STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

CDSS
WILL LIGHTBOURNE
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

July 5, 2013

ALL COUNTY LETTER 13-57

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CalWORKs PROGRAM SPECIALISTS
ALL CONSORTIUM PROJECT MANAGERS
ALL QUALITY CONTROL PROGRAM COORDINATORS

SUBJECT: CALFRESH: NEW (AND REVISED) FORMS FOR THE SEMI-ANNUAL REPORTING (SAR) SYSTEM

REFERENCE: ASSEMBLY BILL (AB) 6 (Chapter 501, Statutes of 2011), ALL COUNTY LETTER (ACL) 12-25; ACL13-08; ACL 13-17

ACL 12-25, dated May 17, 2012, issued new policy instructions to County Welfare Departments (CWDs) for the implementation of SAR in CalWORKs and CalFresh. The purpose of this ACL is to transmit new and revised forms related to SAR. CWDs should begin using these forms upon implementation of the SAR system. Changes to required forms, other than adding the county name, logo and contact information must be approved by the California Department of Social Services (CDSS) prior to making the change unless instructed otherwise.

CAMERA READY COPIES AND TRANSLATIONS

For camera-ready copies in English, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has internet access you may obtain these forms from the CDSS webpage at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

When all translations are completed per MPP Section 21-115.2, including Spanish forms, they are posted on an on-going basis on the CDSS webpage. Copies of the translated forms can be obtained at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

For questions on translated materials, please contact Language Services at (916) 651-8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the *GEN 1365-Notice of Language Services* and a local contact number.

CWDs shall ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services shall be provided free of charge to the applicant/recipient. In the event that CDSS does not provide translations of a form, it is the county's responsibility to provide the translation if an applicant or recipient requests it. More information regarding translations can be found in MPP Section 21-115.

This ACL and other CDSS Letters and Notices are available on the internet at: http://www.dss.cahwnet.gov/lettersnotices/default.htm

If you have any questions regarding this letter, please contact your CalFresh county consultant or call the CalFresh Policy Bureau at (916) 654-1896.

Sincerely,

Original Document Signed By:

TODD R. BLAND
Deputy Director
Welfare to Work Division

Attachment

Attachment
CALFRESH FORMS FOR SEMI-ANNUAL REPORTING (SAR)

Form #	Form Title, Description, Explanation of Changes, and Directions for Use
CF 23 SAR (06/13)	**CalFresh Benefits How to Report Household Changes (Required Form, Substitute Permitted)** This form will replace the current version of the FS 23 upon implementation of SAR. This form is used to inform households of their reporting responsibilities. This form was updated to reflect reporting responsibilities for SAR households and added a check box for counties to inform households that they are approved for benefits with SAR status or have switched from Change Reporting status to SAR status.
CF 29 (06/13)	**CalFresh Recertification Appointment Letter (Required Form, Substitute Permitted)** This form will replace the current version of the FS 29 upon implementation of SAR. The purpose of this letter has not changed. This form is used to notify a CalFresh household of their recertification appointment. This form was updated by removing the last bullet under 'Important Reminders' referencing Quarterly Reporting.
CF 32 (06/13)	**CalFresh Request For Contact (Required Form, Substitute Permitted)** This form is for use when a household makes a mid-period report of a new household member that is considered Verified Upon Receipt (VUR) and that new member either has income that puts the household over their current Income Reporting Threshold (IRT) or if the CWD is not sure if the new income will be over the household's IRT. This form is to request any information needed to add and verify the new household member. This form is to clearly advise the household of the verification it must provide or the actions it must take to clarify its circumstances. If the form is returned completed within 10 days, the CWD shall process the information and take appropriate action. If the form is not returned within 10 days or is incomplete, the CWD shall discontinue the household for failing to respond.
CF 285 SAR (06/13)	**CalFresh Budget Worksheet/Semi-Annual Reporting Households (Recommended Form)** This form will replace the current version of the QR 285B upon implementation of SAR. This form is used for CalFresh SAR cases. This form was updated to remove references to

Quarterly Reporting, added space to provide income information for three more months and corrected outdated form references.

