Quarterly Report of Medi-Cal Recipients Requesting CHDP Services

County/City	Fiscal Year

Reporting Quarter

Beginning Month	Ending Month

Number of CalWORKS and Foster Care (AFDC) Recipients Requesting CHDP Services	
Number of Medi-Cal Only Recipients Requesting CHDP Services	
Total	

Signature of CHDP Representative

Send to: Program Support Section Chief
Children's Medical Services Branch
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

Statement of Citizenship, Alienage, and Immigration Status (MC 13)

Online Version: www.dhs.ca.gov/publications/forms/pdf/mc013.pdf

State of California—Health and Human Services Agency | Department of Health Services

STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS

Print name of applicant (the applicant is the person who wants Medi-Cal)	Date
Print name of person acting for applicant	Relationship to applicant

SECTION A: MEDI-CAL BENEFITS TO CITIZENS AND ALIENS

Citizens and nationals of the United States who meet all eligibility requirements may receive full Medi-Cal benefits.

Aliens who meet all eligibility requirements may receive either full Medi-Cal benefits (if they are in a satisfactory immigration status) or restricted benefits limited to emergency and pregnancy-related services (if they are not in a satisfactory immigration status).

Satisfactory immigration status and full Medi-Cal benefits for aliens: Federal and state law provide that *full* Medi-Cal benefits may be received only by aliens who are in a satisfactory immigration status and who meet all eligibility requirements **including California residency**. Aliens are in a satisfactory immigration status if they are amnesty aliens with valid and current lawful temporary resident cards (I-688) or lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). **The 16 PRUCOL categories are listed in SECTION B, question 6 below.**

Documented aliens not in a satisfactory immigration status who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Undocumented aliens who meet all eligibility requirements, **including California residency**, may receive restricted benefits (limited to emergency and pregnancy-related services).

Citizenship/immigration status information: Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential and cannot be used by the INS for immigration enforcement unless you are committing fraud.

Alien status documents and verification requirements: Aliens who claim to be in a satisfactory immigration status (SIS) for Medi-Cal purposes must present INS documents that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in an SIS, but who cannot obtain an INS document or replacement receipt (for example, aliens in the last PRUCOL category indicated in SECTION B below) should submit other evidence establishing their immigration status. INS documents will be verified by the INS. Aliens who do not have these documents with them, or who have unreadable documents, may bring us receipts which show that they have applied for replacements. Aliens will have 30 days to do this, or until their Medi-Cal application is ruled on, whichever is longer. If the alien is otherwise eligible, Medi-Cal will be issued during this period and while the submitted documentation is being verified by the INS. If none of the documents contains the applicant's photograph, they must show us an identity document which establishes that the applicant is the person named in the documents.

Social Security number requirement: Every person requesting Medi-Cal who has a Social Security number is asked to provide it to the county welfare department. U.S. citizens, U.S. nationals, and aliens claiming to be in a satisfactory immigration status who do not have a Social Security number must apply for one and provide it to the county welfare department. Aliens in satisfactory immigration status for Medi-Cal purposes who need help applying for a Social Security number should ask their eligibility worker for assistance. Aliens who are not in a satisfactory immigration status and who do not have a Social Security number can still get restricted Medi-Cal if they meet all eligibility requirements.

SECTION B: CITIZENSHIP/IMMIGRATION STATUS DECLARATION

1. Is the applicant a citizen or national of the United States? ☐ Yes ☐ No

   If the applicant is a citizen or a national of the United States, where was he/she born? _____ (city, state)

   IF YOU ARE A CITIZEN OR NATIONAL OF THE UNITED STATES, GO DIRECTLY TO SECTION D. IF YOU ARE AN ALIEN, PLEASE ANSWER QUESTIONS 2, 3, AND 4 BELOW (AND QUESTION 5 IF YOU CLAIM TO BE PRUCOL) THEN COMPLETE SECTIONS C AND D. **IF YOU ANSWER "NO" TO QUESTIONS 2, 3, OR 4 BECAUSE THOSE CATEGORIES DO NOT APPLY TO YOU, YOUR ANSWER IS CONFIDENTIAL. THIS INFORMATION CAN ONLY BE USED FOR MEDI-CAL PURPOSES AND CANNOT BE USED BY THE INS FOR IMMIGRATION ENFORCEMENT UNLESS YOU ARE COMMITTING FRAUD.**

2. Is the applicant an amnesty alien with a valid and current I-688? ☐ Yes ☐ No
3. Is the applicant a lawful permanent resident? ☐ Yes ☐ No
4. Is the applicant a PRUCOL alien? ☐ Yes ☐ No

IMPORTANT: All PRUCOL aliens must indicate their specific PRUCOL status in question 5.

5. If the applicant would qualify for Medi-Cal benefits as a PRUCOL alien, indicate the status category which entitles him/her to that classification:

   ☐ A conditional entrant admitted to the United States before April 1, 1980

   ☐ An alien paroled into the United States, including Cuban/Haitian entrants

MC 13 (11/99)

- ☐ An alien subject to an Order of Supervision
- ☐ An alien granted an indefinite stay of deportation
- ☐ An alien granted an indefinite voluntary departure
- ☐ An alien on whose behalf an immediate relative petition (INS Form I-130) has been approved and who is entitled to voluntary departure
- ☐ An alien who has properly filed an application for lawful permanent resident status
- ☐ An alien granted a stay of deportation for a specified period
- ☐ An alien granted asylum
- ☐ A refugee admitted to the United States since April 1, 1980
- ☐ An alien granted voluntary departure who is awaiting issuance of a visa
- ☐ An alien in deferred action status
- ☐ An alien who entered and has continuously resided in the United States since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry Alien)
- ☐ An alien granted a suspension of deportation whose departure INS does not contemplate enforcing
- ☐ An alien granted withholding of deportation pursuant to INA Section 243(h)
- ☐ An alien, not in one of the above categories, who can show that: (1) INS knows he/she is in the United States; and (2) INS does not intend to deport him/her, either because of the person's status category or individual circumstances

SECTION C: VERIFICATION OF IMMIGRATION STATUS (FOR ALIENS WHO CLAIM SATISFACTORY IMMIGRATION STATUS)

IMPORTANT: Complete this section only if you answered "yes" to questions 2, 3, or 4 in SECTION B on the front of this form.

