DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

DEC 10 2013

Dear Mr. Douglas:

Enclosed is an approved copy of California's state plan amendment (SPA) 13-0022-MM2, which was submitted to CMS on September 11, 2013. SPA 13-0022-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into California's Medicaid state plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA 13-0022-MM2 includes full approval of your state's alternative paper application used to apply for multiple human service programs. The state is using an interim online application used to apply for multiple human services programs and by July 1, 2014 will implement a revised application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

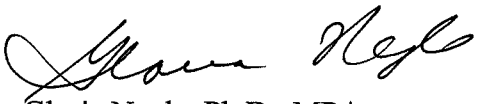
In addition, the state is using interim alternative single streamlined paper and online applications. By July 1, 2014 the state will implement a revised alternative single streamlined paper application and by December 31, 2014, the state will implement a revised alternative single streamlined online application. These revised applications must address CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the end of California's approved state plan:

- S94, pages S94-1, S94-2, S94-3
- Attachment 1 - California Multi-Benefit paper application – SAWS 2 PLUS, 7/13
- Attachment 2 - Statement of use for online application used to apply for multiple human service programs
- Attachment 3 - Statement of use for alternative single streamlined paper application
- Attachment 4 - Statement of use for alternative single streamlined online application

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Tom Schenck at (415)744-3589, or tom.schenck@cms.hhs.gov.

Sincerely,



Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Tara Naisbitt, California Department of Health Care Services
Kathryn Waje, California Department of Health Care Services

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Toby Douglas, Director
California Department of Health Care Services
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Sacramento, CA 95899-7413

DEC 10 2013

Dear Mr. Douglas:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) 13-0022-MM2, which was submitted to CMS on September 11, 2013. Our review of this submission included a review of the alternative single streamlined paper and online applications developed by the state as well as the applications used to apply for multiple human service programs.

The approval of SPA 13-0022-MM2 includes full approval of your state's alternative paper application used to apply for multiple human service programs. Until July 1, 2014, the state is using an interim alternative online application used to apply for multiple human service programs. In addition, the state is using interim alternative single streamlined paper and online applications. By July 1, 2014 the state will implement a revised alternative single streamlined paper application and by December 31, 2014, the state will implement a revised single streamlined online application

All interim applications need to be revised to reflect the following changes.

Necessary changes:	**Date by which changes will be completed:**
Alternative Online Application Used to Apply for Multiple Human Service Programs:	
The state must revise the application to meet the standards as outlined in 42 CFR 435.907 and guidance on alternative applications released by CMS on June 19, 2013.	July 1, 2014

Alternative Single Streamlined Online Application:	
The following questions will not appear on the online application for health coverage only: • Questions regarding the prior year tax return	April 1, 2014
The following questions will not appear for household members not seeking any benefits: • The non-MAGI screening question related to disability, long-term care and Medicare • All citizenship and immigration questions	April 1, 2014
Applicants who are asked questions for APTC eligibility will be asked about the lowest-cost premium they are offered, not the premium for the plan in which they are currently enrolled.	April 1, 2014
Applicants will have the opportunity to identify themselves as American Indians and Alaska Natives for purposes of Medicaid and CHIP cost-sharing protections, and identify American Indian and Alaska Native income not countable for Medicaid and CHIP income determinations.	April 1, 2014
Only applicants who do not appear eligible for Medicaid and CHIP based on income attestation will be asked information about access to employer-sponsored coverage, beyond what is needed for Medicaid and CHIP.	December 31, 2014
Alternative Single Streamlined Paper Application:	
Language in the application that describes newborns that are deemed eligible will be revised to reflect the new process for transitioning AIM-linked infants into Medicaid, as implemented through SPA 13-005.	July 1, 2014

Please submit your revised applications to CMS as follows:

- Alternative online application used to apply for multiple human service programs: please submit to CMS for review no later than June 1, 2014 to ensure approval by July 1, 2014.
- Alternative single streamlined online application: please submit to CMS for review no later than December 1, 2014 to ensure approval by December 31, 2014.

- Alternative single streamlined paper application: please submit to CMS for review no later than June 1, 2014 to ensure approval by July 1, 2014.

We continue to be available to provide technical assistance. If you have any questions about your applications, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any additional questions about this letter, please contact Tom Schenck at (415) 744-3589, or tom.schenck@cms.hhs.gov.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Tara Naisbitt, California Department of Health Care Services
Kathryn Waje, California Department of Health Care Services

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name:
California
Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

CA-13-0022

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$0.00
Second Year	2015	$0.00

Subject of Amendment

Eligibility Process

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  The Governor's Office does not wish to review the State Plan Amendment

Signature of State Agency Official

Submitted By:
Kathryn Waje
Last Revision Date:
Dec 9, 2013
Submit Date:
Sep 11, 2013

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	County web portals	Each county has a web portal that will accept applications with an intake process that operates independently from the federally required State online access portal (CalHEERS). County eligibility workers or individual applicants can enter their application data into their county-specific web portal. This web portal will then interface with the business rules engine in CalHEERS to determine what health programs the applicant's case qualifies for. The eligibility determination will then be sent electronically back to the county web portal.	X
+	Fax	Applications can also be submitted through facsimile.	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER:	**STATE:**
CA-13-0022-MM2	California
Through July 1, 2014, the state is using an interim multi-benefit application. After July 1, 2014, the state will use a revised multi-benefit application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application	☒ Online Application
TRANSMITTAL NUMBER:	**STATE:**
CA-13-0022-MM2	California

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☒Paper Application ☐Online Application	
TRANSMITTAL NUMBER:	**STATE:**
CA-13-0022-MM2	California
Through July 1, 2014, the state is using an interim alternative single streamlined application. After July 1, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

APPLICATION FOR CALFRESH, CASH AID, AND/OR MEDI-CAL/HEALTH CARE PROGRAMS

If you have a disability or need help with this application, let the County Welfare Department (County) know and someone will help you.

If you prefer to speak, read, or write in a language other than English, the County will get someone to help you at no cost to you.

How do I apply?
Use this application if you are applying for food assistance (CalFresh), cash aid (California Work Opportunity and Responsibility to Kids or Refugee Cash Assistance), Medi-Cal and/or other health care programs. If you want to apply for CalFresh only, you can ask the County for the CalFresh only application. CalFresh is a food assistance program to help you with the cost of buying food for your household. If you want to apply for health care only, you can ask the county for a health care only application. Health care includes: low-cost insurance for Medi-Cal; affordable private health insurance; or a tax credit that can help you pay your premiums for health coverage. Do not use this application if you are applying for only health care.

You can also apply for these programs online by going to http://www.benefitscal.org/.

- Fill out the whole application form, if you can. You must at least give the County your name, address, and signature (question 1 on page 1 of the application) to begin the application process for CalFresh. For cash aid you must fill out questions 1 through 5 on pages 1 and 2 of the application and sign it to begin the application process.
- Each program has a symbol (shown at the top of this page) showing what questions pertain to what programs. For cash aid, it is a dollar sign; for CalFresh, it is a shopping cart; and for health coverage, it is an ambulance. For example, if you are not applying for cash aid, you don't need to answer questions marked only with a dollar sign.
- Give the application to the County in person, by mail, by fax or online.
- The day the County receives your signed application starts the time to give you an answer on whether you can get benefits. If you are in an institution, this time starts from the day you leave.

