STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

May 8, 1991

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 91-41

SUBJECT: MONTHLY ELIGIBILITY/STATUS REPORT, SAWS 7

REFERENCE: Department of Social Services All County Letter 91-28

The Statewide Automated Welfare System (SAWS) staff developed a new form called the SAWS 7 (attached). The SAWS 7 was initially developed for use in the SAWS pilot counties. The SAWS 7 is a generic program reporting form of monthly eligibility information. The SAWS 7 solicits information in a different manner and format than the MC 176 S because it was designed as a generic form for AFDC, Food Stamps and Medi-Cal. For the purpose of Medi-Cal monthly reporting, this form may be used in place of the MC 176 S.

State stock of the SAWS 7 will not be produced at this time. To locally reproduce stock, you may request English and Spanish versions of the SAWS 7 from the State Department of Social Services, Forms Management Bureau by calling (916) 322-8738 or ATSS 8-492-8738. Translations in Cambodian, Chinese, Lao and Vietnamese may be requested from the Language Services Bureau at (916) 323-9562 or ATSS 8-473-9562.

The SAWS 7 has no impact on the Quarterly Medi-Cal Status Report, MC 176 SQ or MC 176 SAQ.

If you have questions regarding this information, please contact Elaine Bilot at (916) 327-7154 or ATSS 8-467-7154.

Sincerely,

ORIGINAL SIGNED BY

FRANK S. MARTUCCI, CHIEF
Medi-Cal Eligibility Branch

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF HEALTH SERVICES

MONTHLY ELIGIBILITY/STATUS REPORT

For Cash Aid, Food Stamps and Medical Assistance

THIS REPORT IS FOR THE MONTH OF

- Complete and return this report by the 5th of the month.
- If a complete report still is not in by the 11th, your benefits for Cash Aid, Food Stamps and Medical Assistance may be delayed, lowered or stopped. Also for Cash Aid, you will not get work allowances.
- Important: If you don't want Cash Aid, Food Stamps and/or Medical Assistance anymore, fill in part A below, sign and date item 6 on the back of this form. Facts on who can sign are listed there.
- If you want to keep your benefits, fill in ALL questions in Part B below.

Need Help? Call your worker. Worker: Phone:

PART A Discontinuance Request (If you fill in this part, sign and date item 6 on the back of this form)

I ask that my ☐ Cash Aid ☐ Food Stamps ☐ Medical Assistance be stopped on the last day of: _____ MONTH/YEAR

I know that I may reapply at any time.

PART B

- Answer all of the questions below. If you answer "YES", read and fill in the rest of the section. Attach a separate sheet of paper if needed.
- Attach proof of income and costs or your benefits may be lowered or stopped.

If you get Food Stamps, answer for everyone in your household. If you don't get Food Stamps, answer for everyone on Cash Aid and/or Medical Assistance including children, parents, stepparents and your spouse.

1. Did anyone get money from a job or a training program? ☐ YES ☐ NO

- If YES, list all earnings or training allowances received during the month. Include tips, vacation pay or income in kind such as earned housing. List who got income, employer, gross amount before deductions, actual date received, and the number of days and hours worked in the month. Attach paystubs or other proof of earnings.
- If self-employed, list business costs on a separate sheet of paper and attach proof of income and costs.

NAME	EMPLOYER ☐ Job ☐ Training	DAYS WORKED	HOURS WORKED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED
NAME	EMPLOYER ☐ Job ☐ Training	DAYS WORKED	HOURS WORKED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED
NAME	EMPLOYER ☐ Job ☐ Training	DAYS WORKED	HOURS WORKED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED

- If anyone above paid for care of a child, disabled person or other dependent while working or in training, list here and attach proof of payment.

Who Received Care?	Cost	Who Received Care?	Cost
	$		$

- If you got Cash Aid and/or Medical Assistance, and anyone who had earnings paid court ordered support, list the amount paid. Attach proof. $

2. Did anyone receive money or benefits from any other source? ☐ YES ☐ NO
Such as: Social Security, Railroad Retirement, Unemployment/Disability Benefits, Veterans Benefits; Interest from Stocks, Bonds, Savings Accounts; Worker's Compensation, SSI/SSP, Child/Spousal Support, Child Support Disregard; Loans, Grants, Scholarships; Strike Benefits, Tax Refund, Cash, Lottery Winnings, Gifts, Rental Income; Free Housing, Utilities, Food, Clothing; or Cash from an Insurance Policy, Insurance or Legal Settlement, etc.

- If YES, list who received, source, gross amount and actual date received. Attach proof of any changes.

NAME	SOURCE	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED
NAME	SOURCE	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED	AMOUNT $ DATE RECEIVED

- If you got Child Support this month and it covered more than one month, which months did it cover?
- If you got Cash Aid and/or Medical Assistance and anyone who had income paid court ordered support, list the amount paid. Attach proof. $

COUNTY USE ONLY E.W. INITIALS DATE:

3. Did anyone move into or out of your home or did you move in with someone else? ☐ YES ☐ NO
(Include newborns; anyone who entered or left a hospital, nursing home, or rehabilitation center; or anyone who died).
If YES, give the name(s) of anyone who moved into or out of your home or who you moved in with.
Include the change and the date it took place.

FULL NAME	RELATIONSHIP TO YOU	WHAT CHANGED	DATE

4a. Did you move or change your address? ☐ YES ☐ NO

or

4b. Did you have a change in the amount you pay for rent, housing or utilities? ☐ YES ☐ NO

or

4c. Did you have a change in your shared housing or in the amount paid by someone who is helping you pay for your housing and/or utilities? ☐ YES ☐ NO
If you answered "YES" to any question, complete 4d below. If you get Food Stamps, **attach proof** that shows what was paid, who paid and the amount paid. Include proof of rent or housing costs, utilities, property taxes and/or insurance paid for by you or by someone who is helping you pay.

4d.

NEW HOME ADDRESS (NUMBER, STREET NAME, AVENUE, BLVD, ETC) APT NO	CITY	STATE	ZIP CODE	DATE OF CHANGE

NEW MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS)	CITY	STATE	ZIP CODE	DATE OF CHANGE

NEW ACTUAL UTILITY COST: $	NEW RENT OR HOUSING COSTS: $	I PAY FOR THE FOLLOWING UTILITIES AT MY NEW ADDRESS	NEW PHONE NUMBER
DATE OF CHANGE	DATE OF CHANGE		

5. Does anyone have anything else to report? (Include expected changes) ☐ YES ☐ NO
If YES, explain. Include name of person and **date of change. Attach proof** including any costs.

- Income: Starts, changes or stops.
- Job/ Training: **Start**, stop, quit, refuse a job or training, go out on strike, or change hours or pay.
- School: Start or stop school or college if age 16 or older. Pay school transportation costs, tuition, etc.
- Property: Buy, sell, trade, give away, or get a motor vehicle, home, land, burial plot, trusts or earned income tax credits, etc.
- Checking/ Savings: Open/close a checking or savings account(s) or the balance is different at the end of the month.
- Disability: Become disabled, recover from a disability or a major illness.
- Citizen/ Alien Status: Change in citizen or alien status.
- Babies: Become pregnant, have a baby, abort or miscarry.
- Marital: Marry, divorce, or separate.
- Dependent Care: Have cost for care of a child or disabled person or other dependent while someone seeks work or attends school or training.
- Medical Cost: For Food Stamp recipients: medical costs for those who are disabled, or age 60 or older. For Medical Assistance recipients: medical costs that were due to an injury or accident caused by someone else.
- Insurance: Start, stop or change life or health insurance benefits, including MEDICARE.

CERTIFICATION

I understand that:

- I must contact my worker within 5 days of any change that may affect my eligibility for or the amount of my Cash Aid.
- I must contact my worker within 10 days of any change that may affect my eligibility for Medical Assistance Only or my Share of Cost.
- If I have any doubt about needing to report any changes, I must contact my worker.
- Facts I report may result in benefits going up, down, or being stopped.
- Failing to report facts or giving wrong or incomplete facts for Cash Aid, Food Stamps or Medical Assistance can result in legal prosecution with penalties of a fine, imprisonment, or both.
- **In the Food Stamp Program, the penalties can result in permanent disqualification from the Program, fines up to $10,000 or imprisonment for up to 5 years. Disqualification penalties for Intentional Program Violation(s) are 6 months for the first violation, 12 months for the second violation, and permanent disqualification for the third violation.**
- California law says that I have committed a felony if I don't report any change in income, property, or family status without good cause, and more than $400 is wrongly paid out.
- I have the right to ask for a state hearing on any proposed action by the county welfare department.
- YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE.

6. I declare under penalty of perjury under the laws of the United States and the State of California that the information contained in this report is true and correct and is complete for the entire report month.

For Cash Aid: you and your aided spouse (or the other parent of aided children) living in the home must sign the form.
For Food Stamps: the head of household, a household member or the household's authorized representative must sign the form.
For Medical Assistance: you, your spouse or the person acting for the recipient(s) must sign the form.

SIGNATURE OR MARK	DATE SIGNED	PHONE NUMBER WHERE YOU MAY BE REACHED IN CASE YOUR WORKER NEEDS TO CONTACT YOU	
SIGNATURE OF CASH-AIDED SPOUSE OR OTHER PARENT OF CASH-AIDED CHILDREN	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR OTHER PERSON COMPLETING FORM	DATE SIGNED