**
- **Facts you report may cause your benefits to go up, down, or be stopped.**

INSTRUCTIONS

How Often You Must Complete the SAR 7
Once a year; (6 months after your application/annual renewal). The County will tell you when your SAR 7 is due.

Reporting For People Who Are Living In Your Home
If your family gets *cash aid*, report facts for:

- All **children**-natural, adopted, and stepchildren.
- All **parents**-natural, adoptive, and stepparent.
- Other **aided relatives** in the child's case.
- **Yourself** and your **spouse or registered domestic partner**.
- Anyone who is **temporarily absent** from the home.

If your family gets *CalFresh* (with or without cash aid) you must also report facts for:

- All children.
- All related adults.
- All other people in the household who regularly buy and prepare food with you.

Asking To Stop Benefits

- On the SAR 7, fill out the section to stop benefits **only** if you want to stop any of your benefits. Check the benefits you want stopped, and sign and date the SAR 7. If you only want to stop some of your *benefits and keep others, you must fill out the rest of the SAR 7.*
- You can also stop your benefits by contacting the County.
- If you ask to have your cash aid stopped, your Medi-Cal may also be stopped or changed. You may not be eligible for Medi-Cal or you may have to pay a share of cost for it.

HOW TO FILL OUT EACH QUESTION
Household Information (Question 1)
List any changes in who lives with you, changes to your address (including changes in apartment numbers) and changes in housing costs since you last reported. This includes: newborns; people who are temporarily absent from your home; anyone who died, entered or left a hospital or institution (including jail or prison), etc.

Address Change/Housing Costs (Questions 2 and 3)
Give us the facts about any changes in your address or phone number since you last reported. If you are getting CalFresh, you may be asked to give proof of new housing costs like rent and utilities. If your costs have increased because of the move, be sure to list the new amounts. This may increase your CalFresh benefits.

Convictions, Fleeing and Parole/Probation Violations (Question 4)
This question applies to anyone already living with you who had any of these happen since you last reported. It is ALSO for anyone who moved into your household who may have a drug felony conviction, be running from the law or in violation of parole/probation. We need the person's name, the place, and date of the arrest/conviction.

If you reported the information to the County before, you do not need to report the same information.

Expenses (CalFresh Information) (Questions 5, 6 and 7)
These questions may change your CalFresh benefits. This information may lower the income we count and increase your benefits. For people age 60 and older or who are disabled, report any changes to your out of pocket medical costs. For any CalFresh household, report changes to your costs for child or adult dependent care needed for work or training. If you pay child support, report any changes in the amount paid. **Attach proof to see if you can get more benefits.**

Property (Question 8)
List anyone who got, bought, sold, traded, spent or gave away any property. Property includes: land, home, cars, bank accounts, money payments (lottery or casino winnings, retroactive social security, tax refunds), etc. Include gifts and loans. List whose property, the type of property, when it changed and the value of the property ("amount" on the form). Check the box for what happened. **Attach proof.**

If you have already reported and provided proof of new property, you do not have to report it again unless there has been a change.

Employment Income (Question 9)
List **all** income from employment (work) – earnings, tips, training allowances, benefits, or other earnings anyone got in the report month. List the amount before taxes or deductions (the gross amount). **Attach proof.**

- **Employment income** includes but is not limited to paychecks, cash income, vacation pay, bonuses, money from self-employment, temporary job or training income, rental income, IHSS, etc.
- If **self-employed**, you can get a 40% deduction for expenses without proof. If your expenses are higher and you want to claim actual expenses, list all business expenses on a separate sheet of paper. Attach proof if using actual expenses.

We need to know if you think the income will continue or if you know it will change. If your income will stay the same we will use the amount you report as your income for the next 6 months. If you know your income will change, tell us why, how much and when it will change. If you aren't sure, you can also report the change when it happens. For example, if you were offered a job and know your hourly wage and schedule, you must report this even if you haven't started working or been paid yet. Also, if you are working on-call or have a schedule that changes a lot, write this information on your SAR 7 form.