What do I do next?
- Read about your rights and your responsibilities (Program Rules pages) before you sign the application.
- You must have an interview with the County to discuss your application. If you have a disability, other arrangements can be made.
- If you did not fill out all of the application, you can finish it during your interview.
- You will need to give proof of your income, expenses, and other circumstances to see if you are eligible.

How long will it take?
It may take up to 30 days to process your application for CalFresh. For cash aid and Medi-Cal, it may take up to 45 days. Ask the County how to get your benefits or health care right away if you have an emergency.

You may be able to get CalFresh benefits within 3 calendar days if:

- Your household's monthly gross income (income before deductions) is less than $150 and your cash on hand or in checking or savings accounts is not more than $100; or
- Your household's housing costs (rent/mortgage and utilities) are more than your monthly gross income and money in checking or savings; or
- You are a migrant or seasonal farmworker household with less than $100 in checking or savings and 1) your income stopped, or 2) your income has started but you do not expect to get more than $25 in the next 10 days.

For cash aid, you may get immediate assistance if:

- You are homeless or have an eviction notice or a notice to pay rent or move; or
- Your food will run out within three days;
- Your utilities have been or will be shut off;
- You don't have sufficient clothing or diapers;
- You have another kind of emergency important to health and safety.

Informational Page - Please take and keep for your records.

To help the County see if you can get benefits faster, please complete questions 1, 6 through 9, 15, and 24, and give the County proof of your identity (if you have it) with the application.

The County will send you a letter to let you know if your household is approved or denied for the benefits you applied for.

What do I need for my interview?
To avoid delays, bring proof of the following items with you to your interview. Keep your interview even if you do not have the proof. The County may be able to help if you need help getting proof. During the interview, the County will go over the information on the application and will ask you questions to see if you can get benefits and the amount of benefits you can get.

Proof Needed to Get Benefits
- Identification (Driver's License, State ID card, passport).
- Birth certificates for everyone applying for cash aid.
- Proof of where you live (rental agreement, current bill with your address listed).
- Social Security numbers for everyone applying for aid (see note below about certain noncitizens).
- Money in the bank for all the people in your household (recent bank statements).
- Earned income of everyone in your household for the past 30 days (recent pay stubs, a work statement from an employer). **NOTE:** If self-employed, income and expenses or tax records.
- Unearned income (Unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, rental income, etc.).
- Lawful immigration status **ONLY** for legal noncitizens applying for benefits (an Alien Registration Card, visa).
  NOTE: Certain noncitizens applying for immigration status based on domestic violence, crime prosecution or trafficking may not need this proof. They also may not need a Social Security number.

Proof Needed to Get <u>More</u> CalFresh Benefits
- Housing costs (rent receipts, mortgage bills, property tax bill, insurance documents).
- Phone and utility costs.
- Medical expenses for anyone in your household who is elderly (60 and older) or disabled.
- Child and adult care costs due to someone working, looking for work, attending training or school, or participating in a required work activity.
- Child support paid by a person in your household.

Additional Proof Needed for Health Coverage
- Information about any job related health insurance available to your family.
- Policy numbers for any current health insurance.

Additional Proof Needed for Cash Aid
- Proof of immunizations for children six years of age or younger.
- Vehicle registration for vehicles owned by you or someone you are applying for.

What if I am homeless?
Please let the County know right away if you are homeless so they can help you figure out an address to use to accept your application and get notices from the County regarding your case. For CalFresh and cash aid, homeless means you are:

A. Staying in a supervised shelter, halfway house, or similar place.
B. Staying at the home of another person or family for no more than 90 days straight.
C. Sleeping in a place not designed for, or normally used as, a place to sleep (a hallway, a bus station, a lobby, or similar places).

Informational Page - Please take and keep for your records.

RIGHTS AND RESPONSIBILITIES

You have a responsibility to:

- Give the County all information needed to determine your eligibility.
- Give the County proof of the information you have when it is needed.
- Report changes as required. The County will give you information about what, when, and how to report. For CalFresh and cash aid if you don't meet your household's reporting requirements, your case may be closed or your benefits may be lowered or stopped.
- Look for, get, and keep a job or participate in other activities if the County tells you that it is required in your case.
- Fully cooperate with county, state, or federal personnel if your case is selected for review or investigation to ensure that your eligibility and benefit level were correctly figured. Failure to cooperate in these reviews will result in loss of your benefits.
- Pay back any cash aid or CalFresh benefits that you were not eligible to get.

You have the right to:

- Turn in an application for CalFresh giving only your name, address, and signature.
- Have an interpreter provided by the State at no cost if you need one.
- Have information given to the County kept confidential, unless directly related to the administration of County programs.
- Withdraw your application at any time prior to the County determining eligibility.
- Ask for help to fill out your application or help getting the proof that you need and get an explanation of the rules.
- Be treated with courtesy, consideration, and respect, and not be discriminated against.
- Get CalFresh benefits within 3 days if you qualify for Expedited Service.
- Get cash aid within one day if you qualify for Immediate Need.
- Be interviewed in a reasonable amount of time by the County when you apply and to have your eligibility determined within 30 days for CalFresh or 45 days for cash aid and Medi-Cal.
- Get at least 10 days to give to the County proof that is needed to make a determination of eligibility.
- Get written notice at least 10 days before the County lowers or stops your CalFresh or cash aid benefits.
- Discuss your case with the County and to review your case when you ask to do so.
- Ask for a State hearing within 90 days if you do not agree with the County about your case. If you ask for a hearing before an action on your case takes place, your benefits will stay the same until the hearing or the end of your certification period, whichever is earlier. You can ask the County to let your benefits change until after the hearing to avoid having to pay back any overpaid benefits. If the Administrative Law Judge rules in your favor, the County will give back to you any benefits that were cut.
- Ask about your hearing rights or for a legal aid referral at the toll-free phone numbers – **1-800-952-5253** or for hearing or speech impaired who use TDD, **1-800-952-8349.** You may get free legal help at your local legal aid or welfare rights office.
- Bring a friend or someone with you to the hearing if you do not want to go alone.
- Get help from the County to register to vote.
- Report changes that you are not required to report, if it may increase your CalFresh benefits or cash aid.
- Give proof of your household's expenses that may help you get more CalFresh benefits. Not giving proof to the County is the same as saying that you do not have that expense and you will not be able to get more CalFresh benefits.
- Let the County know if you would like someone else to use your CalFresh benefits for your household or help with your CalFresh case (Authorized Representative).

  You are also giving the Medi-Cal agency the right to pursue and get medical support from a spouse or parent. If you think that cooperating to collect medical support will harm you or your children, you can tell the Medi-Cal agency and you may not have to cooperate.

Please take and keep for your records

Program Rules and Penalties

You are committing a crime if you give false or wrong information, or do not give all the information on purpose to try to get CalFresh, cash aid, and Medi-Cal, that you are not eligible to receive, or to help someone else get benefits that they are not eligible to receive. You must pay back any benefits you get that you were not eligible to receive. If you do this on purpose and receive more than $950 in benefits you were not eligible to receive, you can be charged with a felony.