1. Alien Registration number and/or Alien Admission number (INS Form I-94): _____
2. Date the applicant first entered the United States: _____
3. Applicant's name when he/she first entered the United States: _____
4. Of what country is the applicant a citizen: _____
5. Where was the applicant born: _____

SECTION D: SOCIAL SECURITY NUMBER

Does the applicant have a Social Security number (SSN)? (Aliens who are not in a satisfactory immigration status, and who do not have an SSN, can still get restricted Medi-Cal if they meet all eligibility requirements.)

- ☐ Yes, the applicant's Social Security number is: _____
- ☐ No

SECTION E:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Applicant signature	Date
Signature of person acting for applicant	Date

FOR COUNTY USE ONLY

EW number: _____ County: _____ Date: _____

Action taken:

- ☐ None necessary.
- ☐ SAVE primary verification performed. Date: _____
- ☐ Document Verification Request (INS Form G-845) and copies of documentation of satisfactory immigration status sent to INS Date: _____
- ☐ Full Medi-Cal benefits were granted pending verification of immigration status
- ☐ Copies of alien status documents are in the case file.
- ☐ Person referred to INS to obtain replacement documents. Date: _____

COUNTY DETERMINATION OF THE APPROPRIATE LEVEL OF MEDI-CAL BENEFITS.

Based on the information provided on this form:

- ☐ The above named applicant is a U.S. citizen or national, or an alien, who, if otherwise eligible, would receive **FULL** Medi-Cal benefits
- ☐ The above named applicant is an alien, who, if otherwise eligible, would receive **RESTRICTED** Medi-Cal benefits.

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Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/State-Run County Medical Services Program (SAWS 2)

Online Version: www.dss.cahwnet.gov/pdf/SAWS2.pdf

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY

WORK PAYS

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS, AND MEDI-CAL/ STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (CMSP)

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

COUNTY USE ONLY
CASE NAME
CASE NUMBER
WORKER DATE ROD

☐ New ☐ Restoration
☐ Redetermine ☐ Recertification
☐ Residency Verified
☐ FS ID
☐ FS Aged/Disabled Verified
☐ MC ID
☐ MC Minor Consent: Exempt from ID, Residency, SSN, Verifs

CA FS MC (1) A. **Person applying, or caretaker relative of child(ren) for whom aid is wanted.**
NAME:
HOME PHONE ( )
HOME ADDRESS (NUMBER, STREET) | MAILING ADDRESS (IF DIFFERENT) | DAYTIME PHONE ( )
CITY STATE ZIP CODE | CITY STATE ZIP CODE

FS B. **Are you homeless?** ☐ YES ☐ NO
If "YES": Are you temporarily staying in someone else's home? ☐ YES ☐ NO
If "YES": Give date you began staying at this home:

(2) **For each ADULT living in the home, give us all the facts.**

CA FS MC (A) ADULT'S NAME (FIRST, MIDDLE, LAST)
CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO
☐ AU ☐ NON-AU ☐ MFBU
FS Non-HH/Excluded Member Code:
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE (MONTH DAY YEAR) | SOCIAL SECURITY NUMBER
Work Registration/Exemption Codes: WELFARE to WORK | FS | ABAWD
SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO
BIRTHPLACE CITY STATE COUNTRY
VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Noncitizen ☐ SAVE
TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal ☐ State CMSP
MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed
Alien Reg. # D.O.E.

CA FS MC (B) ADULT'S NAME (FIRST, MIDDLE, LAST)
CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO
☐ AU ☐ NON-AU ☐ MFBU
FS Non-HH/Excluded Member Code:
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE (MONTH DAY YEAR) | SOCIAL SECURITY NUMBER
Work Registration/Exemption Codes: WELFARE to WORK | FS | ABAWD
SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO
BIRTHPLACE CITY STATE COUNTRY
VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Noncitizen ☐ SAVE
TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal ☐ State CMSP
MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed
Alien Reg. # D.O.E.

CA FS MC (C) ADULT'S NAME (FIRST, MIDDLE, LAST)
CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO
☐ AU ☐ NON-AU ☐ MFBU
FS Non-HH/Excluded Member Code:
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) | BIRTHDATE (MONTH DAY YEAR) | SOCIAL SECURITY NUMBER
Work Registration/Exemption Codes: WELFARE to WORK | FS | ABAWD
SEX (✓) ☐ M ☐ F | BLIND, DEAF OR DISABLED ☐ YES ☐ NO | PREGNANT ☐ YES ☐ NO
BIRTHPLACE CITY STATE COUNTRY
VERIFIED: ☐ Blind/Deaf/Disabled ☐ SSN ☐ DED Packet ☐ Citizen ☐ Eligible Noncitizen ☐ SAVE
TYPE OF AID REQUESTED (✓) ☐ Cash Aid ☐ Food Stamps ☐ None ☐ Medi-Cal ☐ State CMSP
MARITAL STATUS (✓) ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed
Alien Reg. # D.O.E.