Proof of income includes but is not limited to: check stubs, copies of checks or statements from the employer, etc. or tax statements for self-employed.

Other Income (Question 10)
List **all** other income from any other source. **Attach proof.**

- **Disability or Retirement income** includes SSI, Social Security, Veteran's disability benefits, worker's compensation or any other disability/retirement payments.
- **Unemployment benefits**
- **Other:** lottery winnings; insurance or legal settlements; gifts or loans; rental assistance; free housing/utilities/ clothing/food (or if someone paid all of these cost for you); or anything else.

List (1) who got the income, (2) where they got the money from, and (3) the amount they got. Tell us if you think the income will continue or if you know it will change. If you know it will change, tell us when it will change and how much.

Proof of other types of income include but is not limited to: check stubs, copies of the checks, award letters from the agency you got the money from, etc.

Any other changes (Question 11)
List other things that could change your eligibility or the amount of your benefits. Examples of changes you should report are listed on the SAR 7.

SEE OTHER SIDE FOR MORE INFORMATION

WHO MUST SIGN THE SAR 7

- For **Cash Aid:** You and your aided spouse, registered domestic partner, and the other parent of the aided child(ren), if they live in your home.
- For **CalFresh:** The head of household, authorized representative, or responsible household member.
- **And for Both:** Any other person who helps fill out the report, an interpreter or the witness to your mark.

WHAT WE MEAN WHEN WE SAY

ACTIVELY SEEKING TO ENFORCE A FELONY WARRANT: There is a felony warrant out for the person, and law enforcement is trying to carry out the arrest. For out of state/county, this means they are trying to return you to or bring you back to another state/county.

CASH AID: CalWORKs (California Work Opportunity and Responsibility to Kids), Refugee Cash Assistance (RCA), Trafficking and Crime Victim Assistance Program (TCVAP), and Emergency Cash Assistance (ECA).

CHILD SUPPORT PAYMENT: The payment you must make to a person for your child or stepchild. Include payments made by a stepparent living in your home.

COMPLETE SAR 7: A SAR 7 is "complete" only when:

- All of the YES/NO questions are answered, *and*
- All of the information is filled in, *and*
- All of the proof is attached when the form asks for it, *and*
- All of the required signatures are on the form, *and*
- The form is signed and dated after the last day of the report month.

CONTROLLED SUBSTANCE: Any drug restricted by federal or state law, including but not limited to, narcotics, stimulants, depressants, hallucinogens and marijuana.

DRUG RELATED FELONY:

A drug-related felony means a conviction for possession, use, manufacturing, or distribution of a controlled substance(s).

FLEEING:

"Fleeing" means law enforcement is actively seeking the person to enforce a felony warrant.

GROSS AMOUNT: The amount of your paycheck or other check (Unemployment benefit, retirement, etc.), before deductions are taken out for taxes, social security, etc.

IN VIOLATION OF PROBATION OR PAROLE: A court has found you to be in violation of the terms of your probation or parole. The original crime for which probation or parole was ordered could be for a felony or misdemeanor.

REPORT MONTH: The month shown at the top of the SAR 7. Report all income you got and any changes that happened in this month.

SUBMIT MONTH: The month you sign and date the report and turn it in. The submit month is shown at the top of the SAR 7, under the title "Eligibility Status Report."

CERTIFICATION SECTION

- You must sign the SAR 7 "under penalty of perjury." This means that you swear (promise) that the facts you give us are true, correct and complete.
- Perjury is a crime – it means you swore (promised) to tell the truth and then you were dishonest.

REMEMBER:

- The report is due by the 5th of the submit month. Try to get it in on time to avoid problems with your benefits.
- If your report is late (after the 11th of the submit month), not complete or not turned in, your benefits may be late, changed or stopped.
- If the County gets your report too late in the month to decrease your benefits based on what you reported, you may be charged with an overpayment and have to pay it back.
- If your report is not complete when you turn it in, you will be asked to complete the questions you did not answer and/or turn in proof that the report asked for. Your benefits may be late.
- If you sign and date your report before the first day of the submit month, you will be asked to sign and date it again.
- If you are not sure how to report, what to report or what proof you need to send in, **ask the county**.
- If your cash aid stops, you may still be eligible for CalFresh benefits even if you are now employed.
- If your cash aid stops, you may still be eligible for no-cost or low-cost health coverage under Medi-Cal.