For CalFresh: I understand that if I commit an intentional program violation by doing any of the following:	**I may...**
• hide information or make false statements	• lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me
• use electronic benefit transfer (EBT) cards that belong to someone else or let someone else use my card	• lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me
• use CalFresh benefits to buy alcohol or tobacco	• lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me
• trade, sell, or give away CalFresh benefits or EBT cards	• be fined up to $250,000, imprisoned up to 20 years, or both
• trade CalFresh benefits for controlled substances, such as drugs	• lose CalFresh benefits for 24 months for the first offense • lose CalFresh benefits permanently for the second offense.
• give false information about who I am and where I live so I can get extra CalFresh benefits	• lose CalFresh benefits for 10 years for each offense
• have been convicted of trading or selling CalFresh benefits worth more than $500, or trading CalFresh benefits for firearms, ammunition, or explosives	• lose CalFresh benefits forever
For cash aid I understand that if I...	**I may...**
• am convicted of an intentional program violation	• lose my cash aid
• do not follow cash aid rules	• be fined up to $10,000 and/or sent to jail/prison for 5 years
• am found guilty by a court of law or an administrative hearing of committing certain types of fraud	• lose cash aid for 6 months, 12 months, 2 years, 4 years, 5 years, or forever.

Important Information for Noncitizens

- You can apply for and get CalFresh benefits or cash aid for people who are eligible, even if your family includes others who are not eligible. For example, immigrant parents may apply for CalFresh benefits or cash aid for their U.S. citizen or qualified immigrant children, even though the parents may not be eligible.
- Getting food benefits will not affect you or your family's immigration status. Immigration information is private and confidential.
- The immigration status of noncitizens who are eligible and apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for benefits. The County will need to know their income and resource information to correctly determine your household's benefits. The County will not contact USCIS about the people who don't apply for benefits.

Use of Social Security Numbers (SSN)

CalFresh and Cash Aid: Everyone applying for CalFresh benefits or cash aid needs to provide a SSN, if you have one, or proof that you have applied for a SSN (such as a letter from the Social Security office). We can deny you or any member of your household who does not give us a SSN. Some people do not have to give SSNs to get help such as, victims of domestic abuse, crime prosecution witnesses, and trafficking victims.
Health Coverage/Medi-Cal: We need your SSN if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting a SSN, Call 1-800-772-1213 or visit the website: www.socialsecurity.gov

Overissuance

This means you got more CalFresh benefits than you should have. You will have to pay it back even if the county made an error or if it wasn't on purpose. Your benefits may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Please take and keep for your records

Overpayment
This means that you got more cash aid than you should have gotten. Just like with CalFresh benefits, you will have to pay it back even if the County made an error or if it wasn't on purpose. Your cash aid may be lowered or stopped. Your SSN may be used to collect the amount of benefits owed, through the courts, other collection agencies, or federal government collection action.

Reporting
Every household that gets benefits must report certain changes. Your county will tell you what changes to report, how to report them, and when to report them. Failure to report the changes may result in your benefits being lowered or stopped. You can also report if things happen that may increase your benefits, such as getting less income.

State Hearings
You have the right to a State hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You can request a State hearing within 90 days of the County's action and you must tell why you want a hearing. The approval or denial notice you receive from the County will have information on how to request an appeal. If you ask for a hearing before the action happens, you may be able to keep your cash aid and CalFresh benefits the same until a decision is made.

Privacy Act and Disclosure
You are giving personal information in the application. The County uses the information to see if you are eligible for benefits. If you do not give the information, the County may deny your application. You have a right to review, change, or correct any information that you gave to the County. The County will not show your information or give it to others unless you give them permission or federal and state law allows them to do so. The County will verify this information through computer matching programs, including the Income and Earnings Verification System (IEVS). This information will be used to monitor compliance with program regulations and for program management. The County may share this information with other federal and state agencies for official examination, with law enforcement officials for the purpose of arresting persons fleeing to avoid the law, and with private claims collection agencies for claims collection action. The County may verify immigration status of household members applying for benefits by contacting the USCIS. Information the County gets from these agencies may affect your eligibility and level of benefits.

The County will use the information from your application to check your eligibility for help with paying for health coverage. The County will check your answers using information in state and federal electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, the County may ask you to send proof.

Nondiscrimination
It is the State and County's policy that all people be treated equally, and with respect and dignity. In accordance with federal law and the U.S. Department of Agriculture (USDA) Policy, discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disabilities is strictly prohibited.

To file a complaint of discrimination, either contact your County's Civil Rights Coordinator, or write to or call the USDA or California Department of Social Services (CDSS):

USDA, Director
Office of Civil Rights, Room 326-W
Whitten Building
1400 Independence Ave.
Washington D.C. 20250-9410
1-202-720-5964 (voice and TDD)

CDSS
Civil Rights Bureau
P.O. BOX 944243, M.S. 8-16-70
Sacramento, CA 94244-2430
1-866-741-6241 (Toll-Free)

USDA is an equal opportunity employer.

Work Rules for CalFresh
The county may assign you to a work program. They will tell you if it is voluntary or if you must do the work program. If you have a mandatory work activity and you do not do it, your benefits may be lowered or stopped.

You may not be eligible for CalFresh if you have recently quit a job.

Please take and keep for your records

Work Rules for CalWORKs (Welfare-to-Work)

If you get cash aid, you must participate in Welfare-to-Work (WTW) unless you are exempt. The county will tell you if you are exempt from WTW. If you do not do your assigned activities your cash aid may be lowered or stopped.

CalWORKs - Fingerprinting/Photo Imaging

All eligible adult household members for cash aid must be fingerprinted/photo-imaged. If anyone who is required to cooperate with these rules does not get fingerprinted/photo-imaged, no benefits will be issued to the entire household. The fingerprinted/photo-images are confidential and can only be used to prevent or prosecute welfare fraud.

How do I get/use my benefits?
CalFresh and Cash Aid:

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to get cash from ATMs or to buy food and/or other items.
- If your EBT card is lost, stolen, or destroyed, call (877) 328-9677 right away. Also, you may call the County right away.
- Make sure your authorized representative also knows how to report a lost or stolen EBT card or PIN. Any benefits taken from your account before you report the EBT card or PIN lost or stolen will **NOT** be replaced.
- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like toothpaste, soap, or paper towels).
- CalFresh benefits are accepted at most grocery stores and other places that sell food. Cash aid can be used at most stores and most ATMs. Some ATMs may charge a fee. There may also be a fee if you use an ATM to get cash after three withdrawals. For a list of locations near you that accept EBT, please go to: https://www.ebt.ca.gov or https://www.snapfresh.org. You can also find out where you can get cash without paying a fee.
- CalFresh benefits are only for you and your household members. Your cash aid is only for you and the members of your family who were approved for cash aid. Your cash aid is to help meet the basic needs of your family (housing, food, clothing, etc.). Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.
- Any use of your EBT card by you, a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **NOT** be replaced.

Medi-Cal and Health Care:

- For Medi-Cal, you will receive a Benefits Identification Card (BIC).
  - Sign your BIC when you get it and use it only to get necessary health care services.
  - Never throw your BIC away (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
  - Take the BIC to your medical provider when you or a family member is sick or has an appointment.
  - Take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.
- For other health care programs you will receive a health plan card from your particular carrier.