CF 377.2 (06/13) **CalFresh Notice of Expiration of Certification (Required Form, Substitute Permitted)**
This form will replace the QR 377.2 upon implementation of SAR. The purpose of this form has not changed. This form was updated to remove reference to Quarterly Reporting and updated the link to electronically transmit an application. This notice informs households when their certification period ends and what the household is required to do to continue receiving CalFresh benefits without having a break in benefits.

CF 377.4 SAR (06/13) **CalFresh Notice of Change for Semi-Annual Reporting Households (Required Form, Substitute Permitted)**
This form will replace the QR 377.4 upon implementation of SAR. The use of this form has not changed. This form is used to inform households of a change or termination of CalFresh benefits. This form was updated to address SAR households and changes references from Food Stamps to CalFresh.

CF 377.5 SAR (06/13) **CalFresh Mid-Certification Period Status Report (Recommended Form)**
This form will replace the QR 377.5 upon implementation of SAR. This form is used for households to report mandatory mid-period changes in income that exceed the CalFresh IRT which is 130 percent of the Federal Poverty Level (FPL) for the household size and Able Bodied Adult Without Dependents (ABAWD) work hours. This form was updated to include space to report the income change, provide a link to a table displaying 130 percent of FPL by household size and to remove the requirement that changes in address are a mandatory mid-period report. Households can use this form to voluntarily report other household changes that may result in increased benefits.

CF 377.6 (06/13) **Notice of Information/Verification Needed (Required Form, Substitute Permitted)**
This form is for use within the certification period and is sent to give clients at least 10 days to respond to a request for information. Use this form when:

- A household wants to add a new member, including a newborn, to an ongoing case. Request name, DOB, SSN, citizen/alien status and income information (when appropriate);
- A client reports a change, but does not provide adequate information or proof required to act on a change;

- More information is needed to determine whether to act on a change;
- Eligibility becomes questionable.

Note: For SAR households, do not send a CF 377.6 to pursue information on a change that is not required to be reported, if it is not to the household's advantage.

The information on this form should be as specific as possible, so the household clearly understands what needs to be provided. The CF 377.6 does not meet the requirements of a timely notice. If the household fails to respond to the notice with information needed to determine eligibility, the worker must send a 10-day notice before reducing or terminating benefits.

NA BACK 9 (06/13)

NA BACK 9

This form will replace the current version of the NA BACK 9. This form will be used for all new forms and replace the current NA BACK 9 on all newly generated forms. The purpose of this form has not changed. This form was updated to change references from Food Stamps to CalFresh.

CALFRESH BENEFITS
HOW TO REPORT HOUSEHOLD CHANGES

Everyone who receives CalFresh benefits must report when their income or household situation changes. If you're not sure how to report changes, what changes to report, or what proof we need, be sure to ask your local county office. You are receiving this notice because:

☐ You have been approved for CalFresh benefits and will be reporting changes on a Semi-Annual basis.
☐ Your household was previously assigned Change Reporting status and will now be reporting on a Semi-Annual basis.

Semi-Annual Reporting requirements are described below.

SEMI-ANNUAL REPORTING

As a semi-annual reporting household, you will need to turn in a completed Semi-Annual Report form (SAR 7) due by the 5th day of the 6th month after your most recent certification. If you do not turn in your completed SAR 7 by the end of the first working day of the next (7th) month, your benefits will stop.

Your worker will use the income and expense information reported on the SAR 7 to calculate your CalFresh benefits for the remainder of the certification period.

For example:
You completed your annual recertification in May. Your SAR 7 will be due 6 months later, on November 5th and you will report what income you had in October. You will also report any income changes you expect to have in December, January, February, March, April and May. You must turn in your completed SAR 7 by no later than the first working day in December or your benefits will stop. You will lose benefits unless you had a good reason for being late. Your annual recertification will be due in May six months later. Your next SAR 7 will be due for the following certification period six months later.