WELFARE FRAUD:

- Welfare fraud is when you fail to report information, or report the wrong information, on purpose in order to try to get more benefits.
- Fraud is a crime.

PENALTIES FOR CASH AID WELFARE FRAUD: If you are convicted of fraud or if you are disqualified for intentionally (on purpose) not reporting your eligibility information correctly, you may lose your share of the cash aid. How long you will lose it depends on what the crime was and whether you had committed fraud before. You may also have to pay a fine up to $10,000 and/or be sent to jail or prison for up to 3 years.

Your cash aid can be stopped:

- For not reporting all facts or for giving wrong facts: 6 months for the first time, 12 months for the second time, or **forever** for the third.
- For turning in more than one application to get aid for the same family members in a different case in the same time period: 2 years for the first conviction, 4 years for the second, and **forever** for the third.
- For conviction of felony welfare fraud: 2 years for extra benefits under $2,000; 5 years for amounts of $2,000 through $4,999; and **forever** for amounts of $5,000 or more.
- **Forever:** for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; intentionally (on purpose) giving the county wrong facts for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud; getting a third conviction for fraud in a court or an administrative hearing.

PENALTIES FOR CalFresh FRAUD:

If you are convicted of fraud or if you are disqualified for intentionally (on purpose) not reporting your eligibility information correctly, your CalFresh can be stopped for 12 months for the first violation, 24 months for the second, and **forever** for the third. You may be fined up to $250,000 and/or sent to jail or prison for 20 years.

Your CalFresh can be stopped if you are found guilty in any court of law or administrative hearing because:

- You traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped **forever** for the first violation.
- You traded or sold CalFresh benefits for controlled substances, your CalFresh benefits can be stopped for 24 months for the first violation and **forever** for the second.
- You traded or sold CalFresh benefits that were worth $500 or more, your CalFresh benefits can be stopped **forever**.
- You gave the county false identity or residence information, to try to get CalFresh benefits in more than one case at the same time, your CalFresh benefits can be stopped for 10 years.

SEE OTHER SIDE FOR MORE INFORMATION

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

INSTRUCTIONS AND PENALTIES
ELIGIBILITY/STATUS REPORT

For Cash Aid and Food Stamps

Need Help? Call your worker.

- If you do not send in a complete report including, but not limited to, answering all questions on the QR 7/SAWS QR 7 and attaching proof when we ask for it, your benefits may be delayed, changed, or stopped. **Attach a separate sheet of paper if needed.**
- Facts you report may result in your benefits going up, down, or be stopped.
- Send in your completed report by the 5th of the month after the report month.

Examples

Income

- Wages
- Vacation pay
- Child/spousal support
- Insurance or legal settlements
- Rental income and rental assistance
- Any government benefits
- State Disability Indemnity
- Self-Employment
- Tips
- Interest or dividends
- Strike benefits
- Tax refunds
- Unemployment
- Social Security
- Supplemental Security Income/State Supplementary Payment (SSI/SSP)
- Salary
- Income In-Kind, such as earned housing, free housing/utilities/clothing/food
- Gambling/Lottery winnings
- Cash, gifts, loans, scholarships
- Other private or government disability or retirement
- Workers Compensation
- Veterans or Railroad retirement

Property

- Motor vehicles
- EBT balance
- Home
- Checking
- Savings Bonds
- Land
- Savings
- Life insurance policies
- Trusts

Housing Costs

- Rent
- Utilities
- Mortgage
- Homeowners insurance
- Property taxes
- Garbage/trash collection fees

Expenses

- Medical expenses
- Health insurance premiums
- Child/dependent Care
- College tuition & supplies
- Mandatory school fees
- Child/spousal support
- Transportation
- Room & Board
- Housing costs

Penalties

PENALTIES FOR CASH AID FRAUD: If on purpose you do not follow Cash Aid rules, your Cash Aid can be lowered for a period of time and you may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.