COUNTY USE ONLY

FS NON-HH/EXCLUDED MEMBER (63-402)
1. Separate HH (Purchase/prepare) (.12, .13)
2. Separate HH (Elderly/disabled) (.17)
3. Roomer (must be listed in (13)) (.211)
4. Live-in attendant (.212)
5. Other shared living quarters (.213)
6. Ineligible alien (.221)
7. Boarder (must be listed in (13)) (.3)
8. SSN disqualified (.222)
9. IPV disqualified (.223)
10. Workfare sanctioned (.225)
11. SSI/SSP recipient (.226)
12. Ineligible student (.227)
13. Work req. disqualified (.228)
14. Questionable Citizenship (300.51(b))
15. Vol. quit ineligible (408.1, .2)
16. Ineligible/disqualified ABAWD (410.4)
17. Fleeing felon/parole or probation violator (.224)
18. Drug felon (.229)

FS WORK/TRAINING EXEMPTIONS (63-407.21)
a. Under 16/60 or older
a.(1) 16/17 not head of household; or 16/17 in school/training at least 1/2 time
b. Mentally/physically unfit for work
c. Mandatory participant in Welfare to Work activities
d. Cares for child under 6 or incapacitated person
e. Applicant for/recipient of UIB
f. Participant in drug/alcohol program
g. 30 hour week/min. x 30
h. 1/2 time student in school, training or higher education

FS ABAWD EXEMPTIONS (63-410.3)
1. ABAWD with FS Work/Training Exemption Code 63-407.21
2. Under 18/50 or older (.321)
3. Pregnant (.322)
4. Adult living in HH with dep. child (.323)
5. Lives in ABAWD exempt area (.33)

WtW WORK EXEMPTIONS (42-712)
Age under 16 (.41)
School Attendance (.42)
Age 60 or older (.43)
Disability (.44)
NCR caring for dependent or ward of the court or at risk of FC placement (.45)
Care of another ill or incap member of the household (.46)
Care of child:
- Age 6 months or under (or as allowed under county's CalWORKs plan) (.471)
- Member (who previously claimed .471) upon birth or adoption of subsequent child(ren) (.472)
Pregnancy (.48)
VISTA-full or part time volunteer (.49)

SAWS 2 (6/02) CA 2/DFA 285-A2/MC 210 REQUIRED FORM—SUBSTITUTE PERMITTED
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③ For each CHILD living in the home, child out of the home for a short time, or child you claim as a tax dependent, give us all the facts. If you are pregnant, list child as "unborn" and give due date.

CA FS MC (A) CHILD'S NAME (FIRST, MIDDLE, LAST) | CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO | CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH, DISABILITY, ABSENCE, UNEMPLOYMENT

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☐ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ None | MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | FATHER'S NAME

AU (✓) | NON-AU (✓) | MFBU (✓) | MFG CHILD ☐ YES ☐ NO | FS Non-HH/Excluded Member Code: ☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

CA FS MC (B) CHILD'S NAME (FIRST, MIDDLE, LAST) | CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO | CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH, DISABILITY, ABSENCE, UNEMPLOYMENT

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☑ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ None | MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | FATHER'S NAME

AU (✓) | NON-AU (✓) | MFBU (✓) | MFG CHILD ☐ YES ☐ NO | FS Non-HH/Excluded Member Code: ☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

CA FS MC (C) CHILD'S NAME (FIRST, MIDDLE, LAST) | CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO | CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH, DISABILITY, ABSENCE, UNEMPLOYMENT

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☐ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ None | MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | FATHER'S NAME

AU (✓) | NON-AU (✓) | MFBU (✓) | MFG CHILD ☐ YES ☐ NO | FS Non-HH/Excluded Member Code: ☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

CA FS MC (D) CHILD'S NAME (FIRST, MIDDLE, LAST) | CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. CITIZEN/NATIONAL ☐ NONCITIZEN: SPONSORED ☐ YES ☐ NO | CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW): DEATH, DISABILITY, ABSENCE, UNEMPLOYMENT

SOCIAL SECURITY NUMBER | SEX (✓) ☐ M ☐ F | BIRTHDATE OR DUE DATE (Month, Day, Year) | AGE OF CHILD

BIRTHPLACE (CITY/STATE/COUNTRY) | PREGNANT ☐ YES ☐ NO | ARE IMMUNIZATIONS UP TO DATE? ☐ YES ☐ NO | BLIND, DEAF OR DISABLED? ☐ YES ☐ NO

IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) ☐ YES ☐ NO

IF YES, NAME OF SCHOOL:

TYPE OF AID REQUESTED ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ None | MOTHER'S NAME

RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | IS CHILD LIVING IN YOUR HOME NOW? ☐ YES ☐ NO | FATHER'S NAME

AU (✓) | NON-AU (✓) | MFBU (✓) | MFG CHILD ☐ YES ☐ NO | FS Non-HH/Excluded Member Code: ☐ MC: not in home, 18-21 & tax dep.

☐ CW 2.1 CW 371 | Alien Reg. # | D.O.E.

Work Registration/Exemption Codes:

Welfare-to-Work | FS

Verified: ☐ Age ☐ Deprivation ☐ SSN

☐ Blind/Deaf/Disabled ☐ DED Packet

☐ Citizen ☐ Eligible Noncitizen ☐ SAVE

☐ Immunization ☐ School Attendance

		COUNTY USE ONLY
CA (4) List any parent(s) of the child(ren) or unborn who does not live in the home with you.	NAME OF PARENT / REASON THE PARENT DOES NOT LIVE IN THE HOME	☐ Verif. on File ☐ MC 13
CA FS (5) Has anyone changed citizenship/immigration status in the last 12 months? If "YES", complete below:	☐ YES ☐ NO	
	NAME / WHAT CHANGED / DATE / ALIEN NUMBER (IF APPLICABLE)	
CA FS (6) A. Is a foster child living in the home? If "YES", who:	☐ YES ☐ NO	☐ CA and FC Elig/CR Chooses: Child: ☐ CA ☐ FC CR: ☐ CA ☐ None ☐ Kin-GAP
FS B. Do you want the foster child(ren) and foster care income counted on the Food Stamp Case?	☐ YES ☐ NO	
CA FS (7) Has anyone ever used any other name (maiden, adoptive, etc.)? If "YES", complete below:	☐ YES ☐ NO	
NAME / OTHER NAME(S) USED		
NAME / OTHER NAME(S) USED		

	YES	NO	
CA MC (8) A. Does everyone live in California? If "NO", explain:			Calif. Resident: ☐ YES ☐ NO
CA B. Does everyone plan to stay in California permanently?			
CA C. Does anyone own, lease or maintain a home outside California?			☐ Property ☐ PA
CA MC D. Is anyone currently getting public assistance outside California? If "YES", explain:			
CA E. Is anyone planning to leave California for more than 30 days?			