Please take and keep for your records

Please use black or blue ink because it is easy to read and copies best. Please print your answers.
If you need more space to answer a question(s), attach additional sheets of paper to provide the information. Please be sure to identify which question you are writing about on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS)

HOME ADDRESS OR DIRECTIONS TO YOUR HOME	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE

I want to get information about this application by email. ☐ Yes ☐ No

I want to get messages about my case by email. ☐ Yes ☐ No

HOME PHONE	WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS

What programs are you applying for?
☐ CalFresh ☐ Cash Aid ☐ Health Coverage

Do you have a disability and need help applying? ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No If **yes,** please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)?_____
What language do you prefer to speak (if not English)?_____

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

Is your household's gross income less than $150 and cash on hand, checking and savings accounts $100 or less?	☐ Yes ☐ No	Have your utilities been shut off or do you have a shut-off notice?	☐ Yes ☐ No
Is your household's combined gross income and liquid resources less than the combined rent/mortgage and utilities?	☐ Yes ☐ No	Will your food run out in 3 days or less?	☐ Yes ☐ No
Is your household a migrant/seasonal farm worker household with liquid resources not exceeding $100?	☐ Yes ☐ No	Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?	☐ Yes ☐ No
Do you have an eviction notice or a notice to pay rent or leave?	☐ Yes ☐ No	Do you need essential clothing, such as diapers or clothing needed for cold weather?	☐ Yes ☐ No

Is anyone pregnant? ☐ Yes ☐ No If yes, did she get a Presumptive Eligibility card? ☐ Yes ☐ No

Does anyone in your household have a personal emergency? ☐ Yes ☐ No **If yes**, check box: ☐ Pregnancy ☐ Immediate Medical Need ☐ Child Abuse ☐ Domestic Abuse ☐ Elder Abuse ☐ Other emergency which threatens health or safety. Explain:

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- Any answers I have given on pages 1 through 18 and appendices A through C of the SAWS 2 Plus are true, correct, and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1).
- I read, or had read to me, the Program Rules and Penalties (Program Rules Pages 2 - 4).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility is fraud and that I may be subject to penalties under federal law if I provide false or untrue information. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits and cash aid.
- I understand that Social Security Numbers or Immigration Status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.
- I am giving the Medi-Cal agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties.

SIGNATURE OF APPLICANT, CARETAKER RELATIVE (OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN) ***If you have an Authorized Representative, please complete Question 2 on the next page.**	DATE
SIGNATURE OF SPOUSE, OTHER PARENT, OTHER AIDED ADULT, OR REGISTERED DOMESTIC PARTNER	DATE

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? ☐ Yes ☐ No

If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME	AUTHORIZED REPRESENTATIVE PHONE NUMBER

Do you want to name someone to receive and spend CalFresh Benefits for your household? ☐ Yes ☐ No

If **yes**, complete the following section:

NAME	PHONE NUMBER

ADDRESS	CITY,	STATE,	ZIP CODE

2a. HEALTH INSURANCE AUTHORIZED REPRESENTATIVES

You can give a trusted person permission to talk about your application for health insurance, see your information, and act for you on things about this part of your application. Do you want to choose an authorized representative for the health insurance part of your application? ☐ Yes ☐ No If yes, fill out the information in Appendix C.

3. Are you or any member of your family American Indian or Alaskan Native? ☐ Yes ☐ No
If yes, and applying for health care, please go to Appendix B for additional questions.

RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY	ARE YOU OF HISPANIC, LATINO, OR SPANISH ORIGIN?	IF YOU ARE OF HISPANIC, OR LATINO ORIGIN, DO YOU CONSIDER YOURSELF
	☐ Yes ☐ No	☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other_____

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed _____

☐ Asian (If checked, please select one or more of the following):

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify)_____

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You will need to have an interview with the County to discuss your application and to receive cash aid or CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. Cash aid applicants must have an in person interview. If you are applying for CalWORKs and CalFresh, your CalFresh interview will be done at the same time as your CalWORKs interview during normal office hours.

☐ Please check this box if you would prefer an in-person interview for CalFresh.

☐ Please check this box if you need other arrangements due to a disability.

5. OTHER PROGRAMS

Has anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Tribal TANF, Medicaid, Supplemental Nutrition Assistance Program [food stamps], General Assistance/General Relief, etc.)? ☐ Yes ☐ No

IF YES, WHO?	WHERE *(COUNTY/STATE)*?
IF YES, WHO?	WHERE *(COUNTY/STATE)*?

6. HOUSEHOLD'S INFORMATION: ADULTS

Complete the following information for all adults in the home. If applying for health care coverage, also include any adults claimed on your tax return.
For noncitizens you are applying for, please complete additional questions 6e and 6f.

APPLYING FOR BENEFITS *(check each type)* CalFresh	Cash Aid	Medi-Cal Health Care	None	**NAME** (Last, First, Middle Initial)	How is the person related to you?	**DATE OF BIRTH**	**GENDER** (M OR F)	Marital Status: Single	Married	Separated	Divorced	Widowed	Full-Time Student (check if yes)	Disabled (check if yes)	Only answer the question below for each person applying for benefits. **U.S. CITIZEN** or **NATIONAL** (check Yes or No) **If no, complete question 6e.**	Social Security number is optional for members not applying for benefits. **SOCIAL SECURITY NUMBER**
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐					☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	

6a. Does everyone listed in question 6 have the same contact information? ☐ **Yes** ☐ **No** **If no, please fill in the person's contact information below. If yes, please skip to the next question.**

NAME (FIRST, MIDDLE, AND LAST)	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
HOME PHONE NUMBER	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS (OPTIONAL)				

NAME (FIRST, MIDDLE, AND LAST)	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
HOME PHONE NUMBER	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS (OPTIONAL)				

6b. HOUSEHOLD'S INFORMATION: CHILDREN

Complete the following information for all children in the home. If applying for health care coverage, also include any children claimed on your tax return.
For noncitizens you are applying for, please complete additional questions 6e and 6f.

APPLYING FOR BENEFITS (check each type)				NAME (Last, First, Middle Initial)	How is the person related to you?	DATE OF BIRTH	PLACE OF BIRTH	SEX (M / F)	Check all that applies to one or both of the child's parents					Full-Time Student (check if yes)	Shots up to date? (check if yes)	Only answer the question below for each person applying for benefits. U.S. CITIZEN or NATIONAL (check Yes or No) If no, complete question 6e.	Social Security number is optional for members not applying for benefits. SOCIAL SECURITY NUMBER
CalFresh	Cash Aid	Medi-Cal Health Care	None						Not in home	Unemployed	Disabled	Deceased	None				
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	
☐	☐	☐	☐						☐	☐	☐	☐	☐	☐	☐	☐ Yes ☐ No	

6c. SOCIAL SECURITY INFORMATION

Does everyone applying for aid have a Social Security Number? ☐ Yes ☐ No If **no**, please fill in the information below.
We need the Social Security Number for everyone who is applying for aid. There are some exceptions for people who are victims of domestic violence or other crimes such as human trafficking. If you need help getting a Social Security Number call 1-800-772-1213 or go online to www.socialsecurity.gov.

NAME	REASON FOR NOT HAVING A SOCIAL SECURITY NUMBER	APPLIED FOR SSN
	☐ The person is a child who is less than one year old. ☐ It is against this person's religion. ☐ This person does not qualify for an SSN. ☐ Other ______	Has this person applied for a Social Security Number? ☐ Yes ☐ No
	☐ The person is a child who is less than one year old. ☐ It is against this person's religion. ☐ This person does not qualify for an SSN. ☐ Other ______	Has this person applied for a Social Security Number? ☐ Yes ☐ No

6d. Has anyone been in the U.S. Military service or are they the spouse, parent or child of a person who was? ☐ Yes ☐ No

If **yes**, please complete the information below. If **no**, please continue to the next question.