Your Cash Aid can be stopped:

- For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second offense, or forever for the third.
- For submitting one or more application to get aid in more than one case for the same time period: 2 years for the first conviction, 4 years for the second, and forever for the third.
- For conviction of felony fraud to get aid: 2 years for theft of amounts under $2,000; 5 years for amounts of $2,000 through $4,999.99; and forever for amounts of $5,000 or more.
- Forever: for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county wrong facts for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing.

PENALTIES FOR FOOD STAMP FRAUD: If on purpose you do not follow Food Stamp rules, your Food Stamps can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to $250,000 and/or sent to jail/prison for 20 years.

- **If you are found guilty in any court of law or administrative hearing because:**
- You traded or sold Food Stamps for firearms, ammunition, or explosives, your Food Stamps can be stopped forever for the first violation.
- You traded or sold Food Stamps for controlled substances, your Food Stamps can be stopped for 24 months for the first violation and forever for the second.
- You traded or sold Food Stamps that were worth $500 or more, your Food Stamps can be stopped forever.
- You gave the county false identify or residence information, so you can get Food Stamps in more than one case at the same time, your Food Stamps can be stopped for 10 years.

"New" Form

INSTRUCTIONS AND PENALTIES
SAR 7 ELIGIBILITY STATUS REPORT

For Cash Aid and CalFresh

Need Help? Call the County.

- If you do not send in a complete report including, but not limited to, answering all questions on the SAR 7 and attaching proof when we ask for it, your benefits may be delayed, changed, or stopped. **Attach a separate sheet of paper if needed.**
- Facts you report may result in your benefits going up, down, or being stopped.
- Send in your completed report by the 5th of the month after the report month. It is late after the 11th.

Examples

Income

- Wages
- Vacation pay
- In-Home Supportive Services (IHSS)
- Child/spousal support
- Insurance or legal settlements
- Rental income and rental assistance
- Any government benefits
- State Disability Indemnity
- Self-Employment
- Tips
- Interest or dividends
- Strike benefits
- Tax refunds
- Unemployment
- Social Security
- Supplemental Security Income/State Supplementary Payment (SSI/SSP)
- Salary
- Income In-Kind, such as earned housing, free housing/utilities/clothing/food
- Gambling/Lottery winnings
- Cash, gifts, loans, scholarships
- Other private or government disability or retirement
- Workers Compensation
- Veterans or Railroad retirement

Property

- Motor vehicles
- EBT cash aid balance
- Home
- Checking
- Savings Bonds
- Land
- Savings
- Life insurance policies
- Trusts

Housing Costs

- Rent
- Utilities
- Mortgage
- Homeowners insurance
- Property taxes
- Garbage/trash collection fees

Expenses

- Medical expenses
- Health insurance premiums
- Child/dependent Care
- College tuition & supplies
- Mandatory school fees
- Child/spousal support
- Transportation
- Room & Board
- Housing costs

Gross income means the amount you get before deductions are taken out (Examples of deductions are: Taxes, Social Security or other retirement contributions, health care plan premiums, garnishments, etc.).

Penalties

PENALTIES FOR CASH AID FRAUD: If on purpose you do not follow Cash Aid rules, your Cash Aid can be lowered for a period of time and you may be fined up to $10,000 and/or sent to jail or prison for up to 3 years.

Your Cash Aid can be stopped:

- For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second offense, or forever for the third.
- For submitting one or more application to get aid in more than one case for the same time period: 2 years for the first conviction, 4 years for the second, and forever for the third.
- For conviction of felony fraud to get aid: 2 years for theft of amounts under $2,000; 5 years for amounts of $2,000 through $4,999.99; and forever for amounts of $5,000 or more.
- Forever: for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county wrong facts for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing.

PENALTIES FOR CALFRESH FRAUD: If on purpose you do not follow CalFresh rules, your CalFresh benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. You may be fined up to $250,000 and/or sent to jail/prison for 20 years.