What you must report on a Semi-Annual Report (SAR 7):

- Earned income from any source;
- Unearned income of any kind;
- Anyone getting free rent or utilities;
- Anyone who has expenses that are paid by someone else;
- Reduced hours of work or training;
- Someone moves in/out of your home;
- If you move;
- Any real or personal property bought, sold or exchanged;
- Any change in legally obligated child support paid by a household member;
- Anyone's citizenship/immigration status changes or receives correspondence from the U.S. Citizenship and Immigration Services (USCIS) (formerly INS);
- Anyone reaches 60 years of age;
- Anyone gets a job or payments for training or school expenses;
- Anyone has a job, training or school costs such as for dependent care or supplies;
- If, since your last report, anyone in your home has been avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or is in violation of probation or parole.
- If, since your last report, anyone in your home has been convicted after August 22, 1996 of a drug-related felony for manufacturing, sale , or distribution of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities.

REPORTING MANDATORY CHANGES DURING THE CERTIFICATION PERIOD

You must report the following changes within ten (10) days even if it is not your report month. You are to report:

- When your household's income is more than 130% of federal poverty level, for your household size (CalFresh IRT).
- If you are meeting the Able Bodied Adult Without Dependents (ABAWD) work rule by working and your work hours drop below 20 hours a week or 80 hours a month. CalFresh rules limit the receipt of CalFresh benefits to 3 months in a 3-year period for ABAWDs who are not working or participating in other allowable activities. You are excused from the ABAWD work rule and do not need to report a drop in your work hours if you are:
  - Living in a county where the ABAWD work rule is waived because of high unemployment rates;
  - Under 18 or 50 years of age or older;
  - Medically certified as physically or mentally unfit for employment;
  - Meeting the CalWORKs Welfare-To-Work rules;
  - Caring for an injured or sick person who will need help for more than 30 days;
  - Participating in an alcohol or drug treatment program that keeps you from working 30 hours or more per week;
  - Getting or have applied for Unemployment Insurance benefits.

REPORTING VOLUNTARY CHANGES

You may also report other information voluntarily, even when it is not your report month. Reporting information voluntarily may cause your household benefits to go up or down. See examples below. The county will take action within ten (10) days after you provide verification. One exception is when the increase results from adding another person to your case. In that situation, the county will take action to increase benefits the first of the month after you provide verification. **Even if you have already reported something to the County, you must also report it on your next SAR 7 or recertification.**

Some examples of voluntary reporting that may cause your benefits to go up include:

- Loss of income;
- Member becomes disabled or 60 years old;
- Member begins to pay court-ordered child support;
- New household member in the home;
- Shelter/housing cost increases;
- Medical expenses.

(Continued on back)

REPORTING VOLUNTARY CHANGES - Continued

Some examples of voluntary reporting that may cause your benefits to go down include:

- Gain or increase of income that is less than your CalFresh IRT;
- Someone with no income moves out of your home;
- Someone in your home who had no income dies;
- Someone with income moves into your home;
- Shelter cost decrease.

You **MAY** report changes during your households certification period either by:

- Mail, telephone or in person at the county CalFresh office or by turning in a Mid-Certification Period Status Report or SAR 3.

OTHER CHANGES

There are other circumstances that will require the county to decrease or discontinue your benefits during the certification period in which they happen. Here are some examples:

- A household member is sanctioned;
- Someone in your household receives benefits in another household;
- A California Food Assistance Program status changes.

TRANSITIONAL CALFRESH BENEFITS

California's Transitional CalFresh program provides CalFresh benefits for five months to households that leave CalWORKs.

If your household begins receiving transitional CalFresh benefits, you do not have to report while receiving these benefits.

If you are receiving Transitional CalFresh benefits, you may reapply to see if you can get more benefits. If you reapply and are approved for regular CalFresh benefits, then all normal reporting rules will apply.

