APPLICATION FOR CALFRESH (2), CASH AID (5), 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 <u>name</u>, <u>address</u>, <u>and signature</u> (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; or
- Your utilities have been or will be shut off; or
- You don't have sufficient clothing or diapers; or
- 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 More 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.

SAWS 2 PLUS (9/13) COVERSHEET PAGE 2 OF 2

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

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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.

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int	r CalFresh: I understand that if I commit an entional program violation by doing any of the lowing:		
•	hide information or make false statements		ay lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid
•	use electronic benefit transfer (EBT) cards that belong to someone else or let someone else use my card	•	to me 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
Fo	r cash aid I understand that if I am convicted of an intentional program violation do not follow cash aid rules am found guilty by a court of law or an administrative hearing of committing certain types of fraud	•	lose my cash aid be fined up to \$10,000 and/or sent to jail/prison for 5 years 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)

<u>CalFresh and Cash Aid:</u> 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

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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

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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 fingerprint/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, destroyed or you think someone may know your PIN number that you don't want to use your benefits call (877) 328-9677 or call the County <u>right away</u> to report it and change your PIN number. Make sure all responsible adults and your authorized representative also know how to report one of these problems <u>right away</u>. 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 <u>only</u> 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. <u>Do not give out your PIN number</u>. <u>Do not keep your PIN number with your EBT card</u>.
- 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.

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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 INFORMATIO		<u></u>			
NAME (FIRST, MIDDLE, LAST)		OTHER NAMES (MAIDEN, NICKNAME	S, ETC.)	SOCIAL SECURITY NU ONE AND ARE APPLYI	MBER (IF YOU HAVE
Kevin, K, Chen				***-**-8312	VOT OTT DEIVETTTO)
HOME ADDRESS OR DIRECTIONS TO YOUR HOME 1479 20th Avenue	APARTMENT # 2nd Floor	CITY San Francisco	COUNTY San Francisco	STATE California	ZIP CODE 94122
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
I want to get information about this application by email.		I want to get messages a	about my case by	email.	Yes No
703-470-9608 703-470-9608	MESSAGE PHONE	kevin.kang.chen@gmail.com kevin.kang.chen@gmail.com			
	ı Coverage	Do you have a disability an	d need help appl	ying? Yes	☑ No
Are you homeless? Yes No figure out an address to use to accept		ase let the County know righ on and get notices from the o			ey can help you
What language do you prefer to read What language do you prefer to speal					
The County will provide an interpreter			0 1		
Is your household's gross income less \$150 and cash on hand, checking and savings accounts \$100 or less?		s No S Have your use a shut-off no	tilities been shut off tice?	or do you have	☐ Yes ☐ No
ls your household's combined gross and liquid resources less than the corrent/mortgage and utilities?	income mbined Yes	s 🗌 No 🌎 Will your foo	d run out in 3 days	or less?	☐ Yes ☐ No
Is your household a migrant/seasonal worker household with liquid resource exceeding \$100?	farm	s No food, cloth	d help with transp ing, medical ca tem(s)?	are or other	☐ Yes ☐ No
Do you have an eviction notice or a no pay rent or leave?	otice to	s 🗌 No 🌎 Do you ne diapers or cl	ed essential cloth othing needed for c	ning, such as cold weather?	☐ Yes ☐ No
Is anyone pregnant? ☐ Yes ☐ No	If yes, did	d she get a Presumptive Elig	ibility card?	Yes No	
Does anyone in your household have Immediate Medical Need threatens health or safety. Explain:	•		If yes , check bo	x: Pregnand Other emerge	-
I understand that by signing this application	under penalty	of perjury (making false stat	ements), that:		
I read, or had read to me, the informa	tion in this appl	ication and my answers to the	ne questions in th	nis application.	
 Any answers I have given on pages 1 complete to the best of my knowledge 		d appendices A through C of	the SAWS 2 Plu	s are true, corre	ct, and
I read or had read to me and I unders	tand and agree	to the Rights and Responsi	bilities (Program	Rules Page 1).	
I read, or had read to me, the Program	n Rules and Pe	nalties (Program Rules Pag	es 2-4).		
 I understand that giving false or misle fraud and that I may be subject to per case to be filed against me and/or I m 	nalties under fed	deral law if I provide false or	untrue information	on. Fraud can ca	use a criminal
 I understand that Social Security Numwith the appropriate government ager 			nembers applying	g for benefits ma	y be shared
 I am giving the Medi-Cal agency the r third parties. 	ight to pursue a	and get any money from othe	er health insurand	ce, legal settleme	ents, or other
SIGNATURE OF APPLICANT, CARETAKER RELATIVE (OR ADL	JLT HOUSEHOLD MEN	MBER/ AUTHORIZED REPRESENTATIVE	E*/GUARDIAN)	DATE	
*If you have an Authorized Representativ Kevin K Chen				10/14/2014	
SIGNATURE OF SPOUSE, OTHER PARENT, OTHER AIDED AD	OULT, OR REGISTERE	ED DOMESTIC PARTNER		DATE	

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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. **✓** No Do you want to name someone to help you with your CalFresh case?

Yes If **yes**, complete the following section: AUTHORIZED REPRESENTATIVE NAME AUTHORIZED REPRESENTATIVE PHONE NUMBER ✓ No Do you want to name someone to receive and spend CalFresh Benefits for your household?

Yes If **yes**, complete the following section: NAME PHONE NUMBER CITY, ADDRESS 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. 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 guestions. **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. ARE YOU OF HISPANIC, LATINO, OR SPANISH ORIGIN? IF YOU ARE OF HISPANIC, OR LATINO ORIGIN, DO YOU CONSIDER YOURSELF **ETHNICITY** Puerto Rican ☐ Cuban ☐ Yes Mexican Other **RACE/ETHNIC ORIGIN** ☐ White ☐ American Indian or Alaskan Native ☐ Black or African American Other or Mixed \square Asian (If checked, please select one or more of the following): Filipino ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese Chinese Asian Indian Laotian U 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 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.)? IF YES, WHO? WHERE (COUNTY/STATE)? IF YES. WHO? WHERE (COUNTY/STATE)?

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6. l	HOL	ISEHC	LD'	S INFORMATION: ADULTS															
on	our/	tax re	turn.	wing information for all adults in			_	also include	e an	y ac	dults	s cla	ime	d		Only a	answe	r the	Social Security
	F BEN che	PLYING FOR NEFITS ck eac pe)	3						N	/larit		Statu	ıs	Full-Time S		questi each p for be	on be person nefits. U. \$	low for applying	number is optional for members not applying for benefits
CalFresh	Cash Aid	Medi-Cal Health Care	None	NAME (Last, First, Mid		How is the person related to you?	DATE OF BIRTH	GENDER (M OR F)		Married	Separated	Divorced	Widowed	Student (check if ye	:	NAT ₁	Yes or	L (check	SOCIAL SECURIT NUMBER
	(\$)	③		Chen, Kevin, K		Self	**/**/1989	M						yes)					***-**-8312
			+-														Yes	□ No	
																	Yes	□ No	
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E) 6		es ev	│ /eryone listed in question 6 h ·lease skip to the next questi		t information	? Yes	☐ No If	no,	ple	ase	fill	-	he	pers	-			ation below.
NAM	E (FIF	•		ND LAST)	HOME (STREET) ADDRESS			APARTMENT	#	CIT	Υ						STATE		ZIP CODE
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ПОІ	E FN	JINE INUIV	IDEN		MAILING ADDRESS (IF DIFFER	TENT FROM ABOVE	-)	APARTMENT	#	CIT	ī						SIAIE		ZIP CODE
WOF	K/ALT	ERNATE	/MESS	AGE PHONE	EMAIL ADDRESS (OPTIONAL)											'			
NAME (FIRST, MIDDLE, AND LAST) HOME (STREET) ADDRESS						APARTMENT	#	CIT	Υ						STATE		ZIP CODE		
HOM	HOME PHONE NUMBER MAILING ADDRESS (IF DIFFE				RENT FROM ABOVE	Ξ)	APARTMENT	#	CIT	Υ						STATE		ZIP CODE	
WOF	K/ALT	ERNATE	/MESS	AGE PHONE	EMAIL ADDRESS (OPTIONAL)														1

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6b	HC	USEH	OLD	'S INFORMATION: CHILDREN													
cla	med	blete the following information for all children in the home. If applying for health care coverage, also include any children ed on your tax return. concitizens you are applying for, please complete additional questions 6e and 6f.															
	BEI (che	PLYING FOR NEFITS ck eac pe)	6						Check all that applies to one or both of the child's parents			ne	hots up to	Only answer question beloeach person applying for benefits.	ow for	Social Security number is optional for members not applying for benefits.	
CalFresh	Cash Aid	Medi-Cal Health Care	None	NAME (Last, First, Middle Initial)	How is the person related to you?	DATE OF BIRTH	PLACE OF BIRTH	SEX (M / F)	Not in home	Linemployed	Deceased	None	Student (check if yes)	date? (check if yes)	U.S. CITIZEN NATIONAL Yes or N If no, com question	(check lo) plete	SOCIAL SECURITY NUMBER
Œ	(\$)	3											s)	<u>s)</u>			
															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 FO	OR NOT HAVING	G A SOC	IAL S	ECU	RIT	Y NU	JMB	ER			PPLIED FOR SSN
☐ 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?						
It is against this person's religion												his person applied Social Security per?					

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Other

☐ Yes ☐ No

s parent or child	of a person w	ho wa	ry service or are they the spous as? Yes IN No on below. If no, please continue to						
Name	U.S Citize	n?	(✔) Status	Honorable Discharge		Dates	s of Service		
		Active duty Veteran Spouse, parent, or child of person in active duty or a veteran		☐ Yes ☐					
	☐ 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. Date entered U.S. (if known) Does this person have an eligible immigration status? If yes, please provide their immigration document and number. Does this person have an eligible immigration document and number. Solution of the U.S. continuously since 1996?									
		DOCUM	ENT TYPE:				question 6f		
		DOCUM	ENT NUMBER:	Yes L No		∐ No	☐ Yes ☐ No		
			ENT TYPE:	Yes No	☐ Yes	☐ No	☐ Yes ☐ No		
			ENT TYPE: ENT NUMBER:	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes ☐ No		
-		-	s (40 quarters) of work history?			Y	es 🗌 No		
If yes , who?									
Does anyone listed above VAWA petition? If yes , who?			oplied for, or do they plan to apply	for a T-Visa or U-V	isa,	☐ Y	es 🗌 No		
Has anyone changed their If yes , please complete the If no , please continue to the	e information b	elow.	the last 12 months?			☐ Y	es 🗌 No		
NAME		HANGED	?	DATE OF CHANGE		ALIEN NUMBER (IF APPLICABLE)			
NAME WHAT CHANGED?			?	DATE OF CHANGE		ALIEN NUMBER (IF APPLICABLE)			

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6f.	Sponsored Noncitizen Information - Pl	ease answer for s	sponsored noncitizens you are a	oplying for.
	Did the sponsor sign an I-864? Yes If the sponsor signed an I-134 then skip	No If yes , pleathis question.	ase answer the rest of the questi	on.
	sponsor regularly help with money? Ye			
	sponsor regularly help with any of the follo	wing (check all tr	тат арріу) <i>?</i>	
rent SPONSOR'S	clothes food other	WHO IS SPONSORED?	<u> </u>	SPONSOR'S PHONE NUMBER
3FON3ON 3	NAME	WHO IS SPONSORED?		SPONSON'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?
3	☐ Yes ☐ No If yes , please list the nam If no, please continue to the next question	,	n) and the name(s) of the parents	s who do not live in the home.
\$ NAM	E OF CHILD		NAME OF PARENT(S) NOT LIVING IN THE H	OME
NAM	E OF CHILD		NAME OF PARENT(S) NOT LIVING IN THE H	OME
\$ 6h.	Does anyone in question 6 live with at of the child?	least one child	under the age of 19 and are the	ey the main person taking care
3	\square Yes \square No If no, skip to the next que	stion. If yes, who	0?	
6i.	Does anyone listed in question 6 have	a physical, men	ital, emotional, or development	tal disability that causes
	limitations in activities (such as bathir person with the disability. If no, please co	ng, dressing, dai ontinue to the nex	ly chores)? \square Yes \blacksquare No If yet t question.	es, please list the name(s) of the
	Name:		Name:	
6 j.	Complete for each disabled person list	ted in question (6.	
Na	ime of person	Does this pe	erson need help with activities of dail	y living through personal assistance or
•		a medical fa	icility? 🗌 Yes 🔲 No	
		If yes , exp	lain:	
Disability	is expected to last: \square 30 days or more	Does this pe working? Fo	erson work and have medical expens or example, a wheelchair, leg braces	es that are needed to help them keep , etc.
	\square 12 months or more	_	No If yes, please explain.	
Does this	person need care so that someone else c	an Is this perso	on in a medical facility or nursing hom	ne? ☐ Yes ☐ No
Yes [at is the name of the medical facil	
Name of	person	Does this pe	erson need help with activities of dail	y living through personal assistance or
rianio oi	po.co		cility? 🗌 Yes 🔲 No	,
		If yes , exp	lain:	
Disability	is expected to last: 30 days or more	Does this pe	erson work and have medical expens or example, a wheelchair, leg braces	es that are needed to help them keep , etc.
	☐ 12 months or more		_	,
Does this work or a	person need care so that someone else c ttend school?	is this perso	on in a medical facility or nursing hom at is the name of the medical facil	
☐ Yes ☐	No			
6k.	Is there a child or disabled person in t ☐ Yes ✓ No If yes, please explain. If			ousehold member?
(±5)				

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\$		If yes, please list the	child's na	and 18 listed in question (me and the name and addr hild is not attending school	ess of the sch			es 🗌 I	No	
NAME O				ME AND ADDRESS OF SCHOOL			REASON FOR NOT AT	TENDING	SCHOOL	-
NAME O	F CHILD		NA	ME AND ADDRESS OF SCHOOL			REASON FOR NOT AT	TENDING	SCHOOL	-
\$		Students Is anyone who is ap If yes, please answer	plying fo this ques	r benefits attending a coll ston. If no , skip to the next	lege or vocat question.	ional sch	ool? 🗌 Yes 🗓	✓ No		
	ı	Name of Person		Name of School/Tra	aining		nrolled Status ✓ check one)		Woı	rking?
					Les	Half-time or more Less than half-time Number of Units:			work hours	
					-time or more s than half-time r of Units:		Average work h			
\$		•		6 or 6b pregnant or a teen tion. If no , skip to the next	-	Yes				
Name				erson under the age of 20? Yes No erson a teen parent? Yes No	Has a hi Has a G Is attend Is not at	gh school ED	diploma I regularly hool	Due of		How many babies are expected with this pregnancy?
Name				erson under the age of 20? Yes No erson a teen parent? Yes No	Has a h Has a G Is attend Is not at	igh school iED	ol regularly chool	Due of (if known)		How many babies are expected with this pregnancy?
\$	С	al-Learn Program?	☐ Yes	h bonus or penalty, or hel	-	care, trans	sportation or ot	her serv	vice fi	rom the
		Name	1	Where (C			Date	(s) Rec	eived	
②		Vas anyone listed in yes, please explain.	question	6 ever in foster care?	☐ Yes ☐ No					
Name	Name:			When: State:			Is this person 26 ye younger and were to care on their 18th b			ey in foster thday?
Name	Name:			When:	State:		Is this person 26 years of age of younger and were they in foster care on their 18th birthday?			ey in foster thday?

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\$	6q. Is there a foster child living in Please answer the following que	your home?	yes, who?							
	Was this child(ren) placed in your hor Do you want the foster care child(ren If yes , the foster care income you red If no , the foster care income will not be) counted in your CalFresh case? ceive will be counted as unearned		☐ Yes ☐ Yes	□ No □ No					
\$	6r. Does everyone listed in quest If no, please explain.	ion 6 live in California and expe	ct to keep living	g here? □ Yes □ No						
\$	6s. Does anyone listed in question If yes, please explain.	n 6 plan to leave California for m	nore than 30 da	ys? 🗌 Yes 🗌 No						
NAME		WHEN DO THEY PLAN TO LEAVE?		PLAN TO RETURN TO CALIFORNIA IF YES, WHEN:						
NAME		WHEN DO THEY PLAN TO LEAVE?		PLAN TO RETURN TO CALIFORNIA IF YES, WHEN:	A?					
	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.									
Che	ck all types of unearned income that a	pply from these examples (there n	nay be others no	ot 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, trapromissary notes Veterans education benefits Government/railroad disabil Veteran benefits or Military Financial aid (school grants Gifts of money or other loan Unemployment Insurance State Disability Insurance (S Worker's Compensation Net Farming/Fishing	s/income ity or retirement pension /loans/scholarsh is	Help with rer Insurance or Private disab						
	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:

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If no, skip to to NOTE: If self Please list all Examples of eothers not list Wages	get income from a jo he next questionemployed, fill out qui income before taxes earned income are (the dhere): Comm ny paid jobs the Coul	estion 8a below. or other deductinese examples c issions	ons are tak an be full-ti	ken out (g	ross incom	e). onal work, or trai	ning, and there	tudents)
Person Working	Employer's Na and Addres		/er′s	Hourly Rate	Average hours per week	How Often Paid? (Once weekly, monthly, other)	Total Gross Earned Income Received This Month?	Expect t Continue (Chec Yes or No
			\$				\$	☐ Yes
			\$				\$	☐ Yes
			\$				\$	☐ Yes
			\$				\$	☐ Yes
In the last year? Did the County he	a job, changed jobs ✓ Yes ☐ No Ip the person get this					,		
YES, WHO? Levin	QUIT, OI	R CHANGE 2013 11/3	OF LAST PAY 80/2013	REASON? Contract e	nded.			
Yes No	, WHO?	DATE WENT ON DAT STRIKE	E OF LAST PAY	REASON?				
40% deduction	ment d household member n off of self-employm by 12 months). If yo	ent income). For	r cash aid, <u>y</u>	you may a	also choose	to use a monthly	y average (yea	arly busine
Person Self-Employed	Business Name	Type of Business	Date Business Started	Gross Month Incom	ly Sei	f-Employment E (please ✓ checl		*Net Monthi Income
				\$		% flat Rate (CalF tual Expenses \$; onthly Average \$;		\$
				\$	∟ Ac	% flat Rate (CalF tual Expenses \$; onthly Average \$;		\$
				\$	☐ 40 ☐ Ac	% flat Rate (CalF tual Expenses \$	resh/cash aid)	\$

Monthly Average \$ _

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^{*} Net monthly income is gross monthly income minus expenses.

\$ 9.	Other Income Does anyone get housing or reallf yes, please answer this quest		s, food or	clothing free or in exchange	e for work	k? ☐ Yes ☐	No
	If no , skip to the next question.						
	Item Received	Free	For Work	Who gets the item?	Value	Wh	o gives the item?
Housing	or Rent				\$		
Utilities					\$		
Food					\$		
Clothing					\$		
10.	Yearly Income Does anyone's total income (un If yes, please answer this quest If no, skip to the next question.		earned, a	nd self employment) chang			
	Name of Person		What	will be their total income this year?	Wh	nat will be the (if you thin	eir total income next year k it will be different)?
		\$			\$		
		\$			\$		
	look for a job? Yes No If no , skip to the next question. Who gets care?	, ,		who gives care?		Amount paid?	How Often Paid?
	who gets care:			and address of provider)		paid?	(weekly/monthly, other)
						\$	
						\$	
						\$	
						\$	
Does an	yone help your household pay al	or part	of your chi	ild/adult care cots listed abo	ove? \square	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 le If yes, please answer this quest If no, skip to the next question.		igated to p	pay child support, including	back chi	ld support? [☐ Yes 🗹 No
W	/ho pays child support?			of child(ren) for whom ild support is paid:		Amount paid?	How Often? (weekly/monthly, other)
						\$	
						Φ.	

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13. Spousal Support/Alimony Is anyone listed in question 6 legally If yes, please answer the questions If no, skip to the next question.		pay spousal support/alimon	y? ☐ Yes ☐ No	
Who pays spousal support/alimo	ny?	Amount paid?	(weekly, bi-wee	w often? ekly. monthly, other)
		\$		
		\$		
\$ 14. Special Needs Expenses Does anyone have a special medical	al condition or s	situation that requires any	of the following?	
Special diet prescribed by a doctor?	☐ Yes ☐ No	Other special need?	(specify)	□ No
Special phone or other equipment?	☐ Yes ☐ No			
Housework (no one in the home can do it)?	☐ Yes ☐ No	Please list the name	of the person with the	special need and explain:
Very high use of utilities?	☐ Yes ☐ No	No One		
Special laundry service?	☐ Yes ☐ No			
If yes, please answer this question. If no, skip to the next question. NOTE: Do no enter amounts paid to other utilities, and the homeless she	by housing assi		ry to fill in the actual ar	mount owed.
Type of Expenses	Have Expense?	Who Pays?	Amount Owed	How Often Billed? (weekly/monthly)
Rent or house payment	✓ Yes □ N	Kevin (pays \$550.00)	\$ 550.00	Monthly
Property taxes and insurance (if billed separate from rent or mortgage)	☐ Yes 🗹 N	0	\$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if separate from rent or mortgage)	☐ Yes 🗹 N	0	\$	
Telephone/cell phone	✓ Yes □ N	o Kevin (pays \$37.35)	\$ 37.35	Monthly
Homeless Shelter Expense	☐ Yes 🗹 N	0	\$	
Water, sewage, garbage	✓ Yes □ N	O Kevin (pays \$8.44)	\$ 33.75	Monthly
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 Low Income Home Energy Assistance Progra		m the ☐ Yes ☑ No	'	1

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13. Spousal Support/Alimony Is anyone listed in question 6 legally If yes, please answer the questions If no, skip to the next question.	-	pay spousal support/alimon	y? ☐ Yes ☐ No							
Who pays spousal support/alimor	ny?	Amount paid?	(weekly, bi-wee	v often? ekly. monthly, other)						
		\$								
		\$								
\$ 14. Special Needs Expenses Does anyone have a special medical	al condition or	situation that requires any o	of the following?							
Special diet prescribed by a doctor?	☐ Yes ☐ No	Other special need?	(specify)	□ No						
Special phone or other equipment?	☐ Yes ☐ No									
Housework (no one in the home can do it)?	Yes No	Please list the name	of the person with the	special need and explain:						
Very high use of utilities?	☐ Yes ☐ No									
Special laundry service?										
15. Household Expenses Does anyone you purchase and pre If yes, please answer this question. If no, skip to the next question. NOTE: Do no enter amounts paid be other utilities, and the homeless she	by housing ass	istance such as HUD or Se	ection 8. The heating a ry to fill in the actual ar	nd cooling, telephone, mount owed.						
Type of Expenses	Have Expense?	Who Pays?	Amount Owed	How Often Billed? (weekly/monthly)						
Rent or house payment	☐ Yes ☐ N	lo	\$							
Property taxes and insurance (if billed separate from rent or mortgage)	☐ Yes ☐ N	lo	\$							
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if separate from rent or mortgage)	☐ Yes ☐ N	lo	\$							
Telephone/cell phone	☐ Yes ☐ N	lo	\$							
Homeless Shelter Expense	☐ Yes ☐ N	lo	\$							
Water, sewage, garbage	✓ Yes □ N	Kevin (pays \$50.00)	\$ 50.00	Monthly						
Does anyone not in your household help you pay for the expenses listed above?		Who helps pay?	How much?	How often paid?						
Yes No If yes, please complete.			\$							
Does your household get, or expect to get any				1						
Low Income Home Energy Assistance Progra	m (LIHEAP)?	☐ Yes ☐ No								

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16	6. Medical Expenses: Are you or anyone you buy	and prepare food	with an elde	erly (60	or older) or d	isabled	I person tha	t has any out-of-pocket
Al	medical expenses? If yes, please answer this q If no, skip to the next quest NOTE: Do not list spouses List expenses you expect to Illowable medical expenses are	No N	ving depend	, ,	,			, ,
	Medical or dental care Hospitalization/outpatient	Medicare costs, etc	premiums (c.)	Medi-Ca	al share of			sportation (mileage or fee) to obtain medical treatment
	treatment/nursing care Prescribed medications		, hearing aic ng an attenc	-			or services	eye glasses and contact
	Health and Hospitalization		ness, or infir		essary due		enses	ye giasses and contact
	insurance policy premiums	☐ The numb furnished	per and cost to an attend	of mea	s	☐ F	Prescribed neguipment	nedical supplies and
			ed over the c		nedications			nals expenses ls, etc.)
Nam	e of Elderly/Disabled Person	Amount of Expense	How ofter (monthly, othe	weekly,	What typ expens (prescript dentures, # of for attendar	se? tions, of meal	for a	household be reimbursed ny medical expenses? Medi-Cal, insurance, amily member, etc.)
							IF YES, BY W	/HO:
		\$					HOW MUCH:	\$
							IF YES, BY W	/HO:
		\$					HOW MUCH:	\$
	health insurance a little low other deductible expenses,	er. Do not includ	de anything	that you	already including to the next	uded in t quest	self-employ	it here could make the cost of yment expenses. If you have How often paid?
	Type of Expenses	Have Ex	pense?		Who p	ays?		(weekly/monthly)
Alimony	/	☐ Yes	□ No					
Student	t loan interest	☐ Yes	☐ No					
Other d	eductions (please identify)	☐ Yes	□ No					
18	Does anyone in question If yes, please answer this q					✓ No		
	Communal dining facility	for the elderly/dis	abled •	Food di	stribution pro	gram o	operated rvation	Other food program
IF YES, WH	HO?		V	WHAT PROGRAM?				
IFYES, WH	HO?		V	/HAT PROG	RAM?			
(E) 19 (S) (C)	9. Does anyone in question If yes, please answer this q • Homeless Shelter • Shelter for battered wome • Reservation for Native Ar • Drug/Alcohol rehabilitatio • Correctional facility/Pena Person's Name	en mericans on center I institution (Jail of	r Prison)	• questid • G • F • F • H • L		sidized spital/r are or E	housing mental institu Board and C	

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\$ 20. Is anyone getting In-Hom If yes, fill in the information		ices (IHSS)?	☐ Yes ☐ No			
WHO GETS SERVICES?			HOW MUCH DO YOU PAY EACH MONTH FOR THE SERVICES?			
21. Does everyone listed in que If no, list the people who dor	estion 6 buy and prepare	prepare food	with you? ✓ Yes □ No			
NAME	rt buy and prepare	NAME	•			
NAME		NAME				
Ole le envene living with veu	ana 60 an aldar an	d upoblo to	any food and fiv mode congretaly because of a disability?			
Yes No If yes, wh	o:		buy food and fix meals separately because of a disability?			
the following? Yes	□ No		overage. Is anyone enrolled in health coverage now from			
	verage and write the	e person(s)' r	ame(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		s this COBRA coverage? Yes No			
care or Line of Duty)			s this a retiree health plan? Yes No			
☐ VA health care programs			s this a state employee benefit plan? Yes No			
Peace Corps			Other			
			Name of health insurance			
			Policy Number:			
			s this plan a limited-benefit plan			
			like a school accident policy?			
22a. Is anyone listed on this a If yes,, you'll need to comp			coverage from a job?			
22b. Is anyone's health insura If yes, please answer the q						
Insurance Company	Person Insured	Expiration Date	Reason it ended or will end			
22c. Does anyone want help fo	or medical bills fro	m the last th	ree months? ☐ Yes 🗹 No			
If yes, who:	action 6 plan to file	o fodoral in	come tax return next year?			
If yes , complete the question of the first	ons below for each t	tax filer.	•			
			ile a federal income tax return next year if you answered yes to you don't file a federal income tax return.			
·	b. Name of person planning to file a federal income tax return:					
	c. Will this person file jointly with a spouse?					
If yes , name of spouse:						
23d. Will this person claim any of the list the name	•		」 Yes No ∷			
23e. How is this person related to						
23f. To make it easier to determ	nine my eligibility for	paying healtl	n coverage in future years. I agree to allow you to use income a notice, let me make any changes, and I can opt out at any			
			e): 5 years 4 years 3 years 2 years 1 year			

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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 belo		household has	:		
Bank/Credit Union account Bank/Credit Union account Safe Deposit box Savings Bond(s) Oil, Mining or Mineral Right	(Savings) Mutual Certific Cash o Notes,	Market Accoun funds/Trust fun tate of Deposit (on hand Mortgages, Dec	ds (CD)/IRA	Stocks Bonds Uncashed c Life or Buria Other:	l insurance
For each box checked above, co	omplete the following informa				
In Whose Name is the Resource Listed?	Type of Resource	How Much is it Worth?		esource? (include the empany where money	e name of the bank or is held)
Kevin	Checking	\$ 1.00	Charles Schwab (N		<u></u>
Kevin	Checking	\$ 17.00	Ally Bank (*****	*095)	
Kevin	Checking	\$ 1,120.34	Capital One Bank ((******630)	
Kevin	Checking	\$ 15,019.51	Lake Michigan Cre	edit Union (*****499)	
Have you or anyone in your hou	sehold sold, traded, given av	vav. or transferre	ed a resource in	the last thirty (30) mo	nths? ☐ Yes 🔽 No
WHEN?	WHAT WAS THE RESOURCE?	,		WHAT WAS IT WORTH?	HOW MUCH DID YOU GET FOR IT
25. Personal Property Does anyone own a	nly answer if someone apply ny personal or business-rela er the question. If no , skip to	ted property?	☐ Yes 🗹 No		
☐ Tools☐ Business inventory☐ Livestock☐ Business equipment	Non-Moto Camper s Personal	tools	trailers	Лusical instruments (F	Piano, Organ, etc.)
Please include the item even if i			-		_
List any other jewelry worth \$10		Is it listed fo		re than \$500 per item ice or Current Value	Amount Owed
		Sale?	\$		\$
					\$
		☐ Yes ☐ No			\$
	☐ Yes ☐ No	_		\$	
		☐ Yes ☐ No			\$
		☐ Yes ☐ No	_		\$
		☐ Yes ☐ No			\$
		□ Voc □ No			\$

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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.					
must answer the question. Check each resource listed below that you or anyone in your household has:					
	, , ,			Ota alsa	
Bank/Credit Union accountBank/Credit Union account		Market Accoun	` '	Stocks Bonds	
Safe Deposit box					
Savings Bond(s)		on hand		Life or Buria	
☐ Oil, Mining or Mineral Righ		Mortgages, De	eds of Trust	Other:	
If joint account with another per For each box checked above, c		ation			
In Whose Name is the Resource Listed? Type of Resource it Worth? Where is the Resource? (include the name of the back it Worth?					
Kevin	Certificate of deposit	\$ 20,240.00	Ally Bank (*****		13 Hold)
Kevin	Savings	\$ 33.25	Lake Michigan Cr	edit Union (*****499)	
Kevin	Savings	\$ 43,130.66	Ally Bank (*****	**008)	
Kevin	Annuities, Trust Funds, IRA or Keogh plans, etc.	\$ 83,569.97	Vanguard		
Have you or anyone in your hou	usehold sold, traded, given av	vay, or transferre	ed a resource in	the last thirty (30) mo	nths? 🗌 Yes 🔲 No
WHEN?	WHAT WAS THE RESOURCE?			WHAT WAS IT WORTH?	HOW MUCH DID YOU GET FOR IT
				\$	\$
If you traded or gave the resour	ce away, please explain:				
Ontional for health care:	only answer if someone apply	ing is 65 or olds	or disabled		
25. Personal Property	-	ing is 65 or olde	ei oi disabled.		
Does anyone own a	any personal or business-rela er the question. If no , skip to		☐ Yes ☐ No on.		
☐ Tools	Sporting	equipment, Gur	าร		
Business inventory		or boats and/or	trailers		
Livestock	☐ Camper :☐ Personal				
Business equipment			es, Collections, I	Musical instruments (F	Piano, Organ, etc.)
Please include the item even if List any other jewelry worth \$10	it is jointly owned with someo	ne else. Do not	include wedding	g or engagement rings	s, family heirlooms, etc.
Ite	m	Is it listed for Sale?	Purchase Pr	rice or Current Value	Amount Owed
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No			\$
		☐ Yes ☐ No	\$		\$

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stocks and bonds, e	urces any resources (cash, money atc.)?	, please answei	r this question.	If no , skip to the next of	
must answer the question				117 3	
Check each resource listed belo					
Bank/Credit Union accountBank/Credit Union account	`	Market Accoun	` '	✓ Stocks	
Bank/Credit Union accountSafe Deposit box	(3 - /	funds/Trust fun ate of Deposit (☐ Bonds☐ Uncashed c	hooks
Savings Bond(s)	Cash o	-	(CD)/INA	Life or Buria	
Oil, Mining or Mineral Right		Mortgages, De	eds of Trust	Other:	
If joint account with another per		3.3.7			
For each box checked above, co	omplete the following informa	tion.			
In Whose Name is the Resource Listed?	Type of Resource	How Much is it Worth?		desource? (include the ompany where money	e name of the bank or is held)
Kevin	Stocks	\$ 10,081.84	Vanguard / Option	sHouse	
		\$			
		\$			
		\$			
Have you or anyone in your hou	sehold sold, traded, given av	vay, or transferr	ed a resource in	the last thirty (30) mo	nths? Yes No
WHEN?	WHAT WAS THE RESOURCE?			WHAT WAS IT WORTH?	HOW MUCH DID YOU GET FOR IT
Optional for health care; o 25. Personal Property	nly answer if someone apply	ing is 65 or olde	er or disabled.		
Does anyone own a	ny personal or business-rela er the question. If no , skip to		☐ Yes ☐ No on.		
☐ Tools	☐ Sporting	equipment, Gur	ns		
☐ Business inventory		or boats and/or	trailers		
Livestock	☐ Camper s				
☐ Business equipment	Personal		as Callactions	Musical instruments (F	Piano Organ etc.)
Please include the item even if i List any other jewelry worth \$10	t is jointly owned with someon	ne else. Do not	include wedding	g or engagement rings	, family heirlooms, etc.
Ite		-		rice or Current Value	
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No			\$
		☐ Yes ☐ No			\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$
		☐ Yes ☐ No	\$		\$

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1	-	٨
1	•	١
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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

4		
ľ	<u> +3</u>)	

Does anyone own, have the us	se of, or have their name o	n any registration of any	motor vehicle, such as:	a car, motorcycle,
snowmobile recreational vehice	ele (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?	n, or transferred to you appropriate box appropriate box				☐ 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		Y	es 🗌 No			Yes	□ N	0	
Are you or someone else currently leasing the vehicle?	☐ Yes ☐ No		☐ Y	es 🗌 No			Yes	□ N	0	
How do you use the vehicle?										
As a home?	☐ Yes ☐ No		Y	es 🗌 No		☐ Yes ☐ No				
To go to work, training, or job search?	☐ Yes ☐ No		☐ Y	es 🗌 No		☐ Yes ☐ No				
For self-employment, self-support, or business use?	☐ Yes ☐ No		☐ Y	es 🗌 No		☐ Yes ☐ No				
To drive a disabled household member?	☐ Yes ☐ No		Y	es 🗌 No		☐ Yes ☐ No				
To get fuel or water for your household?	☐ Yes ☐ No		Y	es 🗌 No		☐ Yes ☐ No				
For recreational use only?	☐ Yes ☐ No		☐ Y	es 🗌 No			Yes	□ N	0	
or country?	restion 6 own or are they buying res No If yes, please explain nly answer if someone applying is Address of the home/pro	s 65 or (older Is re		How mu		t does	no exp	ot liv w bu ects	ving in towner to move nto the omeday?
	☐ Yes ☐ No \$		\$		Not rented			☐ No		
		☐ Yes ☐ No \$		\$	☐ Not rented			Yes	☐ No	
-	d a Diversion cash payment or no er the question. If no , skip to the			-	county or	other s	tate? [Ye	s 🗆] No
Name	County/State Received From		Amount List of Services Rec			eived	ated of ces		te Last ceived	
		\$					\$			

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9	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.					
		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?				
8	32.					
		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?				
		MII- and O				
	0.4	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?				
	35.	Where? Why? Fleeing Felon				
\$	55.	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?				
		b) Participated in a government-recognized drug treatment program?				
		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?				
		If yes, please explain:				

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Ψ		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? \Box Yes	₃ □ No					
		If yes , please explain:						
	39.	Other Services						
\$		The following services are available. Your answers to the questions will not affect your elig	ibility.					
A.	nild Health and Disability Preven-							
	•	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 y	ou want more information about immunization services?	☐ Yes 🗹 No					
C.	If you	u are pregnant, you can get help finding a doctor, getting healthy foods and other help.						
	Do y	ou want to talk to someone about this help?	☐ Yes 🗹 No					
D.	Are v	ou breastfeeding a child?	☐ Yes 🗹 No					
		s, have you given birth within the last 12 months?	☐ Yes 🗹 No					
	-	u checked yes to 39 C or D, you may be eligible for services provided by the						
	•	sial Supplemental Food Program for Women, Infants and Children (WIC).						
E.	Do y	ou 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					
	-	s, call your health care plan or regular doctor. Or, for facts and the location of dential family-planning clinics, call toll-free 1-800-942-1054.						
		Additional Writing Space						
		•						
Appli	cation (Confirmation Number: 000126686						

The following is additional information you provided.

Question 1)

Is your Home Address permanent? No

What is the best way for the county to contact you? Email address

What is the best day and time to reach you, Monday through Friday 8:00~A.M. - 5:00~P.M.?~12:30-2:00PM

What is your preferred method of communication? Phone

Question 4)

What type of interview do you want? By Phone

Question 5)

Has anyone received cash aid, food assistance (CalFresh), or IAP/Medi-Cal? No One

Question 6 for Chen, Kevin, K)

What language does this person prefer to speak (if not English)?: English

What language does this person prefer to read (if not English)?: English

Lawsuit Pending)

Does anyone have a lawsuit pending due to accident or injury? No One

Question 39)

Do you want WIC services?: No

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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?

Is the household's combined gross income and liquid resources less than the combined rent/mortgage and appropriate utility allowance?

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding \$100?

Does the CalWORKs Assistance Unit have a pay-or-quit or other eviction notice?

Is the household a destitute migrant/seasonal farm worker household with liquid resources not exceeding \$100?

Yes No

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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.

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	7. CITY 8. STATE		
10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB?			
11. PHONE NUMBER (IF DIFFERENT FROM EMPLOYER'S PHONE NUMBER) ()	MAIL ADDRESS (EMPLOYER'S REPRESENTATIVE)		
13. Are you currently eligible for coverage offered by thi months?	s employer, or wi	Il you become eligible in the next three	
☐ No (stop here for this section of the application)☐ Yes (continue)			
13a. If you're in a waiting or probationary period, when on the list the names of anyone else who is eligible or will be	eligible for coverage	ge 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 th	ne minimum value	e standard*?	
14a. Is this a State employee benefit plan? Yes N	lo		
15. For the lowest-cost plan that meets the minimum value (don't include family plans): If the employer has wellness programs, provide the pre maximum discount for any tobacco cessation (that help any other discounts based on wellness programs.	emium that the emp	ployee would pay if he/she received the	
a. How much would the employee have to pay in premi	iums for this plan?	\$	
b. How often? ☐ Weekly ☐ Bi-weekly ☐ The employer doesn't offer wellness programs.] Twice a month	\square Monthly \square Quarterly \square Yearly	
16. What change will the employer make for the new pl	an year (if known)?	
 □ Employer will no longer provide health coverage. □ Employer will start offering health coverage to employe available only to the employee that meets the mining a. How much would the employee have to pay in preming b. How often? □ Weekly □ Bi-weekly □ Date of change (mm/dd/yyyy): 	mum value standar iums for this plan? Twice a month	rd.	
☐ No changes are expected.			
*An employer-sponsored health plan meets the "minimum val covered by the plan is no less than 60 percent of such costs (

SAWS 2 PLUS (9/13) APPENDIX A

ou are not registered to vote where you live now, wou	id you like to apply	to regional to vete more teday
Already registered. I am registered to vote at my cu	urrent address.	
Yes. I would like to register to vote.		
No. I do not want to register to vote.		
ivo. I do not want to register to vote.		
TVO. 1 do not want to register to vote.		
The rad flot want to register to vote.	10/14/2014	12:59:30 AM
Applicant Name	10/14/2014 Date	12:59:30 AM Time