Name	U.S. Citizen?	(✔) Status	Honorable Discharge?	Dates of Service
	☐ Yes ☐ No	☐ Active duty ☐ Veteran ☐ Spouse, parent, or child of person in active duty or a veteran	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Active duty ☐ Veteran ☐ Spouse, parent, or child of person in active duty or a veteran	☐ Yes ☐ No	

6e. NONCITIZEN INFORMATION - Please complete for noncitizens you are applying for.

Name	Date entered U.S. (if known)	Does this person have an eligible immigration status? If yes, please provide their immigration document and number.	Has this person lived in the U.S. continuously since 1996?	Is this person a Naturalized Citizen?	Sponsored? (check Yes or No) If yes, complete question 6f
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		DOCUMENT TYPE: DOCUMENT NUMBER:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does anyone listed above have at least 10 years *(40 quarters)* of work history? ☐ Yes ☐ No

If **yes**, who? _____

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa or U-Visa, VAWA petition? ☐ Yes ☐ No

If **yes**, who? _____

Has anyone changed their immigration status in the last 12 months? ☐ Yes ☐ No

If **yes**, please complete the information below.

If **no**, please continue to the next question.

NAME	WHAT CHANGED?	DATE OF CHANGE	ALIEN NUMBER (IF APPLICABLE)
NAME	WHAT CHANGED?	DATE OF CHANGE	ALIEN NUMBER (IF APPLICABLE)

6f. Sponsored Noncitizen Information - Please answer for sponsored noncitizens you are applying for.

Did the sponsor sign an I-864? ☐ Yes ☐ No If **yes**, please answer the rest of the question.
If the sponsor signed an I-134 then **skip** this question.

Does the sponsor regularly help with money? ☐ Yes ☐ No If yes, how much? $ _____

Does the sponsor regularly help with any of the following (check all that apply)?

☐ rent ☐ clothes ☐ food ☐ other_____

SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER
SPONSOR'S NAME	WHO IS SPONSORED?	SPONSOR'S PHONE NUMBER

6g. Does anyone listed in question 6 who is under the age of 21 have a parent who does not live in the home?

☐ Yes ☐ No If **yes**, please list the name of the child(ren) and the name(s) of the parents who do not live in the home.
If no, please continue to the next question.

NAME OF CHILD	NAME OF PARENT(S) NOT LIVING IN THE HOME
NAME OF CHILD	NAME OF PARENT(S) NOT LIVING IN THE HOME

6h. Does anyone in question 6 live with at least one child under the age of 19 and are they the main person taking care of the child?

☐ Yes ☐ No If no, skip to the next question. **If yes, who?**_____

6i. Does anyone listed in question 6 have a physical, mental, emotional, or developmental disability that causes limitations in activities (such as bathing, dressing, daily chores)? ☐ Yes ☐ No If yes, please list the name(s) of the person with the disability. If no, please continue to the next question.

Name:_____ Name:_____

6j. Complete for each disabled person listed in question 6.

Name of person	Does this person need help with activities of daily living through personal assistance or a medical facility? ☐ Yes ☐ No If **yes**, explain:
Disability is expected to last: ☐ 30 days or more ☐ 12 months or more	Does this person work and have medical expenses that are needed to help them keep working? For example, a wheelchair, leg braces, etc. ☐ Yes ☐ No If yes, please explain.
Does this person need care so that someone else can work or attend school? ☐ Yes ☐ No	Is this person in a medical facility or nursing home? ☐ Yes ☐ No If **yes**, what is the name of the medical facility or nursing home?

Name of person	Does this person need help with activities of daily living through personal assistance or a medical facility? ☐ Yes ☐ No If **yes**, explain:
Disability is expected to last: ☐ 30 days or more ☐ 12 months or more	Does this person work and have medical expenses that are needed to help them keep working? For example, a wheelchair, leg braces, etc. ☐ Yes ☐ No If yes, please explain.
Does this person need care so that someone else can work or attend school? ☐ Yes ☐ No	Is this person in a medical facility or nursing home? ☐ Yes ☐ No If **yes**, what is the name of the medical facility or nursing home?

6k. Is there a child or disabled person in the household who needs care from another household member?

☐ Yes ☐ No If **yes**, please explain. If no, skip to the next question.

6l. Is everyone between ages 6 and 18 listed in question 6b attending school regularly? ☐ Yes ☐ No
If **yes**, please list the child's name and the name and address of the school they attend.
If **no**, please explain why the child is not attending school regularly.

NAME OF CHILD	NAME AND ADDRESS OF SCHOOL	REASON FOR NOT ATTENDING SCHOOL
NAME OF CHILD	NAME AND ADDRESS OF SCHOOL	REASON FOR NOT ATTENDING SCHOOL

6m. Students
Is anyone who is applying for benefits attending a college or vocational school? ☐ Yes ☐ No
If **yes**, please answer this queston. If **no**, skip to the next question.

Name of Person	Name of School/Training	Enrolled Status (✔ check one)	Working?
		☐ Half-time or more ☐ Less than half-time Number of Units:_____	Average work hours per week: _____
		☐ Half-time or more ☐ Less than half-time Number of Units:_____	Average work hours per week: _____

6n. Is anyone listed in question 6 or 6b pregnant or a teen parent? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Name	Is this person under the age of 20? ☐ Yes ☐ No Is this person a teen parent? ☐ Yes ☐ No	School status if under the age of 20 ☐ Has a high school diploma ☐ Has a GED ☐ Is attending school regularly ☐ Is not attending school regularly (explain why):	Due date (if known)	How many babies are expected with this pregnancy?
Name	Is this person under the age of 20? ☐ Yes ☐ No Is this person a teen parent? ☐ Yes ☐ No	School status if under the age of 20 ☐ Has a high school diploma ☐ Has a GED ☐ Is attending school regularly ☐ Is not attending school regularly (explain why):	Due date (if known)	How many babies are expected with this pregnancy?

6o. Has anyone ever gotten a cash bonus or penalty, or help with child care, transportation or other service from the Cal-Learn Program? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Name	**Where** (County)	Date(s) Received

6p. Was anyone listed in question 6 ever in foster care? ☐ Yes ☐ No
If **yes**, please explain.

Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? ☐ Yes ☐ No
Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? ☐ Yes ☐ No

6q. Is there a foster child living in your home? ☐ Yes ☐ No If **yes**, who?_____

Please answer the following questions about the foster child(ren):

Was this child(ren) placed in your home under a dependency order of the court? ☐ Yes ☐ No

Do you want the foster care child(ren) counted in your CalFresh case? ☐ Yes ☐ No

If **yes**, the foster care income you receive will be counted as unearned income.

If **no**, the foster care income will not be counted as unearned income.

6r. Does everyone listed in question 6 live in California and expect to keep living here? ☐ Yes ☐ No

If **no**, please explain.

6s. Does anyone listed in question 6 plan to leave California for more than 30 days? ☐ Yes ☐ No

If **yes**, please explain.

NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? ☐ YES ☐ NO IF YES, WHEN:
NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? ☐ YES ☐ NO IF YES, WHEN:

7. Unearned Income

Does anyone get income that does not come from work (unearned)? ☐ Yes ☐ No If **yes**, please answer this question.