- **If you are found guilty in any court of law or administrative hearing because:**
- You traded or sold CalFresh benefits for firearms, ammunition, or explosives, your CalFresh benefits can be stopped forever for the first violation.
- You traded or sold CalFresh benefits for controlled substances, your CalFresh benefits can be stopped for 24 months for the first violation and forever for the second.
- You traded or sold CalFresh benefits that were worth $500 or more, your CalFresh benefits can be stopped forever.
- You gave the county false identify or residence information, so you can get CalFresh benefits in more than one case at the same time, your CalFresh benefits can be stopped for 10 years.

SPONSORED NONCITIZENS APPLYING FOR OR RECEIVING CASH AID AND/OR FOOD STAMPS

Important Information For Noncitizens Sponsored By Individuals

As a noncitizen who is sponsored by an individual(s), you must meet special conditions to receive Cash Aid and/or Food Stamps.

The Special Conditions Are:

- Your sponsor's income and resources will have to be reviewed for you to receive benefits. Your sponsor must provide information on the attached form. Both you and your sponsor must sign this form.
- If your application is approved, you and your sponsor will have to complete quarterly income and resource reports for Cash Aid and Food Stamp benefits. If your sponsor does not provide this information, your benefits may be changed or stopped. Family members who are not sponsored and are otherwise eligible can get and continue to get their benefits.
- **You are the person responsible for getting all the information requested to the county welfare department for both you and your sponsor.**

Important Information For Sponsors

The noncitizen you sponsor has applied for Cash Aid and/or Food Stamps. If you completed an affidavit of support, State regulations require the county welfare department to evaluate your income, resources, and property in deciding whether or not the noncitizen applicant can get benefits. Sponsorship is normally for an indefinite period of time. This form must be completed and signed by you under penalty of perjury. If you are living with your spouse or your spouse has signed an affidavit of support, your spouse's income, resources, and property are also counted.

If the noncitizen's application for Cash Aid is approved, **each quarter** you will have to report your income, resources, and property on the Sponsor's Quarterly Income and Resources Report (QR 72). The noncitizen will provide you with the report form. Your report must be completed and returned to the noncitizen immediately to ensure the noncitizen's continued eligibility. Each quarter, resources and a portion of your income will be used to determine the noncitizen's continued eligibility and benefits.

If the noncitizen receives benefits to which he or she is not entitled because you failed to accurately report information, you and/or the noncitizen may have to repay these benefits.

SPONSOR'S STATEMENT OF FACTS INCOME AND RESOURCES

(Supplemental Application For Food Stamps And Cash Aid)

COUNTY USE ONLY
CASE NAME: _____
CASE NO: _____
WORKER NO: _____

☐

INSTRUCTIONS: PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOURSELF AND YOUR SPOUSE (IF LIVING TOGETHER OR IF SPOUSE HAS SIGNED AN AFFIDAVIT OF SUPPORT) AND RETURN IT TO THE NONCITIZEN IMMEDIATELY.

Noncitizen Name and Address

Proof may be needed to verify answers to the following questions. Attach proof when the form asks for it.

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

HOME ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)

MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS)

(2) YOUR SPOUSE'S NAME (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT) (FIRST, MIDDLE, LAST) | HAS SPONSOR'S SPOUSE SIGNED AN AFFIDAVIT OF SUPPORT? ☐ Yes ☐ No

(3) Do you or your spouse get assistance such as: California Work Opportunity and Responsibility to Kids (CalWORKs), Food Stamps, or Supplemental Security Income (SSI)? If Yes, complete below: ☐ Yes ☐ No

Case Name	Date of Birth	Type of Assistance	County	State

VERIFIED:
☐ Letter on File
☐ Verbal Communication
☐ Other:_____

If **both** you and your spouse get Assistance and the noncitizen is not applying for Food Stamps, complete only the Certification section on Page 3 and return the form. For all others, go to Question (4).

(4) A. Have you or your spouse sponsored any other noncitizen's entry into the United States? ☐ Yes ☐ No
If Yes, complete below using the I-864, I-864A or the I-134:

Noncitizen Name	Noncitizen Address	Date of Admission to U.S.