MC (9) Are you 18 to 21 years of age and claimed as a dependent for income tax purposes? If Yes, who:	☐ YES ☐ NO	☐ Tax Dependent Letter Sent ☐ CA 2.1
CA FS (10) A. Has anyone's cash aid or food stamps been stopped due to: non-cooperation during a quality control review, work or training sanctions or failure to meet the Food Stamp Able Bodied Adults Without Dependent (ABAWD) work requirement, or for any other reason? If "YES", explain below:	☐ YES ☐ NO	
NAME / WHY / WHEN / WHAT COUNTY/STATE		
CA FS B. Has anyone's cash aid or food stamps been stopped for a period of time or forever due to welfare fraud or a food stamp Intentional Program Violation? If "YES", explain below:	☐ YES ☐ NO	
NAME / WHY / WHEN / WHAT COUNTY/STATE		
FS (11) Does anyone living with you buy food and fix meals separately from others in the home? If "YES", who:	☐ YES ☐ NO	Separate household eligible: ☐ YES ☐ NO
FS (12) Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? If "YES", who:	☐ YES ☐ NO	Separate household eligible: ☐ YES ☐ NO

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FS (13) A. Do you pay someone else for meals and/or a room? If "YES", complete below: ☐ YES ☐ NO

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

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

NAME OF PERSON WHO PAYS YOU	CHECK (✔) ☐ Meals ☐ Room ☐ Both	HOW MUCH $	HOW OFTEN	NO. OF MEALS PER DAY

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

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

NAME	NAME OF PROGRAM	NAME	NAME OF PROGRAM

CA FS MC (15) A. Does anyone live in any of the following: If "YES", complete below: ☐ YES ☐ NO

- Shelter, center
- Reservation for Native Americans
- Psychiatric hospital/mental institution
- Group living arrangement for the disabled/blind
- Hospital or nursing home
- Subsidized housing for the elderly
- Drug or alcohol rehabilitation center
- Board and care home
- Penal institution/correctional facility

NAME	NAME OF CENTER, SHELTER, HOSPITAL, ETC.	DATE ENTERED	DATE EXPECTED TO LEAVE

MC B. Does the person who is in a hospital or nursing home have a spouse or other family member at home? ☐ YES ☐ NO

CA (16) List any child age 6-16 who does not attend school regularly and explain why he/she is not attending regularly. ☐ No Child Age 6-16

NAME	REASON NOT ATTENDING SCHOOL REGULARLY

CA FS MC (17) A. Is anyone age 14 or older enrolled in school, college, or a training program? If "YES", complete below: ☐ YES ☐ NO

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

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

NAME	TERM (✔) CHECK STATUS	TUITION/FEES PER TERM	BOOKS, EQUIPMENT, ETC., PER TERM
	☐ Semester ☐ Year ☐ Quarter	$	$

MILES ROUND TRIP PER DAY TO SCHOOL/CHILD CARE	DAYS ATTENDING PER WEEK	TRANSPORTATION USED

TRANSPORTATION COST PER WEEK	AMOUNT PAID PER WEEK BY CAR POOL MEMBERS	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY
$	$	$

CA (18) A. Is anyone under age 20 and pregnant or a parent? If "YES", complete below: ☐ YES ☐ NO

NAME	AGE	CHECK (✔) STATUS
		☐ Pregnant ☐ Teen Parent

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

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

NAME	WHERE (COUNTY)	DATE(S) RECEIVED

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

NAME OF STRIKER	NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM
NAME OF UNION	
DATE WENT ON STRIKE	MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE $

COUNTY USE ONLY

Household Elects		ROOMER
BOARDER	HH MEMBER	

FS Eligible Institution: ☐ YES ☐ NO
CA Eligible: ☐ YES ☐ NO

School Attendence Verified: ☐ YES ☐ NO

School Enrollment Verif.: ☐ YES ☐ NO
Date Verified:
FS Eligible Student: ☐ YES ☐ NO

School Enrollment Verif.: ☐ YES ☐ NO
Date Verified:
FS Eligible Student: ☐ YES ☐ NO

Expenses Verified: ☐ YES ☐ NO
Date Verified:
Financial Aid: ☐ YES ☐ NO
☐ MC 210 S-E

Referred to:
☐ Cal-Learn
☐ CW 25
☐ CW 25A
☐ Referred to Welfare-to-Work

Striker Regs Apply:
☐ CA ☐ FS

CA FS (20) **Has anyone, including children, worked or does anyone expect to go to work, including part-time and occasional work? Check (✔)** "YES" or "NO" for each item. If "YES", complete below:

	YES	NO
Has anyone stopped or refused work or training within the last 60 days?		
Is anyone working or in training now?		
Does anyone expect to be working or in training in the next two months?		

If self-employed: **For Food Stamps:** List your business expenses on a separate sheet of paper.
For Cash Aid: Check (✔) how you want your business expenses figured each month:
☐ 40% standard deduction ☐ Actual business expenses ☐ Monthly average (yearly business costs divided by 12 months). **If actual,** you must list your business expenses on a separate sheet of paper.