If **no**, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- ☐ Social Security Disability
- ☐ SSI/SSP
- ☐ Cash aid
- ☐ CalWORKs/TANF/GA/GR/CAPI/RCA
- ☐ Room and board (from a renter)
- ☐ Pension
- ☐ Child/Spousal support
- ☐ Rental/Royalties
- ☐ Social Security retirement or survivors benefits
- ☐ Per capita payments
- ☐ Work study/welfare to work or other program
- ☐ Sales of notes, contracts, trust deeds, promissory notes
- ☐ Veterans education benefits/income
- ☐ Government/railroad disability or retirement
- ☐ Veteran benefits or Military pension
- ☐ Financial aid (school grants/loans/scholarships)
- ☐ Gifts of money or other loans
- ☐ Unemployment Insurance/ State Disability Insurance (SDI)
- ☐ Worker's Compensation
- ☐ Net Farming/Fishing
- ☐ Lottery/gambling winnings
- ☐ Help with rent/food/clothing
- ☐ Insurance or legal settlements
- ☐ Private disability or retirement
- ☐ Dividend and interest income
- ☐ Strike benefits
- ☐ Other_____

Person Getting the Money?	**From Where?**	**How Much?**	**How Often Received?** (once, weekly, monthly, or other)	**Expect to Continue?** (Check Yes or No)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If this income is not expected to continue, please explain:

8. Earned income

Does anyone get income from a job (earned income)? ☐ Yes ☐ No If **yes**, please answer this question.
If **no**, skip to the next question.
NOTE: If self-employed, fill out question 8a below.
Please list all income **before** taxes or other deductions are taken out (gross income).
Examples of earned income are (these examples can be full-time, temporary seasonal work, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)
- Include any paid jobs the County helped you get.

Person Working	Employer's Name and Address	Employer's Phone Number	Hourly Rate	Average hours per week	How Often Paid? (Once weekly, monthly, other)	Total Gross Earned Income Received This Month?	Expect to Continue? (✔ Check Yes or No)
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No
			$			$	☐ Yes ☐ No

If this income is not expected to continue, please explain:

Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? ☐ Yes ☐ No
In the last year? ☐ Yes ☐ No
Did the County help the person get this job? ☐ Yes ☐ No

IF YES, WHO?	DATE OF JOB LOSS, QUIT, OR CHANGE	DATE OF LAST PAY	REASON?

IS ANYONE ON STRIKE? ☐ Yes ☐ No	IF YES, WHO?	DATE WENT ON STRIKE	DATE OF LAST PAY	REASON?

8a. Self-Employment

Self-employed household members may take actual self-employment expenses (or for CalFresh or cash aid, take a standard 40% deduction off of self-employment income). For cash aid, you may also choose to use a monthly average (yearly business costs divided by 12 months). If you choose actual expenses, you must list your business expenses on a separate sheet of paper.

Person Self-Employed	Business Name	Type of Business	Date Business Started	Gross Monthly Income	Self-Employment Expenses (please ✔ check one)	Net Monthly Income
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$
				$	☐ 40% flat Rate (CalFresh/cash aid) ☐ Actual Expenses $ _____ ☐ Monthly Average $ _____	$

* Net monthly income is gross monthly income minus expenses.

9. Other Income

Does anyone get housing or rent, utilities, food or clothing free or in exchange for work? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Item Received	Free	For Work	Who gets the item?	Value	Who gives the item?
Housing or Rent	☐	☐		$	
Utilities	☐	☐		$	
Food	☐	☐		$	
Clothing	☐	☐		$	

10. Yearly Income

Does anyone's total income (unearned, earned, and self employment) change from month to month? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Name of Person	What will be their total income this year?	What will be their total income next year (if you think it will be different)?
	$	$
	$	$

11. Household's Child/Adult Care Expenses (The actual amount of cost incurred if allowing the expenses to potentially be a deduction).

Does anyone pay for care of a child, disabled adult, or other dependent so you or the other person can go to work, school, or look for a job? ☐ Yes ☐ No If **yes**, please answer this question.

If **no**, skip to the next question.

Who gets care?	Who gives care? (name and address of provider)	Amount paid?	How Often Paid? (weekly/monthly, other)
		$	
		$	
		$	
		$	

Does anyone help your household pay all or part of your child/adult care cots listed above? ☐ Yes ☐ No If **yes,** complete below.

Who gets care?	Who helps pay?	Amount paid?	How Often Paid? (weekly/monthly, other)
		$	
		$	

12. Child Support Payments

Is anyone listed in question 6 legally obligated to pay child support, including back child support? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How Often? (weekly/monthly, other)
		$	
		$	

13. Spousal Support/Alimony

Is anyone listed in question 6 legally obligated to pay spousal support/alimony? ☐ Yes ☐ No

If **yes**, please answer the questions below.

If **no**, skip to the next question.

Who pays spousal support/alimony?	Amount paid?	How often? (weekly, bi-weekly. monthly, other)
	$	
	$	

14. Special Needs Expenses

Does anyone have a special medical condition or situation that requires any of the following?

Special diet prescribed by a doctor? ☐ Yes ☐ No

Special phone or other equipment? ☐ Yes ☐ No

Housework (no one in the home can do it)? ☐ Yes ☐ No

Very high use of utilities? ☐ Yes ☐ No

Special laundry service? ☐ Yes ☐ No

Other special need? (specify) ☐ Yes ☐ No

Please list the name of the person with the special need and explain:

15. Household Expenses

Does anyone you purchase and prepare food with get billed for any household expenses? ☐ Yes ☐ No

If **yes**, please answer this question.

If **no**, skip to the next question.

NOTE: Do no enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances. It is not necessary to fill in the actual amount owed.

Type of Expenses	Have Expense?	Who Pays?	Amount Owed	How Often Billed? (weekly/monthly)
Rent or house payment	☐ Yes ☐ No		$	
Property taxes and insurance (if billed separate from rent or mortgage)	☐ Yes ☐ No		$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if separate from rent or mortgage)	☐ Yes ☐ No			
Telephone/cell phone	☐ Yes ☐ No			
Homeless Shelter Expense	☐ Yes ☐ No			
Water, sewage, garbage	☐ Yes ☐ No			
Does anyone not in your household help you pay for the expenses listed above? ☐ Yes ☐ No If yes, please complete.		Who helps pay?	How much? $	How often paid?

Does your household get, or expect to get any payments from the Low Income Home Energy Assistance Program (LIHEAP)? ☐ Yes ☐ No

16. Medical Expenses:
Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? ☐ Yes ☐ No
If **yes**, please answer this question.
If **no**, skip to the next question.
NOTE: Do not list spouses or children receiving dependent payments for an SSI or disability and blindness recipient. List expenses you expect to have in the near future.
Allowable medical expenses are:

- ☐ Medical or dental care
- ☐ Hospitalization/outpatient treatment/nursing care
- ☐ Prescribed medications
- ☐ Health and Hospitalization insurance policy premiums
- ☐ Medicare premiums (Medi-Cal share of costs, etc.)
- ☐ Dentures, hearing aids and prosthetics
- ☐ Maintaining an attendant necessary due to age, illness, or infirmity
- ☐ The number and cost of meals furnished to an attendant
- ☐ Prescribed over the counter medications
- ☐ Cost of transportation (mileage or fee) and lodging to obtain medical treatment or services
- ☐ Prescribed eye glasses and contact lenses
- ☐ Prescribed medical supplies and equipment
- ☐ Service animals expenses (food, vet bills, etc.)

Name of Elderly/Disabled Person	Amount of Expense	How often paid? (monthly, weekly, other)	What type of expense? (prescriptions, dentures, # of meals for attendant, etc.)	Will the household be reimbursed for any medical expenses? (by Medi-Cal, insurance, family member, etc.)
	$			IF YES, BY WHO: HOW MUCH: $
	$			IF YES, BY WHO: HOW MUCH: $

17. Other Tax-Deductible Expenses
If anyone pays for anything that can be deducted on a federal income tax return, telling us about it here could make the cost of health insurance a little lower. Do not include anything that you already included in self-employment expenses. If you have other deductible expenses, please answer this question. If no, skip to the next question.

