STATEMENT OF FACTS FOR AN ADDITIONAL PERSON

(*Supplemental Application for CalFresh and Request for Cash Aid*)

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

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

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

PLEASE PRINT IN INK

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME

WORKER NUMBER

DATE RECEIVED

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

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

NAME (First Middle Last)

CITIZEN/NONCITIZEN STATUS (✓) ☐ U.S. Citizen/National

☐ Noncitizen: Sponsored ☐ YES ☐ NO

SOCIAL SECURITY NUMBER - -

BIRTHDATE - -

PREGNANT ☐ YES ☐ NO

IS HE/SHE A PARENT? ☐ YES ☐ NO

BIRTHPLACE (City/State/Country)

SEX (✓) ☐ M ☐ F

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

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

BLIND/DEAF/DISABLED ☐ YES ☐ NO

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

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

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

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

Date of Entry to U.S._____
Excluded HH Member Code _____
Work/Training/WTW Code _____

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

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

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

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

VERIFIED: Deprivation ☐ YES ☐ NO

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

LIST NAME, BRANCH OF SERVICE, ETC.

HONORABLE DISCHARGE ☐ YES ☐ NO

CW 5 ☐ YES ☐ NO

Date Initiated _____

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

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

A. Was the child placed in your home under a dependency order from the court? ☐ YES ☐ NO

B. Do you want the foster child and foster care income counted on the CalFresh case? ☐ YES ☐ NO

C. Is the child enrolled in a health care plan? ☐ YES ☐ NO

COUNTY USE ONLY

7A: ☐ Request dependency order

7B: CA and FC Elig/CR Chooses:
Child: ☐ CA ☐ FC
CR: ☐ CA ☐ None
☐ Kin-GAP

7C: ☐ Medi-Cal
☐ Fee for Service

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

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

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

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

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

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

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

WHY	WHEN	WHAT COUNTY/STATE

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

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

CF (12) Does he/she regularly buy food and fix meals separately from others in the home? ☐ YES ☐ NO

Separate household eligible ☐ Yes ☐ No

CF (13) Is he/she age 60 or older and unable to buy food and fix meals separately because of a disability? ☐ YES ☐ NO

Separate household eligible ☐ Yes ☐ No

CF (14) Does he/she pay you for meals and/or a room? ☐ YES ☐ NO

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

Household Elects

BOARDER	HH MEMBER	ROOMER

CF (15) Does he/she get food from any of the following programs? ☐ YES ☐ NO

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

If "YES", complete below:

NAME OF PROGRAM

CA CF (16) Is he/she working now or expecting to be working in the future? ☐ YES ☐ NO
If "YES", complete below. Attach paystubs or other proof of earnings. If job hasn't started what is the anticipated start date? _____
(Note: If self-employed, list business expenses on a separate sheet of paper and attach it to this form).

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

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

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

COUNTY USE ONLY

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

CF S/E Farmer ☐ Yes ☐ No

Verification(s) on file: ☐ Yes ☐ No

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

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

Child Care Informing Given to Client:

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

Dependent Care Eligible

CA	CF
☐ Yes ☐ No	☐ Yes ☐ No

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

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

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

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

	YES	NO
Emp. Statement	☐	☐
Good Cause Determ	☐	☐
Voluntary Quit	☐	☐

☐ CA: 30 days

☐ CF: 60 days

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

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

Striker Regs Apply

CA	CF
☐ Yes ☐ No	☐ Yes ☐ No

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

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

Court Order on File ☐ Yes ☐ No

Amount Ordered
$

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

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

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

CA 22 CF Does he/she own or is he/she buying any real estate, such as land and/or buildings anywhere, including outside the U.S.? ☐ YES ☐ NO

If "YES", complete below:

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

COUNTY USE ONLY

Home Exempt ☐ Yes ☐ No

Other Real Property
Market Value $_____
Amount Owed $_____
Net Value $_____
Lien Applicable ☐ Yes ☐ No

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

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

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

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

SOURCE OF MONEY	HOW MUCH	HOW OFTEN
	$	
	$	

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

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

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

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

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

☐ Owned Jointly
☐ Owned Separately
Net Market Value
$ _____

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

Closed Bank Accounts:
☐ CalFresh in last 3 months

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

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

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

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

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

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

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

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

COUNTY USE ONLY

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

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

NAME OF INSURANCE COMPANY	PREMIUM AMOUNT	HOW OFTEN PAID
	$	
	$	

☐ DHS 6155

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

TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY

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

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

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

If 'YES", explain:

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

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

☐ DFA 285-C

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

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

☐ CHDP Brochure and Explanation Given
Date: _____
☐ Referral

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

☐ Family Planning Information Given
☐ Referred Date _____

CERTIFICATION

I understand that:

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

I also understand that:

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

For cash aid:

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

For CalFresh:

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

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

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

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