(A) NAME — CA FS MC
NUMBER OF HOURS OF WORK/TRAINING PER MONTH — LAST MONTH_____ THIS MONTH_____
EMPLOYER'S NAME AND ADDRESS
PAY DATE(S) — SELF-EMPLOYED ☐ YES ☐ NO — WAGES BEFORE DEDUCTIONS $ per — DATE LAST CHECK RECEIVED — RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS ☐ YES ☐ NO IF "YES", COMPLETE BELOW
REASON FOR LEAVING JOB/TRAINING — LAST DAY OF WORK/TRAINING — AMOUNT RECEIVED $_____ AMOUNT EXPECTED $_____
DATE NEXT CHECK EXPECTED — AMOUNT EXPECTED BEFORE DEDUCTIONS $ — OCCUPATION

(B) NAME — CA FS MC
NUMBER OF HOURS OF WORK/TRAINING PER MONTH — LAST MONTH_____ THIS MONTH_____
EMPLOYER NAME AND ADDRESS
PAY DATE(S) — SELF-EMPLOYED ☐ YES ☐ NO — WAGES BEFORE DEDUCTIONS $ per — DATE LAST CHECK RECEIVED — RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS ☐ YES ☐ NO IF "YES", COMPLETE BELOW
REASON FOR LEAVING JOB/TRAINING — LAST DAY OF WORK/TRAINING — AMOUNT RECEIVED $_____ AMOUNT EXPECTED $_____
DATE NEXT CHECK EXPECTED — AMOUNT EXPECTED BEFORE DEDUCTIONS $ — OCCUPATION

CA FS MC (21) A. **Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job?** ☐ YES ☐ NO
If "YES", complete below and (✔) if for work or training.

WHO GETS CARE	WHO PAYS	WHO GIVES CARE	☐ WORK ☐ TRAINING	AMOUNT PAID/HOW OFTEN
				$ EVERY
				$ EVERY

CA FS MC B. **Does anyone else pay all or part of your child care costs?** ☐ YES ☐ NO
Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc. If "YES", complete below:

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

FS MC (22) **Does anyone pay child or spousal support?** ☐ YES ☐ NO
If "YES", complete below:

WHO PAYS	FOR WHOM	AMOUNT PER MONTH
		$

CA FS MC (23) **Has anyone, including children, applied for or received unemployment or disability insurance benefits in the last 12 months OR expect to receive these benefits in the future?** ☐ YES ☐ NO
If "YES", complete below:

NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED

CA (24) **Has anyone received a Diversion cash payment or non-cash services from any county or other state?** If "YES", complete below: ☐ YES ☐ NO

NAME	COUNTY/STATE	AMOUNT RECEIVED	LIST SERVICES RECEIVED	ESTIMATED VALUE OF SERVICES	DATE RECEIVED
		$		$	

COUNTY USE ONLY

(A) (✔) if exempt — CA ☐ MC ☐ FS Adult ☐ FS Child — FS S/E Farmer ☐ Yes ☐ No
(B) (✔) if exempt — CA ☐ MC ☐ FS Adult ☐ FS Child — FS S/E Farmer ☐ Yes ☐ No
☐ Verif(s) on file for: ☐ (A) ☐ (B)
FS: Work history last 120 days ☐ (A) ☐ (B)

(A)	YES	NO
Empl. Statement		
Good Cause Determ		
Voluntary Quit		

(A) ☐ CA: 28 Days ☐ FS: 60 days ☐ MC: 30 days
(B) ☐ CA: 28 Days ☐ FS: 60 days ☐ MC: 30 days

(B)	YES	NO
Empl. Statement		
Good Cause Determ		
Voluntary Quit		

CA: S/E Client Chooses:
(A) ☐ Actual ☐ 40% deduction ☐ Annualize
(B) ☐ Actual ☐ 40% deduction ☐ Annualize

Child Care Informing:
☐ Trustline Informing (CCP 2)
☐ Health & Safety Certification (CCP 5)
☐ Dependent Care Verified

DEP. CARE ELIGIBLE	YES	NO
FS		
MC		

Is there another person in household who could provide care? ☐ YES ☐ NO
If "YES", who: _____

Court Order on File ☐ YES ☐ NO
Amount Ordered: $

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Employment History

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CA FS (25) **Has any parent living in the home worked or been in training in the past 24 months?** ☐ YES ☐ NO

If "YES", complete below:
- Include all work done in and outside the United States (U.S.).
- Include work done in exchange for something besides money, such as rent, food, utilities or **anything else.**
- Begin with each person's most recent job or training.

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

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	4. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
2. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
3. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly

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

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	4. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
2. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	5. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly
3. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly	6. ☐ Work ☐ Training	From To	$ ☐ Weekly ☐ Monthly

FS (26) **Are all Food Stamp household members citizens of the United States (U.S.)?** ☐ YES ☐ NO

If "NO", complete below for each Food Stamp household member who is **not a citizen of the U.S.**

Name of each noncitizen	A. How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S.?	B. While living in the U.S., in how many of the years reported in Column A did this person, their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S.?	C. While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S?
1.			
2.			
3.			
4.			

CA FS MC (27) **Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service?** If "YES", complete below: ☐ YES ☐ NO

NAME	U.S. CITIZEN	(✓) STATUS	HONORABLE DISCHARGE	BRANCH OF SERVICE	DATE OF SERVICE
	☐ YES ☐ NO	☐ ACTIVE DUTY MILITARY/VETERAN ☐ SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	☐ YES ☐ NO		
NAME	U.S. CITIZEN	(✓) STATUS	HONORABLE DISCHARGE	BRANCH OF SERVICE	DATE OF SERVICE
	☐ YES ☐ NO	☐ ACTIVE DUTY MILITARY/VETERAN ☐ SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	☐ YES ☐ NO		

COUNTY USE ONLY

PRINCIPAL EARNER (PE) *	DATE OF APPLICATION	QUARTER OF APPLICATION

*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.