Type of Expenses	Have Expense?	Who pays?	How often paid? (weekly/monthly)
Alimony	☐ Yes ☐ No		
Student loan interest	☐ Yes ☐ No		
Other deductions (please identify)	☐ Yes ☐ No		

18. Does anyone in question 6 get food from any of the following? ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

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

IF YES, WHO?	WHAT PROGRAM?
IF YES, WHO?	WHAT PROGRAM?

19. Does anyone in question 6 live at any of the following? ☐ Yes ☐ No
If **yes**, please answer this question. If **no**, skip to the next question.

- Homeless Shelter
- Shelter for battered women
- Reservation for Native Americans
- Drug/Alcohol rehabilitation center
- Correctional facility/Penal institution (Jail or Prison)
- Group living arrangement for the blind/disabled
- Federally subsidized housing
- Psychiatric hospital/mental institution
- Hospital
- Long-Term Care or Board and Care Facility

Person's Name	Name of Institution (Center, Shelter, Facility, etc.)	Expected Date of Release (if applicable)

20. Is anyone getting In-Home Supportive Services (IHSS)? ☐ Yes ☐ No
If **yes**, fill in the information below.

WHO GETS SERVICES?	HOW MUCH DO YOU PAY EACH MONTH FOR THE SERVICES?
	$

21. Does everyone listed in question 6 buy and prepare food with you? ☐ Yes ☐ No
If **no**, list the people who don't buy and prepare food with you.

NAME	NAME
NAME	NAME

21a. Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability?
☐ Yes ☐ No If **yes**, who:_____

22. Answer these questions for anyone who needs health coverage. Is anyone enrolled in health coverage now from the following? ☐ Yes ☐ No
If **yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐ Medicaid/Medi-Cal	☐ Employer Insurance
☐ CHIP	Name of health insurance
☐ Medicare	Policy number:
☐ TRICARE (Don't check if you have direct care or Line of Duty)	Is this COBRA coverage? ☐ Yes ☐ No
	Is this a retiree health plan? ☐ Yes ☐ No
☐ VA health care programs	Is this a state employee benefit plan? ☐ Yes ☐ No
☐ Peace Corps	☐ Other
	Name of health insurance
	Policy Number:
	Is this plan a limited-benefit plan like a school accident policy? ☐ Yes ☐ No

22a. Is anyone listed on this application offered health care coverage from a job? ☐ Yes ☐ No
If **yes**, you'll need to complete and include Appendix A.

22b. Is anyone's health insurance expected to end or has it ended in the last 90 days? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

Insurance Company	Person Insured	Expiration Date	Reason it ended or will end

22c. Does anyone want help for medical bills from the last three months? ☐ Yes ☐ No
If **yes**,, who:_____

23. Does anyone listed in question 6 plan to file a federal income tax return next year? ☐ Yes ☐ No
If **yes**, complete the questions below for each tax filer.
If **no**, skip to 23e.

23a. Please complete this section for each person who plans to file a federal income tax return **next year** if you answered yes to question 23. You can still apply for health insurance even if you don't file a federal income tax return.

23b. Name of person planning to file a federal income tax return:_____

23c. Will this person file jointly with a spouse? ☐ Yes ☐ No
If **yes**, name of spouse:_____

23d. Will this person claim any dependents on their tax return: ☐ Yes ☐ No
If **yes**, please list the name of the tax filer who will claim this:_____

23e. How is this person related to the tax filer who will claim them:_____

23f. To make it easier to determine my eligibility for paying health coverage in future years. I agree to allow you to use income data, including information from tax returns. You will send me a notice, let me make any changes, and I can opt out at any time.
Yes, renew my eligibility automatically for the next (check one): ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year
☐ No, don't use information from tax returns to renew my coverage.

24. Household's Resources

Does anyone have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)? ☐ Yes ☐ No If **yes**, please answer this question. If **no**, skip to the next question.

Optional for health care; only answer if someone applying is 65 or older or disabled. If applying for cash aid and CalFresh, you must answer the question.

Check each resource listed below that you or anyone in your household has:

- ☐ Bank/Credit Union account (Checking)
- ☐ Bank/Credit Union account (Savings)
- ☐ Safe Deposit box
- ☐ Savings Bond(s)
- ☐ Oil, Mining or Mineral Rights
- ☐ Money Market Account(s)
- ☐ Mutual funds/Trust funds
- ☐ Certificate of Deposit (CD)/IRA
- ☐ Cash on hand
- ☐ Notes, Mortgages, Deeds of Trust
- ☐ Stocks
- ☐ Bonds
- ☐ Uncashed checks
- ☐ Life or Burial insurance
- ☐ Other: _____

If joint account with another person please say so below.

For each box checked above, complete the following information.

In Whose Name is the Resource Listed?	Type of Resource	How Much is it Worth?	Where is the Resource? (include the name of the bank or company where money is held)
		$	
		$	
		$	
		$	

Have you or anyone in your household sold, traded, given away, or transferred a resource in the last thirty (30) months? ☐ Yes ☐ No

WHEN?	WHAT WAS THE RESOURCE?	WHAT WAS IT WORTH?	HOW MUCH DID YOU GET FOR IT
		$	$

If you traded or gave the resource away, please explain:_____

Optional for health care; only answer if someone applying is 65 or older or disabled.

25. Personal Property

Does anyone own any personal or business-related property? ☐ Yes ☐ No
If **yes**, please answer the question. If **no**, skip to the next question.

- ☐ Tools
- ☐ Business inventory
- ☐ Livestock
- ☐ Business equipment
- ☐ Sporting equipment, Guns
- ☐ Non-Motor boats and/or trailers
- ☐ Camper shells
- ☐ Personal tools
- ☐ Jewelry, Artwork, Antiques, Collections, Musical instruments (Piano, Organ, etc.)

Please include the item even if it is jointly owned with someone else. Do not include wedding or engagement rings, family heirlooms, etc. List any other jewelry worth $100 or more and household goods or personal items worth more than $500 per item.

Item	Is it listed for Sale?	Purchase Price or Current Value	Amount Owed
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$
	☐ Yes ☐ No	$	$

Optional for health care; only answer if someone applying is 65 or older or disabled. If you are applying for cash aid, you must answer the question.

26. Vehicles

Does anyone own, have the use of, or have their name on any registration of any motor vehicle, such as: a car, motorcycle, snowmobile, recreational vehicle (RV), or motorboat, etc., even if it isn't running? ☐ Yes ☐ No

	Vehicle (1)	Vehicle (2)	Vehicle (3)
Owner of vehicle			
Name of person who uses the vehicle			
Year/Make/Model			
License plate number			
Was this vehicle a gift, donation, or transferred to you by a family member?	☐ Yes ☐ No if **yes,** check the appropriate box ☐ gift ☐ donation ☐ transferred by family member	☐ Yes ☐ No if **yes,** check the appropriate box ☐ gift ☐ donation ☐ transferred by family member	☐ Yes ☐ No if **yes,** check the appropriate box ☐ gift ☐ donation ☐ transferred by family member
Estimated value	$	$	$
How much do you still owe on the vehicle?	$	$	$
Is the registration currently paid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you or someone else currently leasing the vehicle?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How do you use the vehicle?			
As a home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
To go to work, training, or job search?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For self-employment, self-support, or business use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
To drive a disabled household member?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
To get fuel or water for your household?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For recreational use only?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

27. Does anyone in question 6 own or are they buying a home, land, or property anywhere including in another state or country? ☐ Yes ☐ No If **yes,** please explain.

Optional for health care; only answer if someone applying is 65 or older or disabled.

Who owns or is buying the home/property?	Address of the home/property	Is someone renting the home from the owner?	How much rent does the owner get?		Not living in now but owner expects to move back into the home someday?
		☐ Yes ☐ No	$	☐ Not rented	☐ Yes ☐ No
		☐ Yes ☐ No	$	☐ Not rented	☐ Yes ☐ No

28. Diversion Program

Has anyone received a Diversion cash payment or non-cash services from any county or other state? ☐ Yes ☐ No

If **yes**, please answer the question. If **no**, skip to the next question.

Name	County/State Received From	Amount Received	List of Services Received	Estimated Value of Services	Date Last Received
		$		$	

29. **Duplicate Benefits**
Have you, or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program) benefits in any State after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

30. **Trafficking Benefits**
Have you, or any member of your household, ever been convicted of trafficking (allowing use of or selling EBT cards to others) SNAP benefits of $500 or more after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

31. **Trading Benefits for Drugs**
Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

32. **Trading Benefits for Firearms or Explosives**
Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition or explosives after September 22, 1996? ☐ Yes ☐ No

If **yes**, who?_____

33. **Fraud**
Have you or anyone in your household had their cash aid stopped for being found guilty of Welfare Fraud? ☐ Yes ☐ No

If **yes**, who?_____ When?_____

Where?_____

34. **Non-Cooperation/Sanctions**
Have you or anyone in your household had their cash aid stopped for failure to cooperate with eligibility requirements, work/training sanctions or any other reason? ☐ Yes ☐ No

If **yes**, who?_____ When?_____

Where?_____ Why?_____

35. **Fleeing Felon**
Are you or any member of your 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? ☐ Yes ☐ No

If **yes**, who?_____

36. **Probation/Parole Violation**
Have you or any member of your household been found by a court of law to be in violation of probation or parole? ☐ Yes ☐ No

If **yes**, who?_____

37. **Drug Felony**
Have you or any member of your household, been convicted of felony possession, use, manufacturing, or distribution of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required) after August 22, 1996? ☐ Yes ☐ No
If **yes**, and the felony conviction was for possession, have you or that household member done (or will do) any of the following (CalFresh only):

a) Completed a government-recognized drug treatment program? ☐ Yes ☐ No

b) Participated in a government-recognized drug treatment program? ☐ Yes ☐ No

c) Enrolled in a government-recognized drug treatment program? ☐ Yes ☐ No

d) Been placed on a waiting list for a government-recognized drug treatment program? ☐ Yes ☐ No

e) Stopped the use of controlled substances and have evidence that you have stopped? ☐ Yes ☐ No

If yes, please explain:_____

38. Other Special Needs

Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and/or unusual circumstances, such as a fire, earthquake, or flood? ☐ Yes ☐ No

If **yes**, please explain:

39. Other Services

The following services are available. Your answers to the questions will not affect your eligibility.

A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.

- Do you want more information about CHDP services? ☐ Yes ☐ No
- Do you want CHDP medical services? ☐ Yes ☐ No
- Do you want CHDP dental services? ☐ Yes ☐ No
- Do you need help making appointments or with transportation to CHDP services? ☐ Yes ☐ No

B. Do you want more information about immunization services? ☐ Yes ☐ No

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? ☐ Yes ☐ No

D. Are you breastfeeding a child? ☐ Yes ☐ No
If **yes**, have you given birth within the last 12 months? ☐ Yes ☐ No
If you checked yes to 39 C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).

E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unwanted pregnancies and/or have the next child? ☐ Yes ☐ No
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.

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY

IF THE ANSWER IS "YES" TO ANY OF THE QUESTIONS BELOW - EXPEDITE

Is the household's gross income less than $150 and is the total of cash on hand, checking and savings accounts $100 or less? ☐ Yes ☐ No

Is the household's combined gross income and liquid resources less than the combined rent/mortgage and appropriate utility allowance? ☐ Yes ☐ No

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding $100? ☐ Yes ☐ No

Does the CalWORKs Assistance Unit have a pay-or-quit or other eviction notice? ☐ Yes ☐ No

Appendix A HEALTH COVERAGE FROM JOBS

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. If there is more than one person who is offered health coverage from a different employer, you can copy this page and use it for the second person (or as many as you need).
First, tell us about the job (employer) who offers coverage.

1. EMPLOYEE NAME (FIRST NAME, MIDDLE NAME, LAST NAME)	2. EMPLOYEE SOCIAL SECURITY NUMBER — —

EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN) —
5. EMPLOYER ADDRESS		6. EMPLOYER PHONE NUMBER ( ) —
7. CITY	8. STATE	9. ZIP CODE

10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB?

11. PHONE NUMBER (IF DIFFERENT FROM EMPLOYER'S PHONE NUMBER) ( )	12. EMPLOYER'S EMAIL ADDRESS (EMPLOYER'S REPRESENTATIVE)

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months?

☐ No (stop here for this section of the application)
☐ Yes (continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (MM/DD/YYYY)

List the names of anyone else who is eligible or will be eligible for coverage from this job.

Name:_____ Name:_____Name:_____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

14a. Is this a State employee benefit plan? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation (that helps the employee to quit smoking) programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

☐ The employee doesn't offer wellness programs.

16. What change will the employer make for the new plan year (if known)?

☐ Employer will no longer provide health coverage.
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly
c. Date of change (mm/dd/yyyy):_____
☐ No changes are expected.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Appendix B QUESTIONS FOR AMERICAN INDIAN AND ALASKAN NATIVE INDIVIDUALS

Complete this section if you or a family member (spouse and/or dependents) are American Indian or Alaskan Native. Submit this with your application.

Tell us about your American Indian or Alaskan Native family member(s).

American Indians and Alaskan Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay a cost share and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible. If you have more than two people to tell us about, make a copy of this page and attach it. You may also use a separate piece of paper. Just remember to write the question number next to your answer.

	AI/AN Person 1	AI/AN Person 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If **yes**, tribe name _____ ☐ No	☐ Yes If **yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or through a referral from one of these programs?	☐ Yes ☐ No If **no**, is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ no	☐ Yes ☐ No If **no**, is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? ☐ Yes ☐ no
4. Certain money may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations) • Money from selling things that have cultural significance	☐ Yes - if yes, please complete information below: ☐ None to report $_____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____	☐ Yes - if yes, please complete information below: ☐ None to report $_____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____

Appendix C ASSISTANCE WITH COMPLETING THIS APPLICATION

If you want someone to be your authorized representative for the health insurance part of this application, please answer the questions on this page. If you're a legally-appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or Suite number

4. City

5. State

6. Zip code

7. Phone number

( )

8. Organization name (if applicable)

9. I.D. Number (if applicable)

By signing you allow this person to get official information about the health insurance part of this application and act for you on all matters with Covered California or your County Human Services Agency. As a reminder you can always change your authorized representative by calling the County or going to the web at www.HealthCare.gov.

10. Your signature

11. Date

For Certified Application Counselors, Navigators, Agents and Brokers Only.

Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. I.D. number (if applicable)