VERIFIED:
☐ Affidavit of Support on File
☐ I-864
☐ I-864A
☐ I-134
☐ Other:_____

B. Are any of the noncitizens listed in (4A) receiving any type of assistance such as: CalWORKs, Food Stamps or SSI? ☐ Yes ☐ No
If Yes, complete below:

Type of Assistance	Date First Applied	County	State

☐ Verified
☐ Verified

(5) Do you or your spouse have other persons who are claimed or could be claimed as dependents for federal income tax purposes? ☐ Yes ☐ No
If Yes, complete below:

☐ IRS Form 1040 Reviewed
☐ Other:_____

Name of Person(s)	Does Person Live With Sponsor	
	☐ Yes ☐ No	Claimed ☐ Yes ☐ No
	☐ Yes ☐ No	Claimed ☐ Yes ☐ No
	☐ Yes ☐ No	Claimed ☐ Yes ☐ No
	☐ Yes ☐ No	Claimed ☐ Yes ☐ No
	☐ Yes ☐ No	Claimed ☐ Yes ☐ No

COUNTY USE ONLY

(6) **Are you or your spouse currently employed?** ☐ Yes ☐ No
If Yes, complete section below. Attach paystubs or other proof of earnings. If you or your spouse are self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

Name	Name of Employer	Gross Pay (Before Deductions)	How Often Paid (Weekly, Monthly, etc.)	Commissions or tips	Number of Tax Dependents Claimed	Check if Exempt	Enter Date Viewed: Pay Stubs	Enter Date Viewed: Other
		$		$		☐ Yes ☐ No		
		$		$		☐ Yes ☐ No		

(7) Do you or your spouse receive or expect to receive any other income such as: Social Security, Unemployment/Disability Insurance, Child/Spousal Support, Veterans Benefits, etc? ☐ Yes ☐ No
If Yes, complete section below and attach proof of the income.

Name	Type of Income	Amount	How Often Received	Check if Exempt	Specify Verification and Date Reviewed:
		$		☐ Yes ☐ No	
		$		☐ Yes ☐ No	

(8) Do you or your spouse have any of the following resources? Check each item. If Yes, explain below.

Resource	Sponsor	Spouse	Resource	Sponsor	Spouse
Checks or Money (At Home or Elsewhere)	☐ Yes ☐ No	☐ Yes ☐ No	Trust Funds	☐ Yes ☐ No	☐ Yes ☐ No
Checking, Savings, Credit Union Account	☐ Yes ☐ No	☐ Yes ☐ No	Stocks, Bonds, Certificates	☐ Yes ☐ No	☐ Yes ☐ No
Notes, Mortgages, Trust Deeds, Sales Contracts	☐ Yes ☐ No	☐ Yes ☐ No	Other (Specify below)	☐ Yes ☐ No	☐ Yes ☐ No

Type of Resource	Owner	Current Value	Location (Home, Bank, Address, etc.)	Account Number	Check if Exempt
		$			☐ Yes ☐ No
		$			☐ Yes ☐ No
		$			☐ Yes ☐ No

(9) Do you or your spouse own (or are you buying) any real property, such as: a house, land, building, etc. If Yes, complete section below: ☐ Yes ☐ No

Name	Type of Property	Address/Location	How Used? (Home, Rent, etc.)	Balance Owed	Value	Name of Mortgage Co.	Check if Exempt
				$	$		☐ Yes ☐ No
				$	$		☐ Yes ☐ No

Date Registration and Records Viewed
1. _____
2. _____

(10) Do you or your spouse own or use or are you buying any motor vehicles, such as: a car, truck, boat, trailer, van, camper, motorcycle, etc. If Yes, complete, section below: ☐ Yes ☐ No

Name	Year, Make, Model	License Number and State of Registration	Amount of current License Fee	Balance Owed	Check if Exempt
					☐ Yes ☐ No
					☐ Yes ☐ No

