

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.

A D O P T

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.

- I agree to cooperate with the county and the LCSA as listed above.
- I claim good cause and refuse to cooperate at this time.

NAME OF NONCUSTODIAL PARENT/ALLEGED FATHER

- 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
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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
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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.

A D O P T

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 <input type="checkbox"/> Spouse <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Friend <input type="checkbox"/> 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)	<input type="checkbox"/> MALE <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
B. WHAT KIND OF INCOME DOES NONCUSTODIAL PARENT HAVE? <input type="checkbox"/> Earnings <input type="checkbox"/> Unemployment or Disability Insurance Benefits <input type="checkbox"/> Social Security <input type="checkbox"/> None <input type="checkbox"/> Other		LAST KNOWN EMPLOYER				
STREET ADDRESS		TELEPHONE NUMBER ()				
CITY	STATE	ZIP	TYPE OF WORK			
WHEN DID THIS PARENT LAST WORK THERE?		UNION MEMBER? <input type="checkbox"/> YES, UNION NAME <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN				
UNION ADDRESS:						
C. DOES THIS PARENT HAVE HEALTH INSURANCE FOR THE CHILDREN? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		WHO IS COVERED?				
NAME OF INSURANCE		POLICY NUMBER		DATE OF COVERAGE		
D. PARENTS ARE OR HAVE BEEN		<input type="checkbox"/> MARRIED DATE _____ WHERE _____		<input type="checkbox"/> DIVORCED DATE _____ WHERE _____		
		<input type="checkbox"/> SEPARATED <input type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> LIVING TOGETHER		
E. IS THERE A COURT ORDER FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING		AMOUNT ORDERED \$	HOW OFTEN?	DATE OF COURT ORDER	COURT ORDER NUMBER	LOCATION OF COURT (COUNTY & STATE)
HOW DOES THE PARENT PAY? <input type="checkbox"/> TO YOU <input type="checkbox"/> TO COUNTY <input type="checkbox"/> PAYROLL DEDUCTION <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		MAKE	MODEL	YEAR	LICENSE NO.	STATE
H. DOES THIS PARENT OWN A HOUSE, LAND, BUILDINGS, OR BANK ACCOUNTS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		WHAT/WHERE				
I. IS THIS PARENT CURRENTLY ON PROBATION OR PAROLE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		WHAT COUNTY OR STATE?				
J. HAS THIS PARENT EVER BEEN IN JAIL OR PRISON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		IF YES, WHEN/WHERE?				
K. HAS THIS PARENT EVER BEEN IN THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		IF YES, WHEN/WHERE?				
L. ARE YOU ABLE TO IDENTIFY OR HELP LOCATE THE NONCUSTODIAL PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						

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

NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK <input type="checkbox"/> DATE SIGNED COUNTY
NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK <input type="checkbox"/> DATE SIGNED COUNTY
NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK <input type="checkbox"/> DATE SIGNED COUNTY
NAME OF CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	SSN	BIRTHDATE	BIRTHPLACE, CITY, STATE	MFG <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK <input type="checkbox"/> 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
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R E P E A L

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

CA ① Name of Person Completing Form (First, Middle, Last) VERIFIED: YES NO

CA ② List new person in the home, including a newborn. SSN

NAME (First Middle Last)	CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National	<input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO	
SOCIAL SECURITY NUMBER	BIRTHDATE	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	IS HE/SHE A PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
BIRTHPLACE (City/State/Country)	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	SCHOOL STATUS (✓)	
MARITAL STATUS	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Has a High School Diploma	
RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Has a GED		
	<input type="checkbox"/> Currently Attending School		
		<input type="checkbox"/> Not Attending School (Explain):	
ANY OTHER NAME USED, BELOW: (Maiden, adoptive, etc.)			

Residency	YES	NO
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 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	FATHER'S NAME	Reason Other Parent Does Not Live in the Home	Child Needs Aid Due to Parent's (Check all boxes which apply)
<input checked="" type="checkbox"/> Lives in Home	<input checked="" type="checkbox"/> Lives in Home		<input type="checkbox"/> Absence
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		<input type="checkbox"/> Unemployment
<input type="checkbox"/> No	<input type="checkbox"/> No		<input type="checkbox"/> Incapacity
			<input type="checkbox"/> Death

VERIFIED: Deprivation YES NO

CA 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 <input type="checkbox"/> YES <input type="checkbox"/> NO
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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? If "NO", explain: YES NO

CA FS ⑧ A. Is he/she a foster child(ren) living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY <input type="checkbox"/> AFDC and FC Eligible/ CR Chooses: Child: <input type="checkbox"/> AFDC <input type="checkbox"/> FC CR: <input type="checkbox"/> AFDC <input type="checkbox"/> None			
FS B. Do you want the foster child and their foster care income included in the Food Stamp case? <input type="checkbox"/> YES <input type="checkbox"/> NO				
CA FS ⑨ A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO	VERIFIED: School Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No FS Eligible Student <input type="checkbox"/> Yes <input type="checkbox"/> No			
NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CA FS B. Complete below if he/she is enrolled in college or attending a similar educational institution.				
TERM <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$	VERIFIED: Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No Financial Aid <input type="checkbox"/> Yes <input type="checkbox"/> No	
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 \$		
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: <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
FS ⑫ Does he/she buy food and fix meals separately from others in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO				Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No
FS ⑬ Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO				Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No
FS ⑭ Does he/she pay you for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO				
CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY	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: <input type="checkbox"/> YES <input type="checkbox"/> 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. YES NO
 (Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form).

COUNTY USE ONLY
 If Exempt
 CA
 FS Adult
 FS Child
 FS S/E Farmer Yes No
 Verification(s) on file: Yes No

EMPLOYER NAME	SELF EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	OCCUPATION	DAYS/HOURS WORKED PER MONTH
PAY DATE(S)	WAGES BEFORE DEDUCTIONS \$ _____ per	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO	

CA FS **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) Yes No
 Health & Safety Certification (CCP 5) Yes No
 Dependent Care Eligible
 CA Yes No
 FS 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

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM	Did this person get or expect to get wages or benefits this month? If "YES", complete below. <input type="checkbox"/> YES <input type="checkbox"/> NO	
	LAST PAYCHECK RECEIVED (DATE)	AMOUNT BEFORE DEDUCTIONS \$ _____
	EXPECTED CHECK (DATE)	AMOUNT BEFORE DEDUCTIONS \$ _____
NUMBER OF HOURS OF WORK/TRAINING Last Month _____ This Month _____	LAST DAY OF WORK/TRAINING	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO
	REASON FOR LEAVING JOB/TRAINING	