COUNTY USE ONLY

PE/UIB Requirements
Earnings from month prior to month of application
App Date: _____
Earnings from _____ to _____

MO/YR	(25) A	(25) B
	$	$
TOTAL	$	$

(25)	A	B
Tribal JOBS Referral		
UIB Verif(s) on file		
Must apply for UIB		
Currently Receiving/Got/ or UIB eligible in last 12 months		

UIB Ineligible Reason:

(26) *FS:* ☐ *40 Quarters Verif.*

(27) ☐ *CW 5*

FS: Noncitizen's Honorable Discharge Verif. ☐ *YES* ☐ *NO*

CA FS MC (28) **A. Does anyone, including children, get or expect to get money from any source listed below?**
Check (✔) "YES" or "NO" for each item.

	YES	NO		YES	NO
Work Study, JTPA, Welfare-to-Work, or other program			VA (Veterans) educational related income		
Other training allowance			VA Aid & Attendence		
Educational grants, loans and scholarships			Social Security disability or supplemental security income/state supplementary payment (SSI/SSP)		
CalWORKs/Cash aid from another state			VA disability		
Refugee (RCA) Assistance			Railroad disability		
Cash Assistance Program for Immigrants (CAPI)			Other disability income from a federal, state, or local governmental agency		
GA/GR (General Assistance/Relief)			Other non-government disability or sick leave		
Workers Compensation			Social Security retirement or survivors		
Child/spousal support or money for medical bills or premiums			Railroad retirement		
Strike benefits			Other retirement income from a federal, state, or local governmental agency		
Loans, gifts, contributions			Other non-government retirement income		
Legal or insurance settlements/ court actions pending			Per capita payments		
Sales of notes, contracts, trust deeds, promissary notes			Winnings (gambling/lottery/bingo, prizes, etc.)		
Military allotment or pension			Other (Explain)		

COUNTY USE ONLY
- ☐ Casualty Unit Notified
- ☐ CWC 6041
- ☐ DHS 6155
- ☐ Verif(s) on File
  Explain Anticip. Income

Workers Comp:
☐ Temporary ☐ Permanent

If "YES", complete below:

NAME	SOURCE	(AMOUNT RECEIVED BEFORE DEDUCTIONS)	WHEN	HOW OFTEN	(✔) if exempt CA	FS	MC
		$					
		$					

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

NAME	WHAT	AMOUNT	WHEN
		$	

CA FS MC (29) **Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?** ☐ YES ☐ NO
If "YES", complete below and check (✔) if free or in exchange for work:

In-Kind Income:
Verif. on file: ☐ YES ☐ NO

ITEM RECEIVED	Free	For Work	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM	Partial	Full	Earned	Unearned
Housing or rent				$					
Utilities				$					
Food				$					
Clothing				$					

CA FS MC (30) **A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?** ☐ YES ☐ NO
If "YES", complete below. Include land and/or buildings in which the title is shared.

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✔)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT					$	$
LISTED FOR SALE	RENTAL PROPERTY						
☐ YES ☐ NO	OTHER (EXPLAIN):						

Home Exempt ☐ YES ☐ NO
Other Real Property
Market Value $
Amount Owed $
Net Value $
Lien Applicable ☐ YES ☐ NO
Listed for sale ☐ YES ☐ NO

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✔)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT					$	$
LISTED FOR SALE	RENTAL PROPERTY						
☐ YES ☐ NO	OTHER (EXPLAIN):						

Home Exempt ☐ YES ☐ NO
Other Real Property
Market Value $
Amount Owed $
Net Value $
Lien Applicable ☐ YES ☐ NO
Listed for sale ☐ YES ☐ NO

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

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

Total countable property: Page 7
(List totals on page 9)
CA $
FS $
MC $

Page 7 of 14

CA FS MC (31) **A. Does anyone, including children, have any of the following personal or business-related resources?** Check (✔) each item either "YES" or "NO".
Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.

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

IF "YES", COMPLETE BELOW:

RESOURCE	BUSINESS-RELATED	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
	☐ YES ☐ NO				$
	☐ YES ☐ NO				$
	☐ YES ☐ NO				$

COUNTY USE ONLY

☐ Trust Fund/Not Court Ordered
☐ Court Petitioned
Date _____
☐ Resource Verified: Explain how:

Total Value = $_____
☐ Burial Reserve or Trust (MCO)
Amount Owed $_____
☐ Revocable
☐ Irrevocable
☐ Designated Fund and Current Value $_____
☐ CA Restricted Account

Check (✔) if exempt

CA	FS	MC

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

NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN	BUSINESS-RELATED
		$		☐ YES ☐ NO
		$		BUSINESS-RELATED ☐ YES ☐ NO

MC (32) **Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services?** ☐ YES ☐ NO
If "YES", complete below.

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

Verified: ☐ YES ☐ NO
Lien Applicable: ☐ YES ☐ NO
Security Agreement: ☐ YES ☐ NO
MC 174 completed and sent: ☐ YES ☐ NO

MC (33) **A. Does anyone own any personal property, such as:** ☐ YES ☐ NO
- Non-motorboats, camper shells, non-motor trailers.
- Guns, tools, or sporting equipment, etc.
- Pets or livestock for personal use.
- Jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

If "YES", complete below: Do not include wedding and engagement rings or heirlooms. List jewelry worth more than $100 and household goods or personal items worth more than $500 per item.

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$

☐ Owned Jointly
☐ Owned Separately
☐ Personal Property $500 + for Pickle Program
☐ Insignificant Value for 1931(b)
☐ Listed for sale (Specify):

MC **B. Does anyone have any business property, including tools, inventory and materials, business equipment, livestock, etc.?** ☐ YES ☐ NO
Include any property that is shared or held jointly with any other person(s). If "YES", complete below.