CALFRESH RECERTIFICATION APPOINTMENT LETTER

Date :
Case Name :
Case Number :
Worker Name :
Worker Number :
Worker Telephone :
Address :

Your CalFresh certification period ends on _____. You need an interview to keep getting CalFresh benefits. This is your appointment letter.
MM/DD/CCYY

You have a telephone CalFresh recertification interview appointment. **If you prefer to be interviewed in person, please call your worker at the number above for an appointment.** The county will call you for your telephone appointment on:

APPOINTMENT DATE:	APPOINTMENT TIME:

YOUR PHONE NUMBER:

We will call you at the number above. If the number is not correct, you must call us and provide a number where you can be reached for your interview. It is very important that we are able to reach you. You may also want to provide an alternative phone number where you can be reached. County phone numbers may be blocked. If your phone does not accept blocked numbers, you may miss the phone call for your telephone interview, and your benefits may be delayed. You will have to reschedule your interview. If you miss the phone interview, call your worker at the number above or go to the above office to reschedule your interview.

IMPORTANT REMINDERS

- Failure to complete this interview may result in a delay or may end your CalFresh benefits.
- If you do not keep the scheduled appointment, it is your responsibility to reschedule it.
- To change your appointment, please contact your worker.
- Required verification must be turned in within 10 days of your worker asking for it. Please tell your worker if you need help getting this information. Your worker can help you get it.

COMMENTS:

CALFRESH REQUEST FOR CONTACT

-
-

Worker: Phone:

We recently received information about a change in your household. In order for us to make sure you can still get CalFresh benefits, we need the following:

We need you to contact us by _____ to provide the information/documentations requested above.

If you do not contact us by this date, your CalFresh benefits may be reduced or stopped.

CALFRESH BUDGET WORKSHEET/SEMI-ANNUAL REPORTING HOUSEHOLDS

CASE NAME	COMPANION CASE REFERENCE	CASE NUMBER	CLASSIFICATION ☐ NA ☐ PA ☐ MIXED ☐ TC
CERTIFICATION PERIOD FROM THROUGH	BUDGET IS BASED ON:	SAR 7 ☐ MID-CERTIFICATION PERIOD REPORT ☐	OTHER ☐ RECERTIFICATION ☐

PART 1 - GROSS INCOME

A. NONEXEMPT GROSS UNEARNED INCOME

	SOCIAL SECURITY, UIB, DIB, PENSIONS	CHILD/SPOUSAL SUPPORT	SCHOLARSHIPS, GRANTS, LOANS	OTHER
1. Month 1/Year _____/_____	$_____	$_____	$_____	$_____
2. Month 2/Year _____/_____	$_____	$_____	$_____	$_____
3. Month 3/Year _____/_____	$_____	$_____	$_____	$_____
4. Month 4/Year _____/_____	$_____	$_____	$_____	$_____
5. Month 5/Year _____/_____	$_____	$_____	$_____	$_____
6. Month 6/Year _____/_____	$_____	$_____	$_____	$_____

7. Unearned Income (A1 + A2 + A3 + A4 + A5 + A6) **Total $_____ (A7)**
8. Averaged Gross Unearned Income (A7 ÷ number of months) **Total $ _____ (A8)**
9. Cash Aid **Total $ _____ (A9)**
10. Less Child Support Paid (enter any remainder in B9) **Total $ _____ (A10)**
11. Total Gross Unearned Income (A8 + A9 - A10) **Total $ _____ (A11)**

B. NONEXEMPT GROSS EARNED INCOME

	GROSS SALARY/WAGES	SELF EMPLOYMENT	TRAINING ALLOWANCES
1. Month 1/Year _____/_____	$_____	$_____	$_____
2. Month 2/Year _____/_____	$_____	$_____	$_____
3. Month 3/Year _____/_____	$_____	$_____	$_____
4. Month 4/Year _____/_____	$_____	$_____	$_____
5. Month 5/Year _____/_____	$_____	$_____	$_____
6. Month 6/Year _____/_____	$_____	$_____	$_____

7. Total Gross Earned Income (B1 + B2+ B3 + B4 + B5 +B6) **Total $_____ (B7)**
8. Averaged Gross Earned Income (B7÷ number of months) **Total $ _____ (B8)**
9. Less Remainder of Child Support Paid (if not fully used in Section A) **Total $_____ (B9)**
10. Total Gross Earned Income (B8 - B9) **Total $ _____ (B10)**