	YES	NO
Emp. Statement		
Good Cause Determ		
Voluntary Quit		
<input type="checkbox"/> CA: 30 days		
<input type="checkbox"/> FS: 60 days		

CA FS **19** Is he/she on strike? If "YES", complete below: 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 \$ _____

Striker Regs Apply
 CA Yes No
 FS Yes No

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 <input type="checkbox"/> YES <input type="checkbox"/> 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
	\$ _____					START: _____ STOP: _____	CA FS

CA 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.?
 FS If "YES", complete below:

ESTIMATED	TYPE (LAND, HOUSE, AMOUNT OWED, 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 23 A. Does he/she have any of the following resources?
 FS 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 B. Does he/she get income from any of these resources, such as interest, dividends, etc.?
 FS If "YES," list each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	\$	
	\$	

CA 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.?
 FS 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
<input type="checkbox"/> Leased				<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

(✓) If Exempt Leased
 Vehicle Valuation
 Exempt
 Leased

CA 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.
 FS 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 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?
 FS 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?
 FS If "YES", complete below:

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

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

CA 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.?
 FS If "YES", complete below:

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

Health Care Options Explanation Given Referral _____
 NA _____
 DHS 8155
 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	COUNTY USE ONLY Retro Medi-Cal Requested <input type="checkbox"/> Yes <input type="checkbox"/> No Approved <input type="checkbox"/> Yes <input type="checkbox"/> No																														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">WANT MEDI-CAL</th> <th colspan="4" style="text-align: center;">WAS PAYMENT MADE</th> </tr> <tr> <td style="background-color: #cccccc;"> </td> <th colspan="2" style="text-align: center;">FOR TREATMENT?</th> <th colspan="2" style="text-align: center;">FOR THOSE MONTHS?</th> </tr> <tr> <td style="background-color: #cccccc;"> </td> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> <tr> <td style="background-color: #cccccc;"> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	WANT MEDI-CAL	WAS PAYMENT MADE					FOR TREATMENT?		FOR THOSE MONTHS?			YES	NO	YES	NO																
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	FOR TREATMENT?		FOR THOSE MONTHS?																												
	YES	NO	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? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	<input type="checkbox"/> DHS 6155																														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">NAME OF INSURANCE COMPANY</th> <th style="width:30%;">PREMIUM AMOUNT</th> <th style="width:40%;">HOW OFTEN PAID</th> </tr> <tr> <td> </td> <td style="text-align: center;">\$</td> <td> </td> </tr> <tr> <td> </td> <td style="text-align: center;">\$</td> <td> </td> </tr> </table>	NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID		\$			\$																							
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	\$																														
	\$																														
CA 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:	VERIFIED: Higher/Lower MAP <input type="checkbox"/> Yes <input type="checkbox"/> No Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C																														
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CA 32 A. Does he/she have a medical condition(s) or situation(s) that requires any of the following? <input type="checkbox"/> YES <input type="checkbox"/> NO Check (✓) each item YES or NO:	CA Special Need <input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____ VERIFIED: CA <input type="checkbox"/> Yes <input type="checkbox"/> No FS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DFA 285-C																														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> </tr> <tr> <td>Special diet—prescribed by a doctor</td> <td> </td> <td> </td> <td>Very high use of utilities</td> <td> </td> <td> </td> </tr> <tr> <td>Special transportation need</td> <td> </td> <td> </td> <td>Special laundry service</td> <td> </td> <td> </td> </tr> <tr> <td>Special telephone or other equipment</td> <td> </td> <td> </td> <td>Other (specify):</td> <td> </td> <td> </td> </tr> <tr> <td>Housework (no one in the home can do it)</td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> If "YES", explain:		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)						
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Special telephone or other equipment			Other (specify):																												
Housework (no one in the home can do it)																															
CA 32 B. Does he/she get In-Home Supportive Services (IHSS)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", how much does he/she pay each month? \$ _____	<input type="checkbox"/> 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.	<input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____ <input type="checkbox"/> Referral																														
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:60%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> </tr> <tr> <td>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. <ul style="list-style-type: none"> • 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? </td> <td> </td> <td> </td> </tr> <tr> <td>B. if anyone in the family is pregnant, you can get help finding a doctor, getting</td> <td> </td> <td> </td> </tr> <tr> <td>C. Is anyone in the family breastfeeding a child?</td> <td> </td> <td> </td> </tr> <tr> <td> If "YES", was the birth within the last 12 months?</td> <td> </td> <td> </td> </tr> <tr> <td> If "YES" checked to 33B or C, you may be eligible for services provided by the Women, Infants and Children (WIC) Special Supplemental Food Program.</td> <td> </td> <td> </td> </tr> <tr> <td>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.</td> <td> </td> <td> </td> </tr> </table>		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. <ul style="list-style-type: none"> • 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 33B 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.			<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date _____									
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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

A D O P T

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.

PLEASE PRINT IN INK

COUNTY USE ONLY		
CASE NAME _____		
CASE NUMBER _____		
WORKER NAME _____		
WORKER NUMBER _____		
DATE RECEIVED _____		
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 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 (✓) <input type="checkbox"/> U.S. Citizen/National
	<input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO

SOCIAL SECURITY NUMBER	BIRTHDATE	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	IS HE/SHE A PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------	-----------	--	---

BIRTHPLACE (City/State/Country)	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	SCHOOL STATUS (✓) <input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Currently Attending School <input type="checkbox"/> Not Attending School (Explain):
----------------------------------	--	--

MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	BLIND/DEAF/DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	
--	---	--

RELATED TO APPLICANT/CARETAKER/HEAD OF HOUSEHOLD? If "YES", explain relationship: <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER NAME USED: (Maiden, adoptive, etc.)
---	---

TYPE OF AID REQUESTED (✓) Cash Aid CalFresh

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 CF 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) <input type="checkbox"/> Absence <input type="checkbox"/> Unemployment <input type="checkbox"/> Incapacity <input type="checkbox"/> Death
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

CA CF 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 <input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------------------	---