Vehicle Valuation
1. $ _____
2. $ _____

(11) Do you or your spouse who receive income pay any court ordered support? ☐ Yes ☐ No
If Yes, enter the monthly amount $_____ Who pays? _____

☐ Verified

(12) Do you or your spouse make support payments to other persons not living in your home? ☐ Yes ☐ No
If Yes, complete section below:

☐ Verified

Who Pays	To Whom Paid (Name)	Amount Paid
		$
		$
		$
		$

(13) Do you or your spouse own or use personal property or resources such as: Jewelry, equipment, instruments, livestock, etc.? Do not list clothing, wedding rings, rugs, furniture, appliances, other household furnishings. If Yes, complete section below: ☐ Yes ☐ No

Name	Name of Item	Date of Purchase	Purchase Price	Gift	Amount Owed	Net Market Value
			$	☐ Yes ☐ No		1.
			$	☐ Yes ☐ No		2.
			$	☐ Yes ☐ No		3.
			$	☐ Yes ☐ No		4.

CERTIFICATION

- **I understand that if on purpose I don't give the right facts or all the facts for the CalWORKs, Food Stamp or cash-based Medi-Cal Programs, I can be punished and I can be legally accused of the crime of fraud. If I am found guilty of committing fraud, I can be fined up to $10,000 for CalWORKs and $250,000 for Food Stamps. And, I can go to jail/prison for up to 5 years for CalWORKs and 20 years for Food Stamps. In the CalWORKs and Food Stamp Programs, my benefits can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years or forever.**
- **I understand that the information provided on this form may be verified by local, state and federal agencies.**
- **I understand that the noncitizen's case, including my statement, may be selected for an additional review to ensure that the noncitizen's eligibility was determined correctly.**
- **I understand that I may be required to repay any benefits which are overpaid because of incorrectly or incompletely reported information.**

- If the noncitizen is applying for Cash Aid, both you and your spouse must sign the form. If the noncitizen is applying for Food Stamps only, either you or your spouse must sign the form.

SPONSOR'S CERTIFICATION:

- I understand that the term for Sponsorship is normally an indefinite period of time.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the above information contained on this statement of facts is true, correct, and complete.

SPONSOR'S SIGNATURE OR MARK	DATE
SPONSOR'S SPOUSE'S SIGNATURE OR MARK (IF LIVING WITH SPOUSE OR HAS SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

- If the noncitizen is applying for Cash Aid, the noncitizen must sign this form. If the noncitizen is applying for Food Stamps only, the form must be signed by the noncitizen, the head of household, a household member, or an authorized representative.

NONCITIZEN'S CERTIFICATION:

- I have reviewed this signed and completed form from my sponsor(s). I declare under penalty of perjury under the laws of the United States of America and the State of California that it is true, correct, and complete to the best of my knowledge.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

COUNTY USE ONLY

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources

A. ITEMS	VALUE
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
B. Total	$ _____

	CW	FS
C. Less: Food Stamp Deduction ($1500)	NA	$1500
D. Equals Subtotal =		
E. Total number of sponsored noncitizens applying for/receiving CW/FS		
F. Total (Divide D by E) =		

Amount in F to be included in each noncitizen's property limits.

CalWORKs Sponsor/Sponsor's Spouse Income Computation

A. Earned Income	$ _____
B. Unearned Income	+ _____
C. Subtotal	= _____
D. Total number of sponsored noncitizens applying for/receiving CalWORKs	_____
E. Divide C by D	= _____
F. Number of sponsored noncitizens in this AU	_____
G. Total (Multiply E by F)	= _____

Amount in G to be deemed income for entire AU.

Food Stamp Sponsor/Sponsor's Spouse Computation

A. Earned Income	$ _____
B. Less 20%	- _____
C. Unearned Income	+ _____
D. Gross Income Deduction for Sponsor's household size	- _____
E. Subtotal	= _____
F. Total number of sponsored noncitizens replace applying for/receiving Food Stamps	_____
G. Total (Divide E by F)	= _____

Amount in G to be deemed income for each sponsored noncitizen.

WORKER SIGNATURE	WORKER SUPERVISOR	DATE