PART 2 - GROSS INCOME

C. GROSS INCOME TEST FOR HOUSEHOLDS WITH NO ELDERLY OR DISABLED MEMBERS

1. Maximum Gross Income allowed for Household Size of _____ (from table) $_____
2. Total Gross Income (A11 + B10) = $_____
3. Gross Income Eligible? (Is C2 less than or equal to C1?) ☐ YES ☐ NO **Total $ _____ (C3)**

PART 3 - NET INCOME

D. NONEXEMPT GROSS INCOME

1. Gross Earned Income (B8) $_____
2. Adjusted Gross Earned Income (80% of D1) $_____
3. Less Remainder of Child Support Paid (B9) (if not fully used in Section A) $_____
4. Total Gross Earned Income (D2 - D3) (If negative amount, enter zero) $_____
5. Total Gross Unearned Income (A11) $_____
6. Nonexempt Gross Income (D4 + D5) $_____

E. STANDARD
Standard Deduction $_____

F. DEPENDENT CARE (100% OF COSTS) $_____

G. HOMELESS SHELTER DEDUCTION $_____

H. TOTAL DEDUCTIONS (E + F + G) $_____

I. ADJUSTED NET INCOME

1. Nonexempt Gross Income (D6) $_____
2. Total Deductions (Line H) $_____
3. Adjusted Net Income (I1 - I2) $_____

J. SHELTER DEDUCTION

1. Total Housing Costs $_____
2. Total Utility Allowance $_____
3. Total Shelter costs $_____
4. Allowable Shelter costs (50% of I3) $_____
5. Excess Shelter costs (J3 - J4) $_____
6. Maximum Allowance For Shelter $_____
7. Allowable Shelter Deduction (Lesser of J5 or J6) $_____

K NET MONTHLY INCOME (I3 - J7) $_____

L. NET INCOME TEST

1. Household Size _____
2. Maximum Net Income Allowable (from table) $_____
3. Net Income eligible ☐ YES ☐ NO

DOCUMENTATION

INCOME:

☐ Weekly $ _____ x 4.33 = $ _____

☐ Biweekly $ _____ x 2.167 = $ _____

HOUSEHOLD WITH ELDERLY AND DISABLED MEMBER:

Is there an elderly member who is disabled and who cannot purchase and prepare meals? ☐ YES ☐ NO

If Yes, is the household's income (less the elderly disabled member's and spouse's income) less than 165% of FPL? ☐ YES ☐ NO

If Yes, certify the elderly and disabled member (and spouse) as a separate household.

CHILD SUPPORT LEGALLY OBLIGATED PAID OUT

Total $_____

Total ÷ by number of months $_____

Amount used in A10: $ _____

Remainder to be used in B9: $_____

☐ Dependent Care

☐ Utilities ☐ Dependent Care

☐ SUA ☐ LUA ☐ TUA

☐ Housing ☐ PRORATED

ALLOTMENT	SUPPLEMENT

PART 4–INCOME COMPUTATIONS

	PAYMENT PERIOD
M. SELF-EMPLOYMENT (Nonexempt Resources Only)	
1. Gross Income from Self-Employment	$_____
2. Expenses: ☐ Standard 40% Deduction ☐ Actual Expenses (Verification Required)	$_____
3. Total Nonexempt Income from Self-Employment (M1 - M2) If averaging self-employment income go to M7. If adjusting a previous average, continue to M4.	$_____
4. Adjustment to Gross Income	$_____
5. Adjustment to Expenses	$_____
6. Adjusted Self-Employment Income (M3 + M4 + M5)	$_____
7. Monthly Self-Employment Income (M3 or M6 ÷ number of months income covers)	$_____

N. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS	**PAYMENT PERIOD**
1. Income from Grants, Scholarships or Loans	$_____
2. Tuition and Mandatory Fees	$_____
3. Total Nonexempt Educational Income (N1 – N2)	$_____
4. Monthly Income from Grants, Scholarships or Loans (N3÷ number of months income covers)	$_____

PART 5–REPORTED CHANGES (Other than the SAR 7 or CF 377.5 SAR)

Type of Change					
Date Change Occurred					
Date Change Reported					
EW Initials					