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

CA 7 Is he/she a foster child living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO CF A. Was the child placed in your home under a dependency order from the court? <input type="checkbox"/> YES <input type="checkbox"/> NO B. Do you want the foster child and foster care income counted on the CalFresh case? <input type="checkbox"/> YES <input type="checkbox"/> NO C. Is the child enrolled in a health care plan? <input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY 7A: <input type="checkbox"/> Request dependency order 7B: CA and FC Elig/CR Chooses: Child: <input type="checkbox"/> CA <input type="checkbox"/> FC CR: <input type="checkbox"/> CA <input type="checkbox"/> None <input type="checkbox"/> Kin-GAP 7C: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Fee for Service															
CA 8 A. Is he/she 16 or older and enrolled in school, college, or a training program? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO CF	VERIFIED: School Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No CF Eligible Student <input type="checkbox"/> Yes <input type="checkbox"/> No															
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM</td> <td style="width:25%;">UNITS/HOURS PER WEEK</td> <td style="width:25%;">EXPECTED DATE OF GRADUATION</td> <td style="width:25%;">WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td colspan="4">IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):</td> </tr> </table>	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	UNITS/HOURS PER WEEK	EXPECTED DATE OF GRADUATION	WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF ENROLLED, CHECK (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):											
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CA B. Complete below if he/she is enrolled in college or attending a similar educational institution. CF																
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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 \$														
CA 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? <input type="checkbox"/> YES <input type="checkbox"/> NO CF If "YES", complete below:																
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">WHY</td> <td style="width:25%;">WHEN</td> <td style="width:50%;">WHAT COUNTY/STATE</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	WHY	WHEN	WHAT COUNTY/STATE													
WHY	WHEN	WHAT COUNTY/STATE														
CA 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: <input type="checkbox"/> YES <input type="checkbox"/> NO CF																
CA 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: <input type="checkbox"/> YES <input type="checkbox"/> NO CF																
CA 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: <input type="checkbox"/> YES <input type="checkbox"/> NO CF																
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">NAME OF PERSON CONVICTED</td> <td style="width:33%;">DATE CONVICTED</td> <td style="width:33%;">DATE CRIME COMMITTED</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED													
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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No															
CF 14 Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO	Separate household eligible <input type="checkbox"/> Yes <input type="checkbox"/> No															
CF 15 Does he/she pay you for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO																
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">CHECK (✓)</td> <td style="width:25%;">HOW MUCH</td> <td style="width:25%;">HOW OFTEN</td> <td style="width:25%;">NO. OF MEALS PER DAY</td> <td style="width:25%;">Household Elects</td> </tr> <tr> <td><input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both</td> <td>\$</td> <td> </td> <td> </td> <td>BOARDER HH MEMBER ROOMER</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY	Household Elects	<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$			BOARDER HH MEMBER ROOMER						
CHECK (✓)	HOW MUCH	HOW OFTEN	NO. OF MEALS PER DAY	Household Elects												
<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both	\$			BOARDER HH MEMBER ROOMER												
CF 16 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: <input type="checkbox"/> YES <input type="checkbox"/> NO																
NAME OF PROGRAM																

CA **17** Is he/she working now or expecting to be working in the future? YES NO
 CF 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).

COUNTY USE ONLY
 If Exempt
 CA
 CF Adult
 CF Child
 CF S/E Farmer Yes No

EMPLOYER NAME	SELF EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	OCCUPATION	DAYS/HOURS WORKED PER MONTH
PAY DATE(S)	WAGES BEFORE DEDUCTIONS \$ _____ per	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____	<input type="checkbox"/> NO

Verification(s) on file: Yes No

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

CA **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
 CF If "YES", complete below:

Child Care Informing Given to Client:
 Trustline Informing (CCP 2) Yes No
 Health & Safety Certification (CCP 5) Yes No
 Dependent Care Eligible
 CA Yes No
 CF 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 \$ _____

CA **B.** Does he/she get child care costs paid for them? YES NO
 CF 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 **19** Has he/she stopped or refused work or training in the last 60 days? YES NO
 CF If "YES", complete below:

	YES	NO
Emp. Statement		
Good Cause Determ		
Voluntary Quit		

CA: 30 days
 CF: 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. <input type="checkbox"/> YES <input type="checkbox"/> NO	
	LAST PAYCHECK RECEIVED (DATE)	AMOUNT BEFORE DEDUCTIONS \$ _____
	EXPECTED CHECK (DATE)	AMOUNT BEFORE DEDUCTIONS \$ _____
NUMBER OF HOURS OF WORK/TRAINING Last Month _____ This Month _____	LAST DAY OF WORK/TRAINING	TIPS OR COMMISSIONS <input type="checkbox"/> YES Amount \$ _____ <input type="checkbox"/> NO
	REASON FOR LEAVING JOB/TRAINING	

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

Striker Regs Apply
 CA Yes No
 CF 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 \$ _____

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

Court Order on File Yes No
 Amount Ordered
 \$ _____

NAME OF CHILD OR SPOUSE	AMOUNT PER MONTH \$ _____	COURT ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO
-------------------------	------------------------------	---

CA **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
 CF 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
	\$ _____					START: _____ STOP: _____	CA <input type="checkbox"/> CF <input type="checkbox"/>

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

CA **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
 CF If "YES", complete below:

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

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

CA **24** A. Does he/she have any of the following resources? YES NO
 CF 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 B. Does he/she get income from any of these resources, such as interest, dividends, etc.? YES NO
 CF If "YES," list each item and explain below:

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	\$	
	\$	

CA **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
 CF If "YES", complete below:

(✓) if Exempt Leased Exempt Leased
 Vehicle Valuation

NAME OF OWNER IF LEASED CHECK (✓)	HOW USED	YEAR, MAKE, MODEL	LICENSE NUMBER & STATE OF REGISTRATION	LICENSED (✓)	ESTIMATED VALUE	BALANCE OWED
<input type="checkbox"/> Leased				<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

CA **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
 CF If "YES", complete below:

Owned Jointly
 Owned Separately
 Net Market Value \$ _____

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

CA **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
 CF 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
 CF If "YES", complete below:

Total CSV
 (1) _____
 (2) _____
 Total Countable Property:
 Items 22-27
 CA \$ _____
 CF \$ _____

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

CA **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
 CF If "YES", complete below:

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

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

CA 30 Did he/she get medical/ pregnancy treatment this month or in the three months before this month? YES NO
 If "YES", complete below:

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

COUNTY USE ONLY
 Retro Medi-Cal Requested Yes No
 Approved 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? YES NO
 If "YES", complete below:

NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID
	\$	
	\$	

DHS 6155

CA 32 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
 CF 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 33 A. Does he/she have a medical condition(s) or situation(s) that requires any of the following?
 CF 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)					

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

If "YES", explain:

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

DFA 285-C

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.

	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. <ul style="list-style-type: none"> 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?		
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.		
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 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 or 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
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R E P E A L

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.

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

COUNTY USE ONLY		
CASE NAME		
CASE NUMBER		
WORKER NAME AND NUMBER		
DATE RECEIVED		

1. Parent's or Caretaker Relative's Name				Phone ()	
A CHILD'S NAME (FIRST, MIDDLE, LAST)		MOTHER'S NAME			
SOCIAL SECURITY NUMBER		SEX(✓) <input type="checkbox"/> M <input type="checkbox"/> F		FATHER'S NAME	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE		BLIND, DEAF, OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE OF AID REQUESTED: <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None		CITIZENSHIP/IMMIGRATION STATUS CHECK (✓)		SFU AU FS Non-HH/Excluded Member Code	
RELATIONSHIP TO APPLICANT/CARETAKER RELATIVE		<input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Undocumented Lawful alien: <input type="checkbox"/> Sponsored <input type="checkbox"/> Refugee <input type="checkbox"/> Other		MFG Child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
B CHILD'S NAME (FIRST, MIDDLE, LAST)		MOTHER'S NAME			
SOCIAL SECURITY NUMBER		SEX(✓) <input type="checkbox"/> M <input type="checkbox"/> F		FATHER'S NAME	
BIRTHPLACE (CITY/STATE/COUNTRY)		BIRTHDATE		BLIND, DEAF, OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE OF AID REQUESTED: <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None		CITIZENSHIP/IMMIGRATION STATUS CHECK (✓)		SFU AU FS Non-HH/Excluded Member Code	
RELATIONSHIP TO APPLICANT/CARETAKER RELATIVE		<input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Undocumented Lawful alien: <input type="checkbox"/> Sponsored <input type="checkbox"/> Refugee <input type="checkbox"/> Other		MFG Child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Did the child(ren) get cash aid or food stamps this month? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> Verification provided	
IF "YES", complete below:					
TYPE OF AID		WHERE (County, State)			
Child A <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps					
Child B <input type="checkbox"/> Cash Aid <input type="checkbox"/> 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. <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> Verification provided	
IF "YES", complete below:					
WHO	WHAT	AMOUNT (Before Deductions, If Any)	WHEN	HOW OFTEN	Income
		\$			Unearned Earned
		\$			(✓) If exempt CA FS: Adult Child
4. Is the child(ren) pregnant or a teen parent? <input type="checkbox"/> YES <input type="checkbox"/> NO				Verified: <input type="checkbox"/> Referred to Cal-Learn <input type="checkbox"/> Referred to GAIN	
NAME		AGE	CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent		
SCHOOL STATUS, CHECK (✓) STATUS					
<input type="checkbox"/> High School Diploma <input type="checkbox"/> GED		<input type="checkbox"/> Not Attending School (explain):			
<input type="checkbox"/> Currently Attending School		<input type="checkbox"/> Other (explain):			

* The Social Security Act [Section 402(a)(25)] and the Food Stamp Act of 1977 (as amended by Public Law 97-96) 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 identity 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", complete below:					COUNTY USE ONLY <input type="checkbox"/> Verification provided <input checked="" type="checkbox"/> Check if exempt <input type="checkbox"/> CA <input type="checkbox"/> FS <input type="checkbox"/> CA <input type="checkbox"/> FS
WHO	TYPE OF RESOURCE	ACCOUNT/POLICY NUMBER	NAME, ADDRESS, OF BANK, ETC.	CURRENT VALUE	
				\$	
				\$	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", list insurance coverage:					<input type="checkbox"/> Verification provided Health Coverage Code: A: _____ B: _____
Child A		Child 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?..... <input type="checkbox"/> YES <input type="checkbox"/> NO • Do you want free CHDP medical or dental services?..... <input type="checkbox"/> YES <input type="checkbox"/> NO • Do you need help making appointments or getting to the doctor or dentist?..... <input type="checkbox"/> YES <input type="checkbox"/> NO B. Do you want facts about non-discrimination, alcohol/drug counseling, past medical expenses, and other special needs?..... <input type="checkbox"/> YES <input type="checkbox"/> NO C. Does anyone who is pregnant need to find a doctor, get medical transportation, and/or other help? <input type="checkbox"/> YES <input type="checkbox"/> NO D. Is anyone breastfeeding a child?..... <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", was the birth within the last three months?..... <input type="checkbox"/> YES <input type="checkbox"/> 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?..... <input type="checkbox"/> YES <input type="checkbox"/> NO					<input type="checkbox"/> CHDP brochure and explanation given <input type="checkbox"/> Referred <input type="checkbox"/> Date: _____ <input type="checkbox"/> Other services referral <input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5. <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning info given <input type="checkbox"/> 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

<input type="checkbox"/> INELIGIBLE (Reason)			
<input type="checkbox"/> ELIGIBLE	Eligibility Conditions Met - Date:	Authorization Date:	Effective Date of Aid:
Signature of Eligibility Worker	Date	Signature of Supervisor	Date

A D O P T

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.

1. Parent's or Caretaker Relative's Name						Phone ()		CHILD NEEDS AID DUE TO PARENT'S				COUNTY USE ONLY									
2. Give us all the facts for this child.								(✓) BELOW													
CHILD'S NAME (FIRST, MIDDLE, LAST)						PARENT OR CARETAKER RELATIVE'S NAME						DEATH		DISABILITY		ABSENCE		UNEMPLOYMENT		CASE NAME	
SOCIAL SECURITY NUMBER			SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F			OTHER PARENT'S NAME						AU		Non-AU		MFG Child <input type="checkbox"/> Yes <input type="checkbox"/> No		CF Non-HH Excl. Member Code:		CASE NUMBER	
BIRTHPLACE (CITY/STATE/COUNTRY)						BIRTHDATE (MONTH, DAY, YEAR)						BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO				DATE RECEIVED					
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> CalFresh						CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> YES <input type="checkbox"/> NO						Work Registration/Exemption Codes: WtW: CF:				VERIF: <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled Citizen <input type="checkbox"/> SAVE <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> Immun.					
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE						IF CHILD IS UNDER AGE 6, ARE IMMUNIZATION SHOTS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not under age 6						Alien Reg. No.				D.O.E.					
3. Is the child a foster child? A. Was the child placed in your home under a dependency order from the court? <input type="checkbox"/> YES <input type="checkbox"/> NO B. Do you want the foster child and foster care income counted on the CalFresh case? <input type="checkbox"/> YES <input type="checkbox"/> NO C. Is the child enrolled in a health care plan? <input type="checkbox"/> YES <input type="checkbox"/> NO												3A. <input type="checkbox"/> Request dependency order 3B. <input type="checkbox"/> CA and FC Elig/CR Chooses: Child: <input type="checkbox"/> CA <input type="checkbox"/> FC CR: <input type="checkbox"/> CA <input type="checkbox"/> None <input type="checkbox"/> Kin-GAP 3C. <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Fee for Service									
4. Did the child get cash aid or CalFresh this month? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:												<input type="checkbox"/> Verification provided									
TYPE OF AID						WHERE (County, State)															
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: <input type="checkbox"/> YES <input type="checkbox"/> NO												<input type="checkbox"/> Verification provided <input type="checkbox"/> FC Income Counted on CF Case <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CA Eligible for Higher MAP									
TYPE OF INCOME			AMOUNT (Before Deductions, if any)			WHEN			HOW OFTEN			Income		(✓) if exempt							
			\$									Unearned		Earned		CA		CF			
Will this income continue? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain any known changes:																					
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? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", explain why he/she does not attend regularly: <input type="checkbox"/> Not Age 6-16												Verified: <input type="checkbox"/> Referred to Cal-Learn Program <input type="checkbox"/> CW 25 <input type="checkbox"/> QR 25A									
B. Is the child pregnant or a teen parent? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", Check (✓) status: <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent																					
SCHOOL STATUS, CHECK (✓)																					
<input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Not Attending School (explain): <input type="checkbox"/> Currently Attending School <input type="checkbox"/> Other (explain):																					
C. Has the child received a cash bonus or sanction, or help with child care, transportation, etc. from the Cal-Learn Program? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:																					
WHERE (COUNTY)						DATE(S) RECEIVED															
7. Has the parent(s) of this child been in the United States (U.S.) military? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:												CW 5 <input type="checkbox"/> YES <input type="checkbox"/> NO Date Initiated									
NAME OF PARENT		PARENT A U.S. CITIZEN		BRANCH OF SERVICE		DATES OF SERVICE		HONORABLE DISCHARGE													
		<input type="checkbox"/> YES <input type="checkbox"/> NO						<input type="checkbox"/> YES <input type="checkbox"/> NO		CF: Honorable Discharge <input type="checkbox"/> YES <input type="checkbox"/> NO											
8. Complete below if you want CalFresh for this child and the child is not a citizen of the U.S.																					
A. How many years total has this child and/or his/her parents lived in the U.S.?																					
B. While living in the U.S., in how many of the years did this child and/or the child's parents earn money by working in the U.S.?																					
C. While living outside the U.S., how many total years did this child and/or the child's parents work in the U.S. or for a U.S. company?																					

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:				<input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY <input type="checkbox"/> Verification provided <input type="checkbox"/> CA Restricted Account <input checked="" type="checkbox"/> Check if exempt <input type="checkbox"/> CA <input type="checkbox"/> 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:				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> 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?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
12. Has the child been found by a court of law to be in violation of probation or parole?				<input type="checkbox"/> YES <input type="checkbox"/> 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.				<input type="checkbox"/> YES <input type="checkbox"/> NO	
DATE CONVICTED		DATE CRIME COMMITTED			

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).			YES	NO	<input type="checkbox"/> CHDP brochure and explanation given <input type="checkbox"/> CHDP Referral <input type="checkbox"/> Date: <input type="checkbox"/> Referred for Immunization <input type="checkbox"/> Other services referral <input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning info given Date Referred:
• 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?.....					

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

<input type="checkbox"/> INELIGIBLE (Reason)				IMMUNIZATION <input type="checkbox"/> Informing (CW 101 / TEMP CW 101A) Regs Met: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> ELIGIBLE	Eligibility Conditions Met - Date:	Authorization Date:	Effective Date of Aid:		
Signature of County Worker	Date	Signature of Supervisor		Date	

A D O P T

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).

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.?
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.
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.
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.

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

A D O P T

**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 \$
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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

A D O P T

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
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A D O P T

APPLICANT TEST

CASE NAME	CASE NUMBER	CASE WORKER NAME	DATE
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- 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)?	
<input type="checkbox"/> YES; eligible, complete CW 30.	
<input type="checkbox"/> NO; ineligible.	

SELF-EMPLOYMENT INCOME CALCULATION		
EARNINGS FROM SELF-EMPLOYMENT	PERSON 1 Line 5a	PERSON 2 Line 5d
Gross earnings from self employment	\$	\$
Expenses <input type="checkbox"/> Actual <input type="checkbox"/> 40%	-	-
Net self-employment income (Include in line 5 for appropriate person)	\$	\$

A D O P T

CALWORKS BUDGET WORKSHEET

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

CASE NAME: _____		CASE NUMBER: _____		SECTION C: GRANT COMPUTATION	
DATA MONTH _____		PAYMENT QUARTER _____		18. Maximum Aid Payment for _____ Family Member (A & C). \$	
<input type="checkbox"/> STANDARD MAP		<input type="checkbox"/> EXEMPT MAP		a. Net nonexempt income (enter amount from line 11 or 15). -	
WORKER NAME: _____				b. Special needs other than HA, (A, C, D) +	
WORKER #: _____		DATE: _____		c. Potential Grant \$	
NAME	Check (✓) One				
	(A) AU (non MFG and non-penalized)	(B) Penalized AU	(C) non-AU (if income counted or oblig. non citizen)	(D) MFG	(E) SANCTIONED
SECTION A: DISABILITY BASED INCOME (DBI)				19. Maximum Aid Payment for _____ persons. (A) \$	
1. Total Average DBI of A, B, C, D, E \$				a. Special Need other than HA (A & D). +	
2. Minus \$225 DBI disregard (If #1 is \$225 or more) or -				b. Subtotal \$	
3. Minus DBI disregard (If #1 is less than \$225) -				c. Aid Payment (lesser of 18c or 19b). \$	
4. DBI Remainder (#1 - #2) -				20. Proration figure	
5. Unused DBI disregard (\$225 - #3) -				Date: _____ X	
SECTION B: EARNED INCOME (EI)				21. Prorated Aid Payment \$	
1. Average monthly earnings from Self-Employment of A, B, C, D, E \$				22. Other adjustments imposed upon the AU:	
2. Minus Self-Employment expenses Actual <input type="checkbox"/> or 40% <input type="checkbox"/> -				a. Child Support non-co-op (25% of Aid Payment) -	
3. Subtotal =				b. Overpayment adjustment -	
4. Other EI of A, B, C, D, E, (From income worksheet) \$				c. Other penalties -	
5. Total Gross EI (#3 + #4) =				d. School bonus +	
6. Unused DBI Disregard (Section A, #5 or \$112, whichever is less) -				23. Adjusted Aid Payment \$	
7. Subtotal =				SECTION D: BUDGET RECOMPUTATION	
8. 50% EI Disregard (#7 divided by 2) =				24. Actual Cash Aid Paid \$	
9. Subtotal: Net Nonexempt Income (#7 - #8) =				a. Adjusted Aid Payment (amount from line 23). \$	
10. Nonexempt DBI (Section A, #4) +				b. Subtotal =	
11. Other Nonexempt Income of A, B, C, D, E including child/spousal support for C, E (but not A, B, D) +				25. Overpayment Amount (line 24b) \$	
12. Subtotal: Net Nonexempt income for grant computation (#9 + #10 + #11) \$				26. Underpayment if line 23 is greater than line 24. \$	
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 <input type="checkbox"/> YES <input type="checkbox"/> NO					

MONTH 1: _____

QR INCOME WORKSHEET

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 *	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

A D O P T

CalWORKs BUDGET WORKSHEET

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

CASE NAME: _____		CASE NUMBER: _____		SECTION B: GRANT COMPUTATION	
DATA MONTH _____		PAYMENT PERIOD _____		18. Maximum Aid Payment for _____	
<input type="checkbox"/> STANDARD MAP		<input type="checkbox"/> EXEMPT MAP		Family Member (A & C). \$	
WORKER NAME: _____				a. Net nonexempt income (enter amount from line 11 or 15). -	
WORKER #: _____		DATE: _____		b. Special needs other than HA, (A, C, D) +	
NAME	Check (✓) One				
	(A) AU (non MFG and non-penalized)	(B) Penalized AU	(C) non-AU (if income counted or not for child)	(D) MFG	(E) SANCTIONED
SELF-EMPLOYMENT INCOME CALCULATION					
EARNINGS FROM SELF-EMPLOYMENT		PERSON 1		PERSON 2	
Gross earnings from self employment		\$		\$	
Expenses					
<input type="checkbox"/> Actual <input type="checkbox"/> 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.				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				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.

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

A D O P T

REFERRAL TO LOCAL CHILD SUPPORT AGENCY (LCSA)

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

<input type="checkbox"/> TO LCSA REPRESENTATIVE	CASE NAME	DATE OF REFERRAL
<input type="checkbox"/> FROM CWD REPRESENTATIVE CW # PHONE	APPLICANT/RECIPIENT NAME (LAST, FIRST, MIDDLE)	AID TYPE/CASE NUMBER
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.

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 <input type="checkbox"/> MFG RULE APPLIES
CHILD'S NAME	DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES
CHILD'S NAME	DATE OF BIRTH <input type="checkbox"/> MFG RULE APPLIES
CHILD'S NAME	DATE OF BIRTH <input type="checkbox"/> 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 \$
---------------	-------------------------------

TO CWD REPRESENTATIVE CW #

DISCONTINUANCE DATE

FROM LCSA REPRESENTATIVE PHONE

REASON/CODE FOR DISCONTINUANCE

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)

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.

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.

A D O P T

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.

R E P E A L

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.

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 might get more benefits than you should. You **must** repay any extra benefits you get. If you do not report on purpose to try to get more benefits, this is fraud, and you may be charged with a crime and/or may no longer get CalFresh for a period of time or life.

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 has been found by a court of law to be in violation of a condition of probation or parole.
3. Anytime someone joins, or is in your household, who is running from the law (has a warrant out for their arrest).
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. Income over your IRT.
2. If you are an Able Bodied Adult Without Dependents (ABAWD), you must report anytime 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.

Note: Some changes you report voluntarily may result in a decrease in your CalFresh benefits.

A D O P T

**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 (_____) _____

- | | |
|---|---|
| <input type="checkbox"/> I receive free rent at this new address. | <input type="checkbox"/> I receive free utilities at this new address. |
| <input type="checkbox"/> My rent amount is \$ _____ per month. | <input type="checkbox"/> My utilities are \$ _____ per month. |
| <input type="checkbox"/> I share the rent (explain) | I have: <input type="checkbox"/> Heating <input type="checkbox"/> Cooling |
| | <input type="checkbox"/> Water <input type="checkbox"/> Sewer |
| | <input type="checkbox"/> Garbage <input type="checkbox"/> Telephone |
| | <input type="checkbox"/> 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

A D O P T

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 (_____) _____

- | | |
|--|---|
| <input type="checkbox"/> I get free rent at this new address. | <input type="checkbox"/> I get free utilities at this new address. |
| <input type="checkbox"/> My rent amount is \$ _____ per month. | <input type="checkbox"/> My utilities are \$ _____ per month. |
| <input type="checkbox"/> I share the rent; my share is \$ _____. | I have: <input type="checkbox"/> Heating <input type="checkbox"/> Cooling |
| <input type="checkbox"/> I became homeless. | <input type="checkbox"/> Water <input type="checkbox"/> Sewer |
| | <input type="checkbox"/> Garbage <input type="checkbox"/> Telephone |
| | <input type="checkbox"/> 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

A D O P T



ELIGIBILITY/STATUS REPORT

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 YES NO
ATTACH PROOF.

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 <input type="checkbox"/>	Who pays?	Amount \$	Who gets care?	What changed?	When will it change?
Dependent Care <input type="checkbox"/>	Who pays?	Amount \$	Who gets care?	What changed?	When will it change?
Court-Ordered Child Support <input type="checkbox"/>	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 \$	<input type="checkbox"/> Bought	<input type="checkbox"/> Sold	<input type="checkbox"/> Won
				<input type="checkbox"/> Gift Received	<input type="checkbox"/> Traded	<input type="checkbox"/> Gave Away
Checking Account <input type="checkbox"/> Opened <input type="checkbox"/> Closed Balance \$	Savings Account <input type="checkbox"/> Opened <input type="checkbox"/> 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



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?
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> Phone <input type="checkbox"/> Trash <input type="checkbox"/> Water <input type="checkbox"/> Electric/Gas <input type="checkbox"/> 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? _____
If Yes, Attach proof.

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:	<input type="checkbox"/> Bought <input type="checkbox"/> Sold <input type="checkbox"/> Gave Away <input type="checkbox"/> Spent
				<input type="checkbox"/> Got as a gift <input type="checkbox"/> Traded <input type="checkbox"/> Won <input type="checkbox"/> 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 <input type="checkbox"/>	Self-employed, check here <input type="checkbox"/>	Self-employed, check here <input type="checkbox"/>
How often paid:	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly
Gross amount they got, list here:	\$ \$ \$ \$ \$ \$	\$ \$ \$ \$ \$ \$	\$ \$ \$ \$ \$ \$
Hours worked per month:			
Will this income continue?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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

ADOPT

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

SAR 7 ELIGIBILITY STATUS REPORT



REPORT MONTH _____

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?
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> In <input type="checkbox"/> Out / /		/ /		<input type="checkbox"/> YES <input type="checkbox"/> 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 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. CalWORKs only: Is anyone in your home:
 A. A felon whose conviction was drug-related?
 B. Running from an outstanding warrant?
 C. Found by a court to be 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: If anyone who gets CalFresh and is 60 years old or older, or disabled, had an increase in medical costs please 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? _____
 If Yes, Attach proof.

7. Dependent or Child Care: If anyone who gets CalFresh and either works, is looking for work, or is going to school, had an increase in dependent care or child care costs since they last reported, please complete the section below and attach proof: 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:	<input type="checkbox"/> Bought <input type="checkbox"/> Sold <input type="checkbox"/> Gave Away <input type="checkbox"/> Spent <input type="checkbox"/> Got as a gift <input type="checkbox"/> Traded <input type="checkbox"/> Won <input type="checkbox"/> 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 <input type="checkbox"/>	Self-employed, check here <input type="checkbox"/>	Self-employed, check here <input type="checkbox"/>
How often paid:	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other <input type="checkbox"/> Monthly <input type="checkbox"/> Twice monthly
Gross amount of income they got in the report month:	\$	\$	\$
	DATE RECEIVED:	DATE RECEIVED:	DATE RECEIVED:
Hours worked per month:			

Will there be any changes to your job or income in the next six months? Examples: Stopping or starting a job; 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. CalWORKs only: 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 SAR 7 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, registered domestic partner, or 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

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.

- ①e 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.**

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

HOW TO FILL OUT YOUR SAR 7 ELIGIBILITY STATUS REPORT**For Cash Aid and CalFresh (formerly known as Food Stamp) Benefits**

Save this form to help you fill out your SAR 7 (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 number, and changes in housing costs since you last reported. This includes: newborns; people who are temporarily absent from the home; anyone who dies, 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, who is 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 costs 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 includes 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, or the other parent (of cash-aided children), 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

RUNNING FROM THE LAW: 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 law enforcement was looking for them.

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

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 report month.

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 the 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 penalties are: 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

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 | <ul style="list-style-type: none"> • Wages • Vacation pay • Child/spousal support • Insurance or legal settlements • Rental income and rental assistance • Any government benefits • State Disability Indemnity | <ul style="list-style-type: none"> • Self-Employment • Tips • Interest or dividends • Strike benefits • Tax refunds • Unemployment • Social Security • Supplemental Security Income/State Supplementary Payment (SSI/SSP) | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Motor vehicles • EBT balance • Home | <ul style="list-style-type: none"> • Checking • Savings Bonds • Land | <ul style="list-style-type: none"> • Savings • Life insurance policies • Trusts |
| Housing Costs | <ul style="list-style-type: none"> • Rent • Utilities | <ul style="list-style-type: none"> • Mortgage • Homeowners insurance | <ul style="list-style-type: none"> • Property taxes • Garbage/trash collection fees |
| Expenses | <ul style="list-style-type: none"> • Medical expenses • Health insurance premiums • Child/dependent Care | <ul style="list-style-type: none"> • College tuition & supplies • Mandatory school fees • Child/spousal support | <ul style="list-style-type: none"> • 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.

**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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Self-Employment • Tips • Interest or dividends • Strike benefits • Tax refunds • Unemployment • Social Security • Supplemental Security Income/State Supplementary Payment (SSI/SSP) | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Motor vehicles • EBT cash aid balance • Home | <ul style="list-style-type: none"> • Checking • Savings Bonds • Land | <ul style="list-style-type: none"> • Savings • Life insurance policies • Trusts |
| Housing Costs | <ul style="list-style-type: none"> • Rent • Utilities | <ul style="list-style-type: none"> • Mortgage • Homeowners insurance | <ul style="list-style-type: none"> • Property taxes • Garbage/trash collection fees |
| Expenses | <ul style="list-style-type: none"> • Medical expenses • Health insurance premiums • Child/dependent Care | <ul style="list-style-type: none"> • College tuition & supplies • Mandatory school fees • Child/spousal support | <ul style="list-style-type: none"> • 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.

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.

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.

- **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)

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

[Empty box for 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

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.

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

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:

Name of Person(s)	Does Person Live With Sponsor
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

VERIFIED:
 Letter on File
 Verbal Communication
 Other: _____

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

Verified
 Verified
 IRS Form 1040 Reviewed
 Other: _____

Claimed Yes No
Claimed Yes No
Claimed Yes No
Claimed Yes No
Claimed Yes No

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.

COUNTY USE ONLY

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
		\$		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	Pay Stubs Other
		\$		\$		<input type="checkbox"/> Yes <input type="checkbox"/> 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:
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trust Funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking, Savings, Credit Union Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stocks, Bonds, Certificates	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Notes, Mortgages, Trust Deeds, Sales Contracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Type of Resource	Owner	Current Value	Location (Home, Bank, Address, etc.)	Account Number	Check if Exempt
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> 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
				\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

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
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