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$
	☐ YES ☐ NO	$	$		☐ YES ☐ NO	$	$

Total Countable Property: Page 8
(List totals on Page 9)
CA $ _____
FS $ _____
MC $ _____
☐ Listed for sale (Specify):

CA MC (34) **Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else?** (List any property sold or traded within the last 12 months for cash aid, 3 months for food stamps, and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when: ☐ YES ☐ NO

CA FS MC (35) **Does anyone own, have the use of or have their name on the registration of any motor vehicle, such as: automobile, motorcycle, snowmobile, recreational vehicle, motorboat, etc., even if not running?** If "YES", complete below. Look at your registration to get facts for each vehicle: ☐ YES ☐ NO

	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
OWNER OF VEHICLE						
NAME OF PERSON WHO USES VEHICLE						
YEAR/MAKE/MODEL						
LICENSE NUMBER						
ESTIMATED VALUE	$		$		$	
BALANCE OWED	$		$		$	
LICENSED	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO
LEASED	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO
HOW DO YOU USE THE VEHICLE? Check (✔) each item "YES" OR "NO."	YES	NO	YES	NO	YES	NO
As a Home						
To go to work or training or for job search						
For self-employment, self-support, or business use						
Needed for disabled household member						
To get household's fuel or water						
For recreational use only						

COUNTY USE ONLY

Transfer of Assets:
☐ CA in last 12 months
☐ FS in last 3 months
☐ Medi-Cal in last 30 months
LTC ONLY
☐ Adequate Consideration
☐ Spenddown
Total Nonexempt Property
$

Compute Vehicle Valuation in Section Below:
☐ Verifications viewed
☐ Leased vehicle:
☐ (1) ☐ (2) ☐ (3)
☐ Pickle Program:
Use Pickle Handbook
(Reference Section 9)

Vehicle Value
(Enter Date of blue book issue or other documentation)

(1) Date:_____ $_____

(2) Date:_____ $_____

(3) Date:_____ $_____

COUNTY USE ONLY - VEHICLES

CASH AID/FOOD STAMPS	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)	☐ YES (Exclude)	☐ NO Go to (B)	☐ YES (Exclude)	☐ NO Go to (B)	☐ YES (Exclude)	☐ NO Go to (B)
(B) (1) Equity: exempt one vehicle, regardless of use. (63-501.523) [If "YES", go to (C). If "NO", go to (B)(2).]	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO
(2) Is other vehicle(s) used for job search, employment or training?	☐ YES Go to (C). Use Excess Value.	☐ NO Go to (C) and (D). Use Greater Value	☐ YES Go to (C). Use Excess Value.	☐ NO Go to (C) and (D). Use Greater Value.	☐ YES Go to (C). Use Excess Value.	☐ NO Go to (C) and (D). Use Greater Value.

(C) Fair Market Values-CA/FS

FMV				
Minus	Minus $4,650	Minus $4,650	Minus $4,650	
Excess Value				

(D) Equity Values-CA/FS

FMV			
Minus Encum-brance			
Equity Value			

MEDI-CAL

	(1)	(2)	(3)
DMV/YR/Class Code	_____	_____	$ _____
Vehicle Market Value	$ _____	$ _____	$ _____
Less Encumbrances	$ _____	$ _____	$ _____
Net Value	$ _____	$ _____	$ _____
Exempt	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Pickle Program (Ref. Sec. 9 in Pickle Handbook)

Is vehicle used:	(1) Exempt	(2) Yes	(2) No	(3) Yes	(3) No
As a home					
For self-employment					
To Go to Work or Medical Appointment					

TOTALS: VEHICLE CA/FS
Excess Value $ _____
Equity Value $ _____

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

Page	CA	FS	MC
(9)	$_____	$_____	$_____
(8)	$_____	$_____	$_____
(7)	$_____	$_____	$_____
Total	$_____	$_____	$_____

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CA FS (36) **A. Does anyone have any housing costs?** ☐ YES ☐ NO
If "YES", complete below:

HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	$	$	$	
House (mortgage) payment	$	$	$	
Property taxes (if not in house payment)	$	$	$	
Insurance (if not in house payment)	$	$	$	
Other (explain)	$	$	$	

CA FS **B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc.** If "YES", complete below: ☐ YES ☐ NO

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		$	
		$	

COUNTY USE ONLY

Housing verified: ☐ YES ☐ NO

Total housing: $ _____

Shared housing: ☐ YES ☐ NO

FS (37) **A. Does anyone have any utility costs?** ☐ YES ☐ NO
If "YES", complete below:

UTILITY COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Gas or other fuel	$	$	$	
Electricity or other fuel	$	$	$	
Is the gas or electricity or other fuel used to heat or cool your house?	☐ YES ☐ NO			
Water	$	$	$	
Sewer	$	$	$	
Garbage or trash	$	$	$	
Telephone (basic rate for one phone plus tax)	$	$	$	
Installation of utilities	$	$	$	
Other (explain)	$	$	$	

FS **B. Does anyone else pay all or part of these utility costs? Include a relative/friend not living in the home, Low Income Energy Assistance, etc.** ☐ YES ☐ NO
If "YES", complete below:

TYPE OF UTILITY COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		$	
		$	

Utilities verified: ☐ YES ☐ NO

Metered: ☐ YES ☐ NO

Client elects
☐ Actual
If Actual, Total Utilities
$_____

☐ SUA
SUA prorated:
☐ YES ☐ NO

FS (38) **You can authorize someone else in your household or someone outside your household to pick up your food stamps or to use them to buy food for you. If you would like to authorize someone, complete below:**

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		( )

☐ F.S. I.D. Issued

CA MC (39) Did anyone 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	PAYMENTS MADE FOR CARE		DO YOU WANT MEDI-CAL FOR THOSE MONTHS?	
		YES	NO	YES	NO

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

CA FS MC (40) Does anyone have MEDICARE coverage? ☐ YES ☐ NO
If "YES", complete below:

PERSON COVERED	MEDICARE CLAIM NUMBER	FOR	(✔) HOW MONTHLY PREMIUM IS PAID: DEDUCTED FROM CHECK	OUT OF POCKET	OTHER
		Part A			
		Part B			
		Part A			
		Part B			

☐ MEDICARE referral
FS: ☐ DFA 285-C
Gross Premium $ _____
☐ QMB
☐ SLMB/QI
☐ QDWI

CA MC (41) Does anyone have health, dental, vision, hospitalization or Long Term Care insurance or health plans, such as Kaiser, Blue Cross, CHAMPUS, etc.? ☐ YES ☐ NO
If "YES", complete below:

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

State Certified LTC Policy: ☐ YES ☐ NO
☐ DHS 6155
Benefits Paid Out $_____

CA MC (42) Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? ☐ YES ☐ NO
If "YES", complete below:

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

☐ DHS 6155

CA MC (43) Is anyone's health insurance expected to end or has it ended within the last 60 days? ☐ YES ☐ NO
If "YES", complete below:

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

☐ DHS 6155

CA MC (44) Does anyone have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? ☐ YES ☐ NO
If "YES", complete below:

NAME OF PERSON	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

☐ Third Party Liability

CA FS (45) A. Does anyone have a medical condition(s) or situation(s) that requires any of the following?
Check (✔) each item "YES" or "NO":

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

If "YES", explain:

Verified: ☐ YES ☐ NO
Special Need: ☐ YES ☐ NO
Amount: $ _____

CA MC FS B. Is there a child or disabled person in the household who needs care from another household member? ☐ YES ☐ NO
If "YES", explain:

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

NAME OF PERSON	TYPE OF EXPENSE	AMOUNT
		$
		$

☐ Receipts
☐ MC 272 ☐ MC 273
☐ IRWE (QMB and SGA)
FS: ☐ DFA 285-C

CA FS D. Is anyone getting In-Home Supportive Services (IHSS)? ☐ YES ☐ NO
If "YES", who gets service? _____ How much do you pay each month? $_____

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			COUNTY USE ONLY	YES	NO
CA (46)	**Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances, such as an earthquake, fire, or flood?** If "YES", explain below.	☐ YES ☐ NO	Special Need Verified		
			Eligible for Special Need		
CA FS (47)	**Is any member of the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole?** If "YES", give name of the person:	☐ YES ☐ NO			
CA FS (48)	**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 food stamps, for crimes and convictions after 8/22/96.** If "YES", complete below:	☐ YES ☐ NO			

NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED

CA MC (49) **The following services are available. Your answers to these questions 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.			☐ CHDP Brochure and Explanation Given Date: _____
• Do you want more information about CHDP Services?			☐ CHDP Referral
• Do you want CHDP medical services?			☐ Social Services Referral (MCO)
• Do you want CHDP dental services?			
• Do you need help making appointments or with transportation to CHDP services?			
B. Do you want more information about immunization services?			☐ Referred for Immuniz.
C. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?			☐ Pregnant ☐ Parent or Guardian of child under 5
D. Are you breastfeeding a child?			☐ Breastfeeding ☐ Postpartum
If "YES", have you given birth within the last 12 months?			
If you checked "YES" to (49) C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).			☐ WIC referral
E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.			☐ Family Planning Information Given ☐ Referred Date:

CERTIFICATION

I understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and food stamps, records will be matched with law enforcement agencies for arrest warrants.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident noncitizen (LPR), (b) an amnesty alien with a valid and current I-688, or (c) a noncitizen permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the INS.
- 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 Food Stamp household, any adult member of a Food Stamp 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 avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of their parole or probation cannot get cash aid or food stamps.
- 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 food stamps or if convicted on or after January 1, 1998, cannot get cash aid.
- For cash aid and food stamps, the county will require that I and certain household members be fingerprint and photo imaged. My benefits may be denied or stopped if I 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, food stamps, 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 $2000; 5 years for amounts of $2000 through $4999.99; and forever for amounts of $5000 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 food stamps:

- If on purpose I do not follow food stamp rules, my food stamps 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 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 filed two or more applications for food stamps at the same time and gave the county false identity or residence information, my food stamps 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 FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)			DATE
SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

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COUNTY USE ONLY

ELIGIBILITY FACTORS REVIEWED	CA		FS		MC	
	YES	NO	YES	NO	YES	NO
Residency						
Deprivation						
Age						
Immunizations						
Citizen/Eligible noncitizen						
School enrollment						
Pregnancy verif./ WIC Referral						
SSN						
Income—Applicant/Recipient test(s)						
SFIS						
TANF Time Limits						
CalWORKs Time Limits						

ELIGIBILITY FACTORS REVIEWED	CA		FS		MC	
	YES	NO	YES	NO	YES	NO
Property/Resources—Within limits						
Work participation						
FSET						
ABAWDs						
CFAP						
Sponsored noncitizen Federal participation established (If "NO", explain)						
Referred for Health Care Options (HCO) Presentation						

FOOD STAMP TESTS	YES	NO	NA
Categorically Eligible			
Gross Income Test Household Size Gross Monthly Income $			
Gross Income Eligible			
Separate HH Income Test Household Size Gross Monthly Income $			
Eligible for Separate HH Status			
Aged/Disabled			
DFA 285-C			

COMMENTS

AU Size:	Non-AU Size:	AU/MFBU Size:
☐ INELIGIBLE (REASON)		
☐ ELIGIBLE ☐ DIVERSION ☐ REDETERMINATION ☐ EXEMPT MAP		AUTHORIZATION DATE
ELIGIBILITY CONDITIONS MET (DATE):		EFFECTIVE DATE
WORKER'S SIGNATURE		DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)		DATE

FS:	HH Size:
☐ INELIGIBLE (REASON)	
☐ ELIGIBLE ☐ RECERTIFICATION	AUTHORIZATION DATE
WORKER'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE (COUNTY OPTION)	DATE