CALFRESH NOTICE OF EXPIRATION OF CERTIFICATION

COUNTY OF

Notice Date :
Case Name :
Case Number :
Worker Name :
Worker Number :
Telephone Number :
Address :

Questions? Ask your worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

1. Your CalFresh Certification period will end on _____.
   MM/DD/CCYY
2. If you want to keep getting your benefits without a break; you must file an application no later than the 15th day of the last month of the certification period. You must also complete an interview with the county, and turn in any proof of income, expenses, or other information before the end of your certification period listed above.
3. If you have a one-month or two-month certification period, contact your worker for when your application needs to be turned in.
4. You will get a separate letter with an interview appointment date and time. Call your worker right away if you do not get the appointment letter within 10 days of this notice. Your appointment letter will tell you if you have a phone interview or if you have to come into the office for your interview.

IMPORTANT RULES

- If you do not turn in an application by the 15th day of the last month of the certification period, complete an interview, **and** turn in any proof of income, expenses, or other information within 10 days of the date of the interview, you may have to wait up to 30 days before final action is taken on your application. In addition, you may get only partial benefits for the first month of your new certification period. If your benefits stop, you may be able to get Expedited Service (ES)
- If you have a good reason for not recertifying on time, you should tell the county welfare department. If you have a good reason for the delay, you may get back lost benefits.
- You have the right to get an application from the county welfare department at any time and to have the county accept your application. The application must be signed and contain at least a readable name, address, and signature or a witness to the mark.
- You or your authorized representative have the right to file a CalFresh application by turning in the form to the county welfare department either in person, by mail, fax, e-mail, through an electronic transmission, or through an on-line electronic application at: http://www.benefitscal.org. The length of time to deliver benefits is calculated from the date the application is filed with the county welfare department. An application signed through the use of electronic signature techniques or an application containing a handwritten signature and then transmitted by fax or other electronic transmission is acceptable.
- You will be given 10 days to turn in any requested information. Please tell your worker if you need help getting this information.

RULES: These rules apply: CalFresh MPP Section(s): 63-300.3, 63-504.25, 63-504.251, 63-504.5, 63-504.6, 63-504.61; Federal Regulation Title 7 CFR § 273.12. You may review them online or at your welfare office.

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COUNTY OF

CALFRESH NOTICE OF CHANGE FOR SEMI-ANNUAL REPORTING HOUSEHOLDS

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

If you have any questions or want more information about this action, please contact your worker.

State Hearing: You can ask for a hearing if you believe the action is wrong. The back of this page tells how to ask for a hearing. If you already had a hearing on the cause of the overissuance that is being collected, you cannot ask for a new hearing, unless you think the new amount of CalFresh benefits you are getting because of the overissuance collection is incorrect.

☐ **CHANGE IN BENEFITS**

Effective_____, your CalFresh benefits are changed from $_____ to $_____each month because:

☐ You have already been told about an overissuance of CalFresh and you are getting less CalFresh benefits because the County has been reducing your monthly allotment by 10% or $10 (whichever is more) to pay back the CalFresh benefits that you got and should not have. It has been decided in court or by a state hearing or because you signed a Disqualification Consent Agreement or an Administrative Disqualification Hearing Waiver that this overissuance is an Intentional Program Violation (IPV). Now your monthly allotment is being changed because the County can begin reducing your allotment by 20% or $10 (whichever is more). If there are any other changes to your monthly CalFresh allotment, this form will tell you.

☐ **PROPOSED CHANGE IN BENEFITS**

Effective_____, your CalFresh benefits may be reduced or terminated because information needed to determine your continued eligibility or the correct amount of your benefits was not received with your Semi-Annual Eligibility Status Report (SAR 7). We must receive the following information by no later than the first day of next month:

If verification of an expense is requested and if you do not provide it, the expense will not be allowed when computing next benefits. Also, if you do not provide other requested information, your benefits may be reduced or terminated.

Rules: These rules apply to the above action(s):
You may review them online or at your welfare office.

☐ **NO CHANGE IN BENEFITS**

Your CalFresh benefits in this period did not change as a result of the document(s)/information we received because:

Any changes you voluntarily reported must be reported again on your next Semi-Annual Report (SAR 7), along with proof of the change.