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
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		1. _____
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		2. _____
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		3. _____
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> 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	CalWORKs Sponsor/Sponsor's Spouse Income Computation	Food Stamp Sponsor/Sponsor's Spouse Computation																																																																																																																																		
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">A. ITEMS</td> <td style="width:10%; text-align: center;">VALUE</td> <td style="width:10%;"></td> </tr> <tr> <td>_____</td> <td style="text-align: center;">\$</td> <td>_____</td> <td>A. Earned Income</td> <td style="text-align: center;">\$</td> <td>_____</td> <td>A. Earned Income</td> <td style="text-align: center;">\$</td> <td>_____</td> <td></td> </tr> <tr> <td>_____</td> <td style="text-align: center;">\$</td> <td>_____</td> <td>B. Unearned Income</td> <td style="text-align: center;">+</td> <td>_____</td> <td>B. Less 20%</td> <td style="text-align: center;">-</td> <td>_____</td> <td></td> </tr> <tr> <td>_____</td> <td style="text-align: center;">\$</td> <td>_____</td> <td>C. Subtotal</td> <td style="text-align: center;">=</td> <td>_____</td> <td>C. Unearned Income</td> <td style="text-align: center;">+</td> <td>_____</td> <td></td> </tr> <tr> <td>_____</td> <td style="text-align: center;">\$</td> <td>_____</td> <td>D. Total number of sponsored noncitizens applying for/receiving CalWORKs</td> <td></td> <td>_____</td> <td>D. Gross Income Deduction for Sponsor's household size</td> <td style="text-align: center;">-</td> <td>_____</td> <td></td> </tr> <tr> <td>_____</td> <td style="text-align: center;">\$</td> <td>_____</td> <td>E. Divide C by D</td> <td style="text-align: center;">=</td> <td>_____</td> <td>E. Subtotal</td> <td style="text-align: center;">=</td> <td>_____</td> <td></td> </tr> <tr> <td>B. Total</td> <td style="text-align: center;">\$</td> <td></td> <td>F. Number of sponsored noncitizens in this AU</td> <td></td> <td>_____</td> <td>F. Total number of sponsored noncitizens replace applying for/receiving Food Stamps</td> <td></td> <td>_____</td> <td></td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">CW FS</td> <td>G. Total (Multiply E by F)</td> <td style="text-align: center;">=</td> <td>_____</td> <td>G. Total (Divide E by F)</td> <td style="text-align: center;">=</td> <td>_____</td> <td></td> </tr> <tr> <td>C. Less: Food Stamp Deduction (\$1500)</td> <td></td> <td style="text-align: center;">NA \$1500</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>D. Equals Subtotal</td> <td style="text-align: center;">=</td> <td>_____</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>E. Total number of sponsored noncitizens applying for/receiving CW/FS</td> <td></td> <td>_____</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>F. Total (Divide D by E)</td> <td style="text-align: center;">=</td> <td>_____</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Amount in F to be included in each noncitizen's property limits.</td> <td></td> <td></td> <td>Amount in G to be deemed income for entire AU.</td> <td></td> <td></td> <td>Amount in G to be deemed income for each sponsored noncitizen.</td> <td></td> <td></td> <td></td> </tr> </table>	A. ITEMS	VALUE									_____	\$	_____	A. Earned Income	\$	_____	A. Earned Income	\$	_____		_____	\$	_____	B. Unearned Income	+	_____	B. Less 20%	-	_____		_____	\$	_____	C. Subtotal	=	_____	C. Unearned Income	+	_____		_____	\$	_____	D. Total number of sponsored noncitizens applying for/receiving CalWORKs		_____	D. Gross Income Deduction for Sponsor's household size	-	_____		_____	\$	_____	E. Divide C by D	=	_____	E. Subtotal	=	_____		B. Total	\$		F. Number of sponsored noncitizens in this AU		_____	F. Total number of sponsored noncitizens replace applying for/receiving Food Stamps		_____				CW FS	G. Total (Multiply E by F)	=	_____	G. Total (Divide E by F)	=	_____		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.			Amount in G to be deemed income for entire AU.			Amount in G to be deemed income for each sponsored noncitizen.					
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WORKER SIGNATURE	WORKER SUPERVISOR	DATE
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SPONSORED NONCITIZENS APPLYING FOR OR RECEIVING CASH AID AND/OR CALFRESH

Important Information For Noncitizens Sponsored By Individuals

As a noncitizen who is sponsored by an individual(s), you must meet special rules to get Cash Aid and/or CalFresh.

The Special Rules Are:

- Your sponsor's income and resources will have to be reviewed to see if you can get benefits. Your sponsor must fill out the attached form. Both you and your sponsor must sign this form.
- If your application is approved, you and your sponsor will have to report your income and resources every six months to keep getting Cash Aid and CalFresh 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 keep getting their benefits.
- **You are the person responsible for getting all the information requested to the county welfare department for both you and your sponsor. Let the county know if you need help.**
- If your sponsor has abandoned you (you don't know where they are or they don't help you out) you might still be able to get benefits.

Important Information For Sponsors

The noncitizen you sponsor has applied for Cash Aid and/or CalFresh. If you signed an affidavit of support, State regulations require the county welfare department to review 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 semi-annual period (every six months)** you will have to report your income, resources, and property on either this form or on the Sponsor's Semi-Annual Income and Resources Report (SAR 72). The noncitizen will give you the report form. Your report must be completed and returned to the noncitizen immediately to ensure the noncitizen's continued eligibility. Each semi-annual period, 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**

(Supplement to the SAWS 2, Application For CalFresh And Cash Aid)

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.

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

Noncitizen Name and Address

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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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③ Do you or your spouse get assistance such as: CalWORKs/TANF/cash assistance, CalFresh/SNAP/food benefits or Supplemental Security Income (SSI)? If Yes, complete below: Yes No

Case Name	Date of Birth	Type of Assistance	County	State

If **both** you and your spouse get Assistance and the noncitizen is **not** applying for CalFresh, 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.

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

Type of Assistance	Date First Applied	County	State

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:

Name of Person(s)	Does Person Live With Sponsor	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claimed <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claimed <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claimed <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claimed <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claimed <input type="checkbox"/> Yes <input type="checkbox"/> No

VERIFIED:
 Letter on File
 Verbal Communication
 Other: _____

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

Verified
 Verified
 IRS Form 1040 Reviewed
 Other: _____

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Enter Date Viewed	
							Pay Stubs	Other
		\$		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		\$		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No		

COUNTY USE ONLY

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify Verification and Date Reviewed:
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	

8 Will there be any changes to this income in the next six months? Yes No
If Yes, list below what change is expected. Attach any proof you may have such as: a letter from an employer, benefit award letter, etc.

Whose income will change?	What income will change?	How and when will it change?

9 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trust Funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking, Savings, Credit Union Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stocks, Bonds, Certificates	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Notes, Mortgages, Trust Deeds, Sales Contracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Type of Resource	Owner	Current Value	Location (Home, Bank, Address, etc.)	Account Number	Check if Exempt <input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No

10 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$	\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

11 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Verified

13 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
		\$
		\$
		\$
		\$

14 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount Owed	Net Market Value
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		1. _____
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		2. _____
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		3. _____
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No		4. _____

CERTIFICATION

- I understand that if on purpose I don't give the right facts or all the facts for the CalWORKs, CalFresh 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 CalFresh. And, I can go to jail/prison for up to 5 years for CalWORKs and 20 years for CalFresh. In the CalWORKs and CalFresh 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 CalFresh benefits 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 SPOUSE 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 CalFresh 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	CalWORKs Sponsor/Sponsor's Spouse Income Computation	CalFresh Sponsor/Sponsor's Spouse/Registered Domestic Partner Computation																																																																														
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WORKER SIGNATURE	WORKER SUPERVISOR	DATE
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