☐ **TERMINATION**

Effective_____, your CalFresh benefits are terminated because:

☐ Based on the reason your benefits are terminated, your household is also disqualified from participating in the CalFresh Program until_____. You may reapply for benefits at the end of this disqualification period.

☐ **COMMENTS**

CALFRESH MID-CERTIFICATION PERIOD STATUS REPORT

INSTRUCTIONS:

Because you get CalFresh, you must report within 10 days when your household's total monthly income increases more than the CalFresh Income Reporting Threshold (IRT) as well as when ABAWD work hours drop below 20 hours a week or 80 hours a month.
Use this form to report an income increase of more than the CalFresh IRT 130% of FPL per household size that have occurred since your last Semi-Annual Report (SAR 7) and changes in ABAWD work hours.
Use this form to report changes you think will increase your CalFresh benefits, please provide proof, such as, pay stubs; copies of checks; letters from agencies, etc.
If you are reporting changes in expenses, please provide proof, such as, receipts; canceled checks, paid invoices; etc.

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-

Worker: Phone:

MANDATORY REPORT OF INCOME OVER IRT

YOUR HOUSEHOLD IS ONLY REQUIRED TO REPORT CHANGES WHEN YOUR HOUSEHOLD'S TOTAL MONTHLY GROSS INCOME EXCEEDS 130% OF THE FEDERAL POVERTY LEVEL. Your gross income means all of the money your household receives including wages before taxes or other deductions, social security, SSI, cash contributions, unemployment compensation, child support, worker's compensation, etc. **This change must be reported within 10 days of when the change occurred. Failure to report this change may result in an overpayment of CalFresh benefits which you will have to repay.**

You were told your IRT when your case was approved, if you are unsure of your household's IRT, contact your local county office. To review a chart of gross income per household at 130% of the federal poverty level visit: http://www.CalFresh.ca.gov/PG3221.htm

To report a change, you may: Complete this form, **sign it on the other side** and return it to your local county office or contact your local county office. If you need assistance in completing this form you may contact your local county office.

I want to report that:

☐ My household's gross monthly income is over 130% of the federal poverty level.

List the monthly income by each type received:

Source of Money	Who gets it?	How much each month?	Is this new income to your household?	When did it start?

Total gross monthly income is: $ _____.

Do you expect the changes in income you have reported will remain the same? ☐ Yes ☐ No

If you answer no, please explain:_____

_____

_____

_____

_____

_____

MANDATORY ABAWD INFORMATION

☐ I want to report changes in Able-Bodied Adult without Dependents (ABAWD) hours for my household.

The number of hours worked or in training dropped from 20 hours a week or 80 hours a month to _____ hours a week or _____ hours a month.

In the week(s) of _____ _____ _____ _____ _____ _____ _____

In the month(s) of _____ _____ _____

Name of Person(s) _____ Relationship to You _____

Explain What Happened _____

VOLUNTARY INFORMATION *(All households)*

I would like to report the following information: _____

CERTIFICATION

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I understand I may be charged with committing a felony if more than $950 in CalFresh benefits is wrongly paid out.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW:	Head of household, household member or the household's authorized representative.

Signature or Mark	Date Signed	Home Phone	Contact Phone

Signature of Spouse or other Adult Household Member or Authorized Representative	Date Signed	Signature of Witness to Mark, interpreter or other person completing form	Date Signed

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION INFORMATION/VERIFICATION NEEDED

Notice Date: _____
Case Name: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Telephone Number: _____
Worker Hours: _____
Address: _____
_____

We recently received information about a change in your household. We need your help to figure out if this change will affect your benefits. We want you to have all the benefits for which you qualify. You will get a notice if this lowers or ends your benefits.

☐ You reported a change that could increase your benefits for the next month. To be sure your next benefits are right, please return the items listed below to us by _____. Please let us know before this date, if you need more time to return these items. If the listed items are received after this date, any increase in benefits will be delayed. If you need help getting any of these items, you can contact your county CalFresh office.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh
☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list)_____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE