

Veterans Benefits: An Overview of Compensation and Pension

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Introduction

Veterans Benefits Planning is an integral part of an elder law practice. Many wartime veterans or their surviving spouses could be eligible for a tax-free payment each month to help cover their cost of care, called service pension with a housebound or aid and attendance allowance. However, there are very strict medical and financial requirements that must be met. In addition, if a veteran (including a non-wartime veteran) is currently disabled due to an injury that was caused by or aggravated by her service, that veteran could be eligible for tax-free payments because of that service-connected disability, with no financial requirements attached.

This outline covers the differences between Compensation and Pension, with an in-depth look at Pension, as this program has income and asset requirements, and as a result, many seniors may need assistance understanding the rules and opportunities available within the Pension program. In addition, it is important to understand the Pension rules as many of them conflict with the federal rules pertaining to Medicaid and special needs trusts.

Veterans Compensation – Overview

Compensation is the benefit paid to veterans who have disabilities incurred or aggravated during active duty. The disability does not need to be related to combat or a job held during active duty. Rather, it had to have occurred during with service and in the line of duty. Compensation is not based on income or assets. It is awarded based solely on a disability determination.

Compensation is similar to workers compensation in the private sector. But unlike disability determinations for social security benefits, where total disability is required before any award is given, disability ratings for VA benefits are made in increments of 10 percent. The monthly award is directly related to the percentage of disability – the higher the disability, the higher the monthly award.

Veterans Pension – Overview

Veterans who served during a period of war (as defined by Congress) and who are permanently and totally disabled from a cause *not* solely related to their military service may be eligible for pension

benefits. Unlike compensation, pension benefits are awarded based both on disability and income, as well as the net worth of the veteran. In many cases, pension pays less for a total disability than the compensation program pays. However, there are additional allowances to pension, known as Housebound and Aid and Attendance, that can increase the monthly pension amount paid and will be discussed more thoroughly below.

Survivor's Rights to Compensation or Pension – Quick Overview

Surviving spouses or dependent children of military personnel who die on active duty and surviving spouses or dependent children of veterans who die as a result of a service-connected disability are eligible for dependency and indemnity compensation (DIC). Low-income surviving family members may also be eligible for what is referred to as Death Pension (or Improved Death Pension), as well as the additional allowances for Housebound and Aid and Attendance.

Eligibility Overview

While each benefit administered by the Department of Veterans Affairs (VA) has its own unique set of eligibility requirements there are some basic principles of eligibility common to many VA benefits programs. These fundamental principles center around what it means to be a veteran. This includes whether a person had military service, whether that military service was active, and under what circumstances a person was discharged. The length of active military service (and timing of that service) can also affect VA pension, VA health care and some education benefits.

There are two steps required for any VA benefit. First, the person applying for VA benefits must establish basic eligibility for a given benefit. Basic eligibility normally relates to the type of service, length of time and time period. Second, the person applying for benefits must establish entitlement to the particular benefit being sought. The term entitlement relates to the qualification of the person applying, either a veteran, dependent of a veteran, or survivor of a veteran, for a particular benefit, assuming that the basic eligibility of the veteran has been established. It is also important to note that there are some veterans who would be entitled to benefits (under step two), but who do not meet the basic eligibility requirements for VA benefits (they fail under step one).

Active Duty

In order to qualify for most VA benefits, the person applying for benefits must be a veteran or the dependent or survivor of a veteran. The VA defines a veteran as “a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.” The VA’s definition of a veteran requires not only that a person served in the military, but also that that service was active. In some cases, this may encompass members of

the Armed Forces Reserves or National Guard who serve on active duty. For example, a Reservist who is activated to serve in Afghanistan for 12 months is considered to have served on active duty during that time. A National Guard member would be eligible for VA benefits if for federal purposes.

Type of Discharge

The type of discharge will also determine whether the VA will consider a person a veteran. A person desiring veteran status must have been discharged or released under conditions other than dishonorable. The language that the VA uses to describe the character of a veterans service does not correspond precisely with the language used by the military. The military has its own language that it uses to describe the circumstances under which a person was discharged.

The military issues essentially five types of discharges:

1. Honorable discharge (HD);
2. Discharge under honorable conditions (UHC), or general discharge (GD);
3. Discharge under other than honorable conditions (OTH), or undesirable discharge (UD);
4. Bad conduct discharge (BCD) (which can be issued by sentence of either a special court-martial or a general court-martial); and
5. Dishonorable discharge (DD) or a dismissal, the latter in the case of an officer (both are issued only by a general court-martial).

Individuals with dishonorable discharges generally cannot get benefits. Individuals with discharges under other than honorable conditions, undesirable discharges and bad conduct discharges may or may not be eligible for VA benefits. Individuals with honorable discharges, discharges under honorable conditions, and general discharges usually do qualify for benefits.

For those discharges that are questionable, the VA will first adjudicate the issue of the character of service to decide whether the veteran was separated from service under dishonorable conditions or other than dishonorable conditions. In a character of service determination, the VA reviews the entire period of service to evaluate the quality of service and judge if it was good enough to merit receipt of veterans benefits. Initial decisions are rendered at the VA regional office having

jurisdiction over the claim. Adverse decisions can be appealed to the Board of Veterans Appeals and subsequently to the United States Court of Appeals for Veterans Claims.

There may be situations when a discharge may be changed by administrative action. The statutory bars to benefits described above may be overcome if the discharge is upgraded by the service department's Board for Correction of Military Records (BCMR). All discharges upgraded by a service department BCMR to at least a general discharge (GD) are final and conclusive on the Department of Veterans Affairs and may be enough to allow a veteran to meet the discharge requirements that apply to eligibility for veterans benefits.

In 1982, the Department of Defense (DoD) created three new categories of administrative discharges that do not characterize the individual's service: entry level separation, void enlistment or induction, and dropped from the rolls. Entry-level separation is considered a discharge under conditions other than dishonorable. In cases of void enlistment or induction and dropped from the rolls, the VA will decide if the claimant is eligible for VA benefits on a case-by-case basis.

Time Period of Service for VA Pension

Only veterans with service during a period of war are eligible for non-service-connected disability pension benefits. Service in a combat zone is not required. The veteran only had to serve during a time designated as a period of war as designated by Congress. A veteran will have met the service requirements by serving ninety consecutive days (active duty), at least one day of which occurred during a period of war. Listed below are the periods of war that Congress has designated for VA pension purposes, beginning with World War I (prior wartime periods included the Mexican Border War, Spanish-American War and Indian Wars of which no survivors are alive today).

Periods of War:

World War I: April 6, 1917, through November 11, 1918, or, for those who served in Russia, April 1, 1920. Service after November 11, 1918, and before July 2, 1921, qualifies as wartime service if the veteran had any active service from April 6, 1917, through November 11, 1918.

World War II: December 7, 1941, through December 31, 1946, extended to July 25, 1947, if continuous with service on or before December 31, 1946.

Korean Conflict: June 27, 1950, through January 31, 1955.

Vietnam Era: August 5, 1964, through May 7, 1975. However, February 28, 1961, through May 7, 1975, for a veteran who served in the Republic of Vietnam during that period.

Persian Gulf War: August 2, 1990, through a date to be prescribed by Presidential proclamation or law.

Specific Eligibility – Pension

Disability Pension is a benefit payable by the Department of Veterans Affairs to veterans of a period of war who are permanently and totally disabled because of non-service connected disability or age, which disability is not a result of their own willful misconduct.¹ There are five elements of eligibility for a disability pension claim: service, disability, age, unemployability, and income and net worth.² For ease of determining whether a veteran will be qualified for Disability Pension, however, we use a three part test: Service, disability, and means.

For Disability Pension, first the Claimant must meet the definition of a veteran, and have served 90 days on active duty,³ one day during a declared period of war.⁴ The Claimant must have been released from the service with a discharge characterized as less than dishonorable.⁵

Second, the Claimant must be disabled, although the VA characterizes someone over the age of 65 as disabled.⁶ However, if the veteran is under age 65, he or she has to be 100% disabled.⁷ The VA presumes a veteran is permanently and totally disabled if he or she is a patient in a nursing home for long-term care because of a disability, or has been determined to be disabled by the Social Security Administration.⁸

Finally, we apply a “means” test to determine whether the veteran is financially qualified for the pension. The means test is essentially a look at income and net worth. The means test is split into a gross income test and a net worth test. The gross income is the household income, including the income of the veteran, the spouse, and any dependents.⁹ The VA calls a spouse a dependent.¹⁰ A

¹ 38 U.S.C. Section 1521; 38 C.F.R. Section 3.3(3)

² M21-1MR, Part V, Subpart I, Chapter 2

³ 38 U.S.C. Section 101(21) and (24)

⁴ 38 C.F.R. Section 3.2

⁵ 38 C.F.R. Section 3.1(d). In general, an honorable, general, or medical discharge should meet that requirement

⁶ 38 C.F.R. Section 3.3(a)(3)(vi)(A) and (B)

⁷ 38 C.F.R. Section 3.3(a)(3)(vi)(B)

⁸ M21-1MR, Part V, Subpart i, Chapter 2, 1.d

⁹ 38 C.F.R. Section 3.274(a)

dependent child has a very specific definition; it is someone who was disabled and incapable of self-support prior to age 18, someone who is a minor, or someone between the ages of 18 and 23 and still in school.¹¹ For elderly clients, a dependent child is typically going to be a child who was rendered incapable of self-support prior to age 18.¹²

When it comes to income, the VA means payments of any kind, from any sources,¹³ unless excluded under 38 CFR §3.272. The VA considers recurring income to be income which is received in equal amounts at regular intervals and continues during a twelve-month period.¹⁴ The VA also considers irregular income, such as income received in uneven amounts or different intervals. For VA purposes, the amount of irregular income they will consider is the amount received during a 12-month annualization period.¹⁵ This can be interest on a savings account, for example. Finally, the VA will consider non-recurring income—income that’s received on a one-time basis, such as inheritance.¹⁶ When first making a claim, one has to project the anticipated income for the next twelve months. The VA will request information about the gross amount of recurring income, the date the first check was received, any retroactive payments received, and the dates of any changes in the monthly rate of income.¹⁷

Aid and Attendance

Many people refer to any pension benefit as “Aid and Attendance”. However, Aid and Attendance is actually an added allowance paid to a veteran or surviving spouse who qualifies for Improved Pension or Service-Connected Compensation and is in need of the aid and attendance of another person on a regular basis.¹⁸ Aid and attendance is the highest level of the Pension benefit and, thus, provides the most money to the veteran. It also has the most stringent medical requirements.

The VA lists the basic criteria for regular aid and attendance at 38 C.F.R. Section 3.352(a): “inability of claimant to dress or undress himself (herself), or to keep himself (herself) ordinarily clean and

¹⁰ 38 C.F.R. Section 3.23(d)(1)

¹¹ 38 C.F.R. Section 3.57

¹² 38 C.F.R. Section (a)(1)(ii)

¹³ 38 U.S.C. Section 1503 – Determinations with respect to annual income; 38 C.F.R. Section 3.271

¹⁴ 38 C.F.R. Section 3.271(a)(1). In general, wages, Pension, or Social Security are examples of recurring income

¹⁵ 38 C.F.R. Section 3.271(a)(2)

¹⁶ 38 C.F.R. Section 3.271(a)(3)

¹⁷ M21-1MR, Part V, Subpart i, Chapter 3, Section C

¹⁸ 38 U.S.C. Section 1521(d); 38 C.F.R. Section 3.351(a)1; 3.351(b)and (c); 38 C.F.R. Section 3.352(a) Basic criteria for regular aid and attendance and permanently bedridden

presentable; frequent need of adjustment of any special prosthetic or orthopedic appliances which by reason of the particular disability cannot be done without aid (this will not include the adjustment of appliances which normal persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc.); inability of the claimant to feed himself (herself) through loss of coordination of upper extremities or through extreme weakness; inability to attend to the wants of nature; or incapacity, physical or mental, which requires care or assistance on a regular basis to protect the claimant from hazards or dangers incident to his or her daily environment.”

Providing medical evidence that the veteran lacks the ability to do three activities of daily living or is bedridden will satisfy this requirement. The VA accepts evidence provided by either a private physician or a VA physician. However, providing statements by private physicians will speed up this already lengthy process.

Housebound Allowance

The Housebound Allowance is a benefit provided to a veteran who is “permanently housebound” by reason of disability or disabilities. This requirement is met when the veteran is substantially confined to his or her dwelling and the immediate premises or, if institutionalized, to the ward or clinical area and it is reasonably certain that the disability or disabilities and resultant confinement will continue throughout his or her lifetime”.¹⁹

Death Pension

Death pension is the pension available to a surviving spouse or to dependent children of deceased veterans.²⁰ There is no disability requirement attached to this for the service pension part, but there is a disability requirement for housebound or aid and attendance.²¹ In the case of a surviving spouse, there has to be a valid marriage at the time of the veteran’s death.²² The CFR has some very specific rules dealing with divorces and remarriages, based on the date of the end of the marriage.²³ The veteran has to meet the wartime and disability requirements for service pension.²⁴ The spouse

¹⁹ 38 C.F.R. Section 3.351(d)(2) or is rated as 100% disabled and has an additional disability or disabilities rated at 60% or more. 38 C.F.R. Section 3.351(d)(1)

²⁰ 38 C.F.R. Section 3.3(b)(4)

²¹ 38 C.F.R. Section 3.23(d)(2) and (3)

²² 38 U.S.C. Section 101(3) and Section 103; 38 C.F.R. Section 3.50(b)

²³ See 38 C.F.R. Sections 3.53, 3.54, and 3.55

²⁴ 38 U.S.C. Section 1541; 38 C.F.R. Section 3.3(4)(i)

does not have to meet the wartime and disability requirements, but does have to meet the income and net worth requirements.²⁵

If the surviving spouse applies within a year of the veteran's death, the benefits will be retroactive to the first day of the veteran's death. If substantial life insurance is going to be paid, it might make sense to wait to apply for death pension, because that life insurance can disqualify the surviving spouse for benefits.

Surviving children can also receive death pension if they meet the definition of a dependent child. A dependent child is a legitimate child, a child adopted before age 18, an illegitimate child, or a step-child who became a step-child before the age of 18 and is a member of the veteran's household.²⁶ A dependent child also includes one who is between the ages of 18 and 23 if he or she is a full-time student pursuing a course of instruction at an educational institution approved by the VA,²⁷ or a child who became permanently incapable of self-support before the age of 18.²⁸

In order for a dependent child to be eligible for Death Pension, the veteran had to have met the definition of a veteran, served on active duty for the requisite time, with one day of service being during a period of declared war, and have been discharged under other than dishonorable conditions. A child can also be eligible for benefits if the veteran was receiving (or was entitled to receive) compensation or retirement pay for a service-connected disability at the time of his or her death.²⁹ The child must not be in the custody of the surviving spouse.³⁰ If the veteran died leaving a surviving spouse, the claim belongs to the spouse and he or she can receive an added monthly amount for children in her custody.³¹ However, if the child is not in the custody of the surviving spouse, is not in the custody of someone required by law to provide support, has no personal custodian or is in the custody of an institution, the amount the child can receive is currently \$2129 per year.³²

²⁵ 38 C.F.R. Section 3.3(4)(iii) and 3.274 and 3.23 and 3.24

²⁶ 38 C.F.R. Section (1); 38 C.F.R. Section 3.210

²⁷ 38 C.F.R. Section 3.57(a)(1)(iii)

²⁸ 38 C.F.R. Section 3.57(a)(1)(ii)

²⁹ 38 U.S.C. Section 1542(1)

³⁰ 38 U.S.C. Section 1542(2); 38 C.F.R. Section 3.24(a)

³¹ 38 C.F.R. Section 3.24(a)

³² See http://benefits.va.gov/PENSIONANDFIDUCIARY/pension/rates_survivor_pen12.asp for the current rates for 2012-2013

Calculating Income for VA Purposes (IVAP)

The IVAP calculation begins with the gross income of the Claimant, along with the income of the spouse and any dependent children. Once unreimbursed medical expenses are deducted, the amount remaining is the IVAP. In order to determine the benefit that the Claimant will receive, one looks at the Maximum Annual Pension Rate for the year. The annual IVAP is subtracted from the MAPR, and the result is an annual benefit amount. Although the figures are based on an annual amount, the VA does divide that amount by 12 and pays the benefit amount on a monthly basis. The calculations are based on the benefit figures for the year, which are the Maximum Annual Pension Rates, or MAPR. The pension tables are published in December for the following year on the VA's website.³³

The expenses to be excluded are the gross household medical expenses, and they can be incurred or paid either by the veteran or the spouse, any dependents, or any other relative the claimant has a moral or legal duty to support and who is a household member.³⁴ For purposes of this calculation, the definition of a child has nothing to do with the definition of a dependent child; this is simply whose expenses can be excluded from the claimant's income.³⁵

The VA requires that the medical expenses exceed 5% of the service pension amount. The 5% is not of the maximum benefit being applied for, but 5% of the basic service pension amount—not the service pension plus housebound or plus aid and attendance. Just like income, when first applying for the pension, the projected medical expenses for the next twelve months are given to the VA. It must be clear and reasonable that these medical expenses will occur in the next twelve months—costs such as nursing home and assisted living expenses and in-home care are normally accepted as prospective costs.³⁶ “In most instances, the medical expense deduction is allowed after the fact. However, if a claimant has consistently recurring unreimbursed medical expenses (for example, a nursing home patient), it may be possible to allow the medical expense deduction on a continuing basis.”³⁷

³³ http://www.benefits.va.gov/PENSIONANDFIDUCIARY/pension/rates_veteran_pen12.asp

³⁴ 38 C.F.R. Section 3.272(g)

³⁵ 38 C.F.R. Section 3.272(g)

³⁶ 38 C.F.R. Section 3.272(g); M21-1MR, Part V, Subpart i, Chapter 3, Section D, Paragraph 13 d., e. , and h

³⁷ M21-1MR, Part V, Subpart i, Chapter 3, Section D. Paragraph 13 d

The VA cares most about recurring out-of-pocket expenses, which are those that are incurred on a monthly basis and will likely be incurred in the future—those expenses are what determine the monthly award amount. At the end of the year, if the claimant had one-time medical expenses, they can be submitted on the EVR, and the VA might send the veteran a reimbursement check.³⁸ Oddly enough, the VA does not consider medication as a recurring expense, so medication expenses will have to be added as one-time expenses at the end of the year.

In-home care costs are counted unless the claimant doesn't have enough medical evidence to support a claim for housebound or aid and attendance.³⁹ (If the claimant is not rated housebound, the in-home attendant care can only be counted if the attendant is a licensed health professional.) A family member can provide in-home care to a claimant and the expenses will still be counted.⁴⁰ Although a contract is not required, the VA does require documentation that the expense was incurred, who provided the care, what type of care they provided, how many hours and the hourly rate of the care provider.⁴¹ Often, a contract is the easiest way to document the care provided by a family member. Note that a spouse may not be paid for providing care to the other spouse. If the care is through a home care or home health agency, the agency will keep track of all the documentation.

An Example - Income for VA Purposes (IVAP) Calculation

Harry, a married World War II veteran, and his wife, Martha, have combined monthly income of \$3,000.00. Together, Harry and Martha have \$4,000.00 each month in unreimbursed medical expenses - \$3,000.00 of the medical expenses is attributed to Harry and \$1000.00 to Martha. In calculating the IVAP for Harry, start with Harry and Martha's annual income, which is \$36,000.00. Their medical expenses exceed 5% of the of the maximum annual pension rate (MAPR) so that requirement is met.

In Harry's case, his annual UME's are \$48,000. Household income is \$36,000 annually. We subtract \$36,000 from \$40,000 and end up with a negative IVAP of \$4,000. To have a negative amount is ideal, as an IVAP of zero or less means a claimant will receive the maximum pension award. In

³⁸ 38 C.F.R. Section 3.277(b) and (c); See M21-1MR, Part V, Subpart iii, Chapter 7, Section A

³⁹ M21-1MR, Part V, Subpart i, Chapter 3, Section D. Paragraph 13h

⁴⁰ Id.

⁴¹ M21-1MR, Subpart i, Chapter 3, Section D. Paragraph 13i

Harry's case, he can qualify for the maximum pension amount with aid and attendance award of \$2,120 a month.

If the calculated IVAP amount is a positive number, that number must be subtracted from the total that could have been awarded.

Net Worth and IVAP

Net worth is a difficult subject because the net worth limits are really unknown. The purpose of the pension program is "intended to afford beneficiaries a minimum level of security, and *not* intended to protect substantial assets or build up the beneficiary's estate for the benefit of heirs."⁴² The VA decides if the Claimant has too many assets on a case-by-case basis by determining whether it is reasonable for the claimant to consume part of his net worth for his or her maintenance. 38 C.F.R. Section 3.274 provides that "pension shall be denied or discontinued when the corpus of the estate of the veteran, and of the veteran's spouse, are such that under all the circumstances, including consideration of the annual income of the veteran, the veteran's spouse and the veteran's children, it is reasonable that some part of the corpus of such estates be consumed for the veteran's maintenance."

Net worth, also known as the "corpus of estate," is defined as "market value less mortgages or other encumbrances, of all real and personal property owned by the claimant and/or spouse, except the claimant's single-family dwelling and reasonable personal effects."⁴³ Reasonable personal effects include normal household objects and motor vehicles that are used for transportation of the family.⁴⁴ The VA also includes a reasonable lot area. Whether the size of the lot is reasonable depends on whether the land is connected to the dwelling and whether it is reasonable, considering the customary size of lots in the area.⁴⁵

If the personal residence and a business are the same, as for example a farm, the VA will consider the value of the dwelling and the value of the business property separately to determine the value. The VA will exclude the value of the residence, but will include the value of the business property in

⁴² M21-1MR, Part V, Subpart i, Chapter 3, Section A, paragraph 1.d

⁴³ M21-1MR, Part V, Subpart i, Chapter 3, Section A, Topic 1b

⁴⁴ M21-1MR, Part V, Subpart iii, Chapter 1, Section J, Topic 67b

⁴⁵ M21-1MR, Part V, Subpart iii, Chapter 1, Section J, Topic 71 c and d

determining the Claimant's net worth.⁴⁶ Some things to consider here are the amount of the claimant's income and whether the property can be readily converted into cash at no substantial sacrifice.⁴⁷ As an example, the VA considers a real property that cannot be sold for more than the loan amount to have a net worth value of \$0.⁴⁸ The VA will take into consideration the type and amount of property, the countable income and the life expectancy of the claimant, the number of people dependent on the claimant, and their health.⁴⁹

Although there is no hard and fast rule regarding how much net worth the Claimant can have and be approved, if the reported net worth is over \$80,000, a formal determination of net worth must be prepared for approval by the Senior Veteran Services Representative. Thus, the Veterans Service Officer will be required to do more work in order to allow a claim to go through with over \$80,000 and a Claimant with assets in excess of \$80,000 is more likely to be denied.⁵⁰

Secured debt on real property will decrease net worth, but unsecured debt will not decrease net worth. According to the VA manual, unsecured debts (such as credit card debt) that do not affect the market value of an asset are not considered in determining the claimant's net worth.⁵¹

Currently, there are no penalties for transferring assets to reduce net worth. The only restrictions on transfer are that the transfer of property to a relative living in the same household will not reduce the net worth of the claimant and that a gift of property to someone outside the household will not reduce net worth unless it is clear that the claimant has relinquished all right and control of the property.⁵²

A transfer has to relinquish all rights of ownership, including the right to income. Thus, income-only trusts will not work in this area.

Specific Eligibility – Compensation

In general, veterans (who meet the requirements above) are entitled to disability compensation if (1) they were discharged or released under conditions other than dishonorable, (2) their disease or

⁴⁶ M21-1MR, Part V, Subpart iii, Chapter 1, Section J, Topic 71 d and e

⁴⁷ M21-1MR, Part V, Subpart iii, Chapter 1, Section J, Topic 70f

⁴⁸ Id

⁴⁹ M21-1MR, Part V, Subpart iii, Chapter 1, Section J, 69b. See the Life Expectancy for Net Worth Determinations at 72, Exhibit 1

⁵⁰ M21-1MR, Part V, Subpart iii, Chapter 1, Section J, 69c

⁵¹ M21-1MR, Part V, Subpart I, Chapter 3, Section A, 1b

⁵² 38 C.F.R. Section 3.276(b)

injury was incurred or aggravated in the line of duty, and (3) the disability is not a result of their own willful misconduct or abuse of alcohol or drugs.

Veterans eligible for disability compensation receive monthly payments. The disability compensation rates increase in December of each year (assuming there is an increase in Social Security Benefits) with the first increased payments beginning in January. The rates of compensation payments are not automatically adjusted for inflation, and they can be increased only if Congress passes specific enabling legislation. The annual increase is equal to the consumer price index or the cost-of-living formula that determines the Social Security old-age increase.

Before any type of disability rating is assigned and any money paid, the VA must first determine whether the veteran's disability is service connected. The definition of "service connected" involves the term "In the line of duty."

For the VA to find a disability or death to be service connected, it must determine that the disability or death was incurred or aggravated during active service in the line of duty or that the death resulted from a disability that was incurred or aggravated in the line of duty during active military service. The phrase, "In the line of duty" means that an injury or disease was incurred or aggravated during a period of active service, unless caused by the veteran's own willful misconduct or abuse of alcohol or drugs.

Once service connection is established (often the most challenging part of a compensation claim), a disability rating is assigned. This disability rating determines how much the claimant will receive in monthly compensation payments. The disability ratings are to be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations. The rating schedule provides 10 grades of disability: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, and 100%. A 100% disability rating is also called a total rating because it means that a veteran is totally disabled. The higher the disability percentage assigned, the higher the monthly compensation payment the veteran will receive.

If a service-connected condition increases in severity, the veteran may apply for an increase in the evaluation of the service-connected condition.

All is not lost for a veteran whose injury is service connected but who receives a 0% rating. First of all, the toughest part of the application processed has been achieved – establishing service connection. If the veteran’s injury worsens, the veteran can submit additional medical evidence without having to start the claims process over. Also, the veteran may be entitled to certain benefits within the VA health care arena.

Willful misconduct as a bar

A determination by the VA that an injury or disease was the result of willful misconduct creates a bar to any benefits that may be based on that disability. Similarly, if a veterans death is the result of his or her willful misconduct, the death will not be considered service connected and that persons survivors will not be entitled to dependency and indemnity compensation (DIC) under 38 U.S.C. §1310 (discussed below).

There is a presumption that an injury or death suffered while an individual is on active military service is incurred in the line of duty and is not the result of willful misconduct. To overcome this presumption, the VA must establish by a preponderance of the evidence that the service member engaged in willful misconduct, and that misconduct proximately caused the service member’s injuries or death. Willful misconduct is an act involving conscious wrongdoing or known prohibited action with knowledge of or wanton and reckless disregard of its probable consequences.

There are circumstances where a veteran can receive more than the rate provided for a disability rated at 100% disabling. If a veteran has suffered certain severe disabilities, the veteran may be entitled to special monthly compensation (SMC), which can provide compensation payments at a rate much greater than the 100 percent rate. Severely disabled veterans in need of regular aid and attendance (interpreted as help with certain activities of daily living on a regular basis) or daily health-care services may be eligible for additional compensation.

As noted above, the VA pays a form of compensation to surviving spouses, children, and parents of deceased veterans whose deaths were caused by service-connected conditions dependency and indemnity compensation (DIC). DIC for surviving spouses is not based on the disability or income of the surviving spouse; however, income is a factor when the parents of a deceased veteran have basic eligibility for DIC.

Entitlement to VA compensation benefits is not affected by earned or unearned income. Today the value of the veteran’s estate is never a factor as to entitlement to VA compensation benefits.

On occasion, a veteran may be entitled to both compensation and pension. The VA cannot pay both benefits concurrently. The veteran can either elect which benefit to receive but in most cases the VA will notify the veteran of the dual entitlement and select the benefit paying the highest amount.

Conclusion

Effective representation of claimants before the VA requires a thorough understanding of the differences between compensation and pension. Both benefits are based on disability. Pension, however, is a needs-based program where a claimant must have low income and low assets. Compensation is not based on need or income, nor is it limited to wartime service. On the other hand, in addition to low income and assets, to be eligible for pension benefits, a veteran must have wartime service. Veterans aged sixty-five years and older are conclusively presumed to be permanently and totally disabled for pension purposes. Veterans applying for compensation benefits do not need to have total disability, low income, or wartime service; however, veterans seeking compensation benefits must connect their disability to the period of their military service.

CMCS Informational Bulletin

DATE: December 2, 2016

FROM: Vikki Wachino
Director
Center for Medicaid and CHIP Services

SUBJECT: 2017 SSI and Spousal Impoverishment Standards

This CMCS informational bulletin is to provide an update on the 2017 Supplemental Security Income (SSI) and Spousal Impoverishment Standards.

Certain Medicaid income and resource standards are adjusted beginning each January in accordance with changes in the SSI federal benefit rate (FBR) and the Consumer Price Index (CPI). Many states offer, for example, categorical eligibility to individuals who are not receiving SSI but who meet the financial eligibility requirements of the program, as authorized by 1902(a)(10)(A)(ii)(I) of the Social Security Act (“the Act”). Similarly, most states have adopted the “special income level” institutional eligibility category authorized under Section 1902(a)(10)(A)(ii)(V) of the Act, the maximum income standard for which is 300% of the SSI FBR. Additionally, certain eligibility standards relating to coverage of long-term services and supports, including the home equity limitation in Section 1917(f) of the Act and elements of the spousal impoverishment statute in Section 1924, are increased each year based on increases in the CPI for All Urban Consumers (CPI-U).

Included with this informational bulletin is the *2017 SSI and Spousal Impoverishment Standards* chart that displays the new standards. These standards are also available on Medicaid.gov at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Spousal-Impoverishment-Page.html>. Please update your standards in accordance with this information for the provisions that become effective on January 1, 2017.

If you have any questions or need additional information, please contact Gene Coffey at 410-786-2234 or Gene.Coffey@cms.hhs.gov.

2017 SSI and Spousal Impoverishment Standards

Supplemental Security Income (SSI)

Effective 1-1-17

	SSI Federal Benefit Benefit Rate (FBR)	SSI Resource Standard	Income Cap Limit (300%)	Earned Income Break Even Point	Unearned Income Break Even Point
Individual	735.00	2,000.00	2,205.00	1,555.00	755.00
Couple	1,103.00	3,000.00	N/A	2,291.00	1,123.00

Substantial Gainful Activity (SGA) Limit: 1,170.00 (Blind SGA: 1,950.00)

CPI Increase for 2017:

1.5%

CPI Increase, Since September 1988:

101.5%

Spousal Impoverishment

Effective 1-1-17 Unless Otherwise Noted

Minimum Monthly Maintenance Needs Allowance (MMMNA):
(Effective 7-1-16)

2,002.50
2,502.50
2,302.25

All States (Except Alaska and Hawaii)
Alaska
Hawaii

Maximum Monthly Maintenance Needs Allowance:

3,022.50

Community Spouse Monthly Housing Allowance:
(Effective 7-1-16)

600.75
750.75
690.68

All States (Except Alaska and Hawaii)
Alaska
Hawaii

Community Spouse Resources:

Minimum Resource Standard: 24,180.00
Maximum Resource Standard 120,900.00

Home Equity Limits:

Minimum: 560,000.00
Maximum: 840,000.00



COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY MEDICAL SERVICES PROGRAM (CMSP)

TO APPLY FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP, complete Items 1-13 on the attached application, and sign the Certification Section (Item 19). Give the form to the welfare office. If you have a disability and need help to apply for or keep getting cash aid, benefits, and services, tell the county.

BEFORE YOU CAN GET CASH AID, FOOD STAMPS, OR MEDI-CAL/34-COUNTY CMSP, INCLUDING IMMEDIATE NEED, HOMELESS ASSISTANCE, OR FOOD STAMP EXPEDITED SERVICE, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

FOR CASH AID AND FOOD STAMPS, the county will tell you if and when you need to be fingerprint and photo imaged in order to get benefits.

TO GET IMMEDIATE NEED AND/OR HOMELESS ASSISTANCE, you must appear to be eligible for Cash Aid. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your social security number(s), trying to get income available to you, and agreeing to cooperate with the local child support agency about child, spousal, and medical support.

FOR FOOD STAMPS, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household or another adult household member saying that you can apply for the household, pick up their food stamps, and/or use the food stamps to buy food for the household.

FOOD STAMPS — Date of Eligibility
If you are eligible for food stamps, we will figure your benefits from the date you apply. You can apply for food stamps the first day you contact the welfare office.

CASH AID IMMEDIATE NEED

If you have an emergency, you may be able to get up to \$200 while we work on your application. You will need to tell us about your emergency situation and you will need to show that you do not have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety.

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

CASH AID HOMELESS ASSISTANCE

If you are homeless, or have received a Pay Rent or Quit Notice, and want to apply for homeless assistance, tell the county. Homeless Assistance is available once in a lifetime, with exceptions.

CalWORKs DIVERSION SERVICES

Diversion services can help applicants who need some assistance but do not want or need to go on welfare. Diversion services allow you to choose to get a lump sum cash payment or non-cash services instead of going on aid. You can only choose to get Diversion services at time of application for cash aid, and you may be eligible for Medi-Cal, child care assistance, and food stamps if you get Diversion services.

After reviewing your facts, the county will tell you if you would be eligible for Diversion services. If eligible and you choose to get a Diversion cash payment or non-cash services instead of cash aid:

- You will get a denial notice for cash aid.
- Your cash aid may be lowered or the amount of time you can get cash aid may be reduced if you go on aid later.

APPLICANTS FOR FOOD STAMPS: All you have to do the day you apply is give us your name and address, tell us you want food stamps (Item 8) and sign the application (Item 19). Before we can tell if you are eligible, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. You should be told if you are eligible within 30 days after you apply.

FOOD STAMP EXPEDITED SERVICE

You may have the right to get food stamps within three days. Your household must be eligible for the Food Stamp Program AND HAVE:

- Rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions (**see the other side of the page for definitions of income and liquid resources**),
OR
- No more than \$100 liquid resources and less than \$150 income for the month before deductions,
OR
- No more than \$100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get food stamps within three days, **complete Items 1 - 17 on the attached application**; give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer PE. If you apply for CalWORKs or Medi-Cal by the end of the month after the month you get a PE card, your temporary Medi-Cal will continue until aid is approved or denied. If you are getting PE, tell the county and check "YES" in both parts of Item 12.

MEDI-CAL/34-COUNTY CMSP - MEDICAL EMERGENCY/PREGNANCY

If you have a medical emergency or are pregnant AND want Medi-Cal/34-County CMSP as soon as possible, complete Items 1-13. You must also give all the facts we ask for during your eligibility interview and meet all eligibility requirements.

WHAT WE MEAN WHEN WE SAY:

- **CalWORKs:** California Work Opportunity and Responsibility to Kids Program.
- **Cash Aid:** Aid from CalWORKs and/or Refugee Cash Assistance (RCA) programs.
- **Diversion Services:** A lump sum cash payment or non-cash services instead of going on cash aid.
- **Food Stamps:** Benefits for low income households to help buy food.
- **Food Stamp Expedited Service:** Getting food stamps within 3 days.
- **Medi-Cal:** Medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** Temporary Medi-Cal coverage from certain doctors or clinics for many out-patient prenatal care services.
- **34-County CMSP:** Medically necessary benefits for eligible adults who are not on Medi-Cal and who live in some rural counties.
- **Restricted Medi-Cal:** Medical Care for emergency and pregnancy only.
- **Restricted 34-County CMSP:** Emergency care only.
- **Authorized Representative:** A person picked by an applicant or recipient for food stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** A responsible member of the food stamp household.
- **Income:** Money received or expected, such as:
 - Earnings, welfare, child/spousal support, Supplemental Security Income/State Supplementary Program (SSI/SSP), or Cash Assistance Program for Immigrants (CAPI);
 - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
 - Strike funds; payments from roomers and boarders; school grants and loans;
 - Cash gifts, cash winnings, any other cash payments.
- **Liquid Resources:** Money other than income, such as:
 - Cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
 - Trust deeds, notes receivable, stocks or bonds, etc.
- **Utilities:** Gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** Any and all persons who live in your home.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid, food stamps and Medi-Cal at the same time and have one interview for all.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **OVERPAYMENTS/OVERISSUANCES:** means you got more cash aid or benefits than you should have gotten. You will have to pay it back even if the county made an error. Your cash aid or food stamps will be lowered or stopped. Your Medi-Cal/34-County CMSP share of cost may be changed.

- **FRAUD AND PERJURY:** Fraud and perjury are crimes. The law says you must sign a penalty of perjury statement on most forms to get and to keep getting cash aid, food stamps, and Medi-Cal/34-County CMSP. Perjury means that you lied when you swore under oath to give true, correct, and complete facts. If you lie about facts or **on purpose** do not give us all the facts or situations that affect your eligibility and aid payment levels, you can be charged with fraud.

- **If you are found guilty of committing fraud, you may be fined up to \$10,000 for cash aid and \$250,000 for food stamps and/or sent to jail/prison for 3 years for cash aid and 20 years for food stamps. Cash aid and/or food stamps can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years, 20 years or forever; and for Refugee Cash Assistance, 3 months and 6 months.**

- **SOCIAL SECURITY NUMBER (SSN) RULES:** We computer match SSNs against records from tax, welfare, employment, the Social Security Administration, and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you are not getting aid in more than one case, or in another county or state; and for cash aid and food stamps, with law enforcement agencies for outstanding arrest warrants.

Cash aid and food stamps: You must give us the SSN for each applicant/recipient for cash aid and/or food stamps. If you refuse to give us either the SSN or proof of application for the SSN, you will not be able to get cash aid or food stamps. For cash aid, you must give us your SSN(s) or proof of application for the SSN within 30 days of application and give the SSN to the county when you get it.

Medi-Cal/34-County CMSP: Each applicant for Medi-Cal/34-County CMSP who has a SSN is asked to give it to the county. Any U.S. citizen, U.S. national, amnesty alien with a valid and current I-688, noncitizen with lawful permanent residence in the U.S. (LPR), or noncitizen permanently residing in the U.S. under color of law (PRUCOL) who refuses to give an SSN or proof of application for an SSN, will not be able to get Medi-Cal/34-County CMSP and who is not an amnesty alien with a valid and current I-688 or an LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

COMPLAINTS

If you think you have been **discriminated against**, contact your county's civil rights representative or write to:
State Civil Rights Bureau
P.O. Box 944243
Sacramento, CA 94244-2430
or call collect (916) 654-2107
or for the hearing or speech impaired
TDD 1 - (916) 654-2098

For other kinds of complaints, contact your county first. If you and the county cannot agree, write or call to:
Public Inquiry and Response (PIAR)
744 P Street, M.S. 6-23
Sacramento, CA 95814
Phone 1 - (800) 952-5253
or for the hearing or speech impaired
TDD 1 - (800) 952-8349

STATE HEARINGS

You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing. You can ask for a State Hearing by writing to your local county appeals office or by calling one of the phone numbers listed for PIAR above, if you:

- Do not agree with any action taken by the county, or
- Are asking for a state hearing for cash aid, food stamps, Medi-Cal.

To appeal all 34-County CMSP eligibility issues, you can **only write** to your county.

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)		2. SOCIAL SECURITY NUMBER (SSN)		COUNTY USE ONLY	
3. MAIDEN OR OTHER NAME (IF ANY)		2A. DATE OF BIRTH (MM-DD-YYYY)			
4. HOME ADDRESS: NUMBER STREET		5. MAILING ADDRESS (IF DIFFERENT)		CASE NUMBER	
CITY STATE ZIP CODE		CITY STATE ZIP CODE		DATE RECEIVED	
6. TELEPHONE NUMBER(S): HOME WORK MESSAGE				TYPE OF APPLICATION:	
7. Is your home address permanent? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO HOME				CA: <input type="checkbox"/> CA <input type="checkbox"/> RCA	
If not permanent, please explain:				FS: <input type="checkbox"/> Initial <input type="checkbox"/> Recert <input type="checkbox"/> Rest	
8. Is anyone applying for: Cash Aid <input type="checkbox"/> YES <input type="checkbox"/> NO Food Stamps <input type="checkbox"/> YES <input type="checkbox"/> NO				MC: <input type="checkbox"/> CMSP: <input type="checkbox"/>	
Medi-Cal <input type="checkbox"/> YES <input type="checkbox"/> NO 34-County CMSP <input type="checkbox"/> YES <input type="checkbox"/> NO				Homeless:	
Any Other Program(s) <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain:				FS: <input type="checkbox"/> YES <input type="checkbox"/> NO	
9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/34-County CMSP/Medicaid or Diversion cash or non-cash services? If "YES", list:				CA: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CW 42	
				Pickle Screening <input type="checkbox"/>	
				Ethnic Group:	
				Race:	
				Primary Language:	
10. The law says we must record your ethnic group, race and language. This won't affect your eligibility.				CA I.N.	
A. ETHNICITY (Everyone must also answer B)				<input type="checkbox"/> Denied/NOA prep	
Are you Hispanic or Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> Approved	
B. RACE/ETHNIC ORIGIN - Check all boxes that apply to you. If you do not complete this question the county will do it for you.				<input type="checkbox"/> Expedited Grant	
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White				<input type="checkbox"/> Applicant requested CWD to complete SAWS 1	
<input type="checkbox"/> Asian (If checked, please select one or more of the following)				(Initials)	
<input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian				FS E.S.	
<input type="checkbox"/> Cambodian <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian (specify) _____				<input type="checkbox"/> E.S. questions not completed	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following)				<input type="checkbox"/> Screened for E.S.	
<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other (specify) _____				Date _____	
C. PRIMARY LANGUAGE:				(Initials)	
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Lao <input type="checkbox"/> Tagalog <input type="checkbox"/> American Sign <input type="checkbox"/> Cantonese <input type="checkbox"/> Cambodian				FS Referral for:	
<input type="checkbox"/> Vietnamese <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify) _____				<input type="checkbox"/> E.S. Processing	
				<input type="checkbox"/> Regular Processing	
11. Is anyone a migrant or seasonal farmworker? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> CWD records cleared	
12. Is anyone pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", did she get a Presumptive Eligibility card? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> MEDS CDB cleared	
13. Does anyone have a personal emergency? If "YES", check (✓) type: <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> IEVS initiated	
<input type="checkbox"/> Immediate Medical Need <input type="checkbox"/> Pregnancy <input type="checkbox"/> Child Abuse <input type="checkbox"/> Domestic Abuse				<input type="checkbox"/> Copy of SAWS 1 and coversheet given to applicant	
<input type="checkbox"/> Elder Abuse <input type="checkbox"/> Other emergency which threatens health or safety. Explain:				TRANSITIONING CASE NUMBER	
IF YOU NEED: CASH AID IMMEDIATE NEED PAYMENTFILL IN ITEMS 14 - 18.				COUNTY OF APPLICATION	
FOOD STAMP EXPEDITED SERVICEFILL IN ITEMS 14 - 17.				COUNTY OF RESIDENCE (IF DIFFERENT)	
14. How much liquid resources does everyone, including children, have?		17. How much are your utilities that are not included in your rent this month? \$			
<input type="checkbox"/> Cash, uncashed checks or money orders \$ _____					
<input type="checkbox"/> Checking/savings or credit union account(s) \$ _____		18. Do you have an eviction notice or notice to pay or quit?		YES NO	
<input type="checkbox"/> Trust deeds, notes receivable, stocks or bonds \$ _____		Have your utilities been shut off or do you have a shut-off notice?			
<input type="checkbox"/> Other (explain) \$ _____		Will your food run out in 3 days or less?			
15. How much income did everyone, including children, get or will they get this month?		Do you need essential clothing, such as diapers or clothing needed for cold weather?			
Date Amount Date Amount		Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?			
_____ \$ _____ _____ \$ _____					
_____ \$ _____ _____ \$ _____					
16. How much is your rent or mortgage this month?					
\$ _____					
<ul style="list-style-type: none"> I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified. I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service. I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete. 					
19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE		DATE SIGNED			
SIGNATURE OF WITNESS TO MARK OR INTERPRETER		DATE SIGNED			

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

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)		OTHER NAMES (MAIDEN, NICKNAMES, ETC.)		SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS)	
HOME ADDRESS OR DIRECTIONS TO YOUR HOME	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE

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

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

HOME PHONE	WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS
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What programs are you applying for?
 CalFresh Cash Aid Health Coverage

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

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

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

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

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

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

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

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

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

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

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

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

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

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

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

AUTHORIZED REPRESENTATIVE NAME _____ AUTHORIZED REPRESENTATIVE PHONE NUMBER _____

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

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

NAME _____ PHONE NUMBER _____
ADDRESS _____ CITY, _____ STATE, _____ ZIP CODE _____

2a. HEALTH INSURANCE AUTHORIZED REPRESENTATIVES

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

3. Are you or any member of your family American Indian or Alaskan Native? Yes No

If yes, and applying for health care, please go to Appendix B for additional questions.

RACE/ETHNICITY

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

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

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

RACE/ETHNIC ORIGIN

- White American Indian or Alaskan Native Black or African American Other or Mixed _____
- Asian (If checked, please select one or more of the following):
 - Filipino Chinese Japanese Cambodian Korean Vietnamese Asian Indian Laotian
 - Other Asian (specify) _____
 - Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): Native Hawaiian
 - Guamanian or Chamorro Samoan

4. INTERVIEW PREFERENCE

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

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

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

5. OTHER PROGRAMS

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

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

6. HOUSEHOLD'S INFORMATION: ADULTS

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

APPLYING FOR BENEFITS (check each type)	NAME (Last, First, Middle Initial)	How is the person related to you?	DATE OF BIRTH	GENDER (M OR F)	Marital Status				Full-Time Student (check if yes)	Disabled (check if yes)	U.S. CITIZEN or NATIONAL (check Yes or No) If no, complete question 6e.	SOCIAL SECURITY NUMBER
					Single	Married	Separated	Divorced				
CalFresh												
Cash Aid												
Medi-Cal Health Care												
None												

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

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

6b. HOUSEHOLD'S INFORMATION: CHILDREN

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

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

6c. SOCIAL SECURITY INFORMATION

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

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



6d. Has anyone been in the U.S. Military service or are they the spouse, parent or child of a person who was? Yes No
 If **yes**, please complete the information below. If **no**, please continue to the next question.

Name	U.S. Citizen?	(✓) Status	Honorable Discharge?	Dates of Service
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active duty <input type="checkbox"/> Veteran <input type="checkbox"/> Spouse, parent, or child of person in active duty or a veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active duty <input type="checkbox"/> Veteran <input type="checkbox"/> Spouse, parent, or child of person in active duty or a veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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

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

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

If **yes**, who? _____

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

If **yes**, who? _____

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

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

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

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



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

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

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

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

rent clothes food other _____

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



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

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



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



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



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



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

Name: _____ Name: _____



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



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



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

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



6l. Is everyone between ages 6 and 18 listed in question 6b attending school regularly? Yes No

If **yes**, please list the child's name and the name and address of the school they attend.

If **no**, please explain why the child is not attending school regularly.

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

6m. Students

Is anyone who is applying for benefits attending a college or vocational school? Yes No

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

Name of Person	Name of School/Training	Enrolled Status (✓ check one)	Working?
		<input type="checkbox"/> Half-time or more <input type="checkbox"/> Less than half-time Number of Units: _____	Average work hours per week: _____
		<input type="checkbox"/> Half-time or more <input type="checkbox"/> Less than half-time Number of Units: _____	Average work hours per week: _____

6n. Is anyone listed in question 6 or 6b pregnant or a teen parent? Yes No

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

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

6o. Has anyone ever gotten a cash bonus or penalty, or help with child care, transportation or other service from the Cal-Learn Program? Yes No

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

Name	Where (County)	Date(s) Received

6p. Was anyone listed in question 6 ever in foster care? Yes No

If **yes**, please explain.

Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	When:	State:	Is this person 26 years of age or younger and were they in foster care on their 18th birthday? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

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

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

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

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

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

If **no**, please explain.

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

If **yes**, please explain.

NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN:
NAME	WHEN DO THEY PLAN TO LEAVE?	DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN:

7. Unearned Income

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

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

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

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

Person Getting the Money?	From Where?	How Much?	How Often Received? (once, weekly, monthly, or other)	Expect to Continue? (Check Yes or No)
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

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

8. Earned income

Does anyone get income from a job (earned income)? Yes No If **yes**, please answer this question. If **no**, skip to the next question.

NOTE: If self-employed, fill out question 8a below.

Please list all income **before** taxes or other deductions are taken out (gross income).

Examples of earned income are (these examples can be full-time, temporary seasonal work, or training, and there may be others not listed here):

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

Person Working	Employer's Name and Address	Employer's Phone Number	Hourly Rate	Average hours per week	How Often Paid? (Once weekly, monthly, other)	Total Gross Earned Income Received This Month?	Expect to Continue? (✓ Check Yes or No)
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? Yes No

In the last year? Yes No

Did the County help the person get this job? Yes No

IF YES, WHO?	DATE OF JOB LOSS, QUIT, OR CHANGE	DATE OF LAST PAY	REASON?
IS ANYONE ON STRIKE? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, WHO?	DATE WENT ON STRIKE	DATE OF LAST PAY
			REASON?

8a. Self-Employment

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

Person Self-Employed	Business Name	Type of Business	Date Business Started	Gross Monthly Income	Self-Employment Expenses (please ✓ check one)	Net Monthly Income
				\$	<input type="checkbox"/> 40% flat Rate (CalFresh/cash aid) <input type="checkbox"/> Actual Expenses \$ _____ <input type="checkbox"/> Monthly Average \$ _____	\$
				\$	<input type="checkbox"/> 40% flat Rate (CalFresh/cash aid) <input type="checkbox"/> Actual Expenses \$ _____ <input type="checkbox"/> Monthly Average \$ _____	\$
				\$	<input type="checkbox"/> 40% flat Rate (CalFresh/cash aid) <input type="checkbox"/> Actual Expenses \$ _____ <input type="checkbox"/> Monthly Average \$ _____	\$

* Net monthly income is gross monthly income minus expenses.

 **9. Other Income**

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

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

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

Item Received	Free	For Work	Who gets the item?	Value	Who gives the item?
Housing or Rent	<input type="checkbox"/>	<input type="checkbox"/>		\$	
Utilities	<input type="checkbox"/>	<input type="checkbox"/>		\$	
Food	<input type="checkbox"/>	<input type="checkbox"/>		\$	
Clothing	<input type="checkbox"/>	<input type="checkbox"/>		\$	


 **10. Yearly Income**

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

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

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

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

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

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

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

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

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

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

 **12. Child Support Payments**

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

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

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

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

**13. Spousal Support/Alimony**

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

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

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

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

**14. Special Needs Expenses**

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



Special diet prescribed by a doctor? Yes No Other special need? (specify) Yes 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? Yes No

**15. Household Expenses**

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

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

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

NOTE: Do not enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances. It is not necessary to fill in the actual amount owed.

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

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

**16. Medical Expenses:**

Are you or anyone you buy and prepare food with an elderly (60 or older) or disabled person that has any out-of-pocket medical expenses? Yes No
 If **yes**, please answer this question.
 If **no**, skip to the next question.

NOTE: Do not list spouses or children receiving dependent payments for an SSI or disability and blindness recipient. List expenses you expect to have in the near future.

Allowable medical expenses are:

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

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

**17. Other Tax-Deductible Expenses**

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

Type of Expenses	Have Expense?	Who pays?	How often paid? (weekly/monthly)
Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Student loan interest	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other deductions (please identify)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**18. Does anyone in question 6 get food from any of the following?** Yes No

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

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

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

**19. Does anyone in question 6 live at any of the following?** Yes No

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



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

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

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

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

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

NAME	NAME
NAME	NAME

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24. Household's Resources
 Does anyone have any resources (cash, money in the bank, Certificate of Deposit, stocks and bonds, etc.)? Yes No If **yes**, please answer this question. If **no**, skip to the next question.
 Optional for health care; only answer if someone applying is 65 or older or disabled. If applying for cash aid and CalFresh, you must answer the question.

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

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

If joint account with another person please say so below.

For each box checked above, complete the following information.

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

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

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

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


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

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

- | | |
|---|--|
| <input type="checkbox"/> Tools | <input type="checkbox"/> Sporting equipment, Guns |
| <input type="checkbox"/> Business inventory | <input type="checkbox"/> Non-Motor boats and/or trailers |
| <input type="checkbox"/> Livestock | <input type="checkbox"/> Camper shells |
| <input type="checkbox"/> Business equipment | <input type="checkbox"/> Personal tools |
| | <input type="checkbox"/> Jewelry, Artwork, Antiques, Collections, Musical instruments (Piano, Organ, etc.) |

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


Item	Is it listed for Sale?	Purchase Price or Current Value	Amount Owed
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$


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

 **26. Vehicles**

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

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

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

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


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

 **28. Diversion Program**


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

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


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

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


If **yes**, who? _____

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


If **yes**, who? _____

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

If **yes**, who? _____


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

If **yes**, who? _____

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


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

Where? _____


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

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


Where? _____ Why? _____

 **35. Fleeing Felon**
Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? Yes No

If **yes**, who? _____

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

If **yes**, who? _____

 **37. Drug Felony**
Have you or any member of your household, been convicted of felony possession, use, manufacturing, or distribution of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required) after August 22, 1996? Yes No

If **yes**, and the felony conviction was for possession, have you or that household member done (or will do) any of the following (CalFresh only):

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


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


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

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

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

If **yes**, please explain: _____

-
-  **38. Other Special Needs**
Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and/or unusual circumstances, such as a fire, earthquake, or flood? Yes No
If **yes**, please explain:

-
-  **39. Other Services**
The following services are available. Your answers to the questions will not affect your eligibility.



-
- A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.
- Do you want more information about CHDP services? Yes No
 - Do you want CHDP medical services? Yes No
 - Do you want CHDP dental services? Yes No
 - Do you need help making appointments or with transportation to CHDP services? Yes No
-
- B. Do you want more information about immunization services? Yes No
-
- C. If you are pregnant, you can get help finding a doctor, getting healthy foods and other help. Do you want to talk to someone about this help? Yes No
-
- D. Are you breastfeeding a child? Yes No
If **yes**, have you given birth within the last 12 months? Yes No
If you checked yes to 39 C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).
-
- E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unwanted pregnancies and/or have the next child? Yes No
If **yes**, call your health care plan or regular doctor. Or, for facts and the location of confidential family-planning clinics, call toll-free 1-800-942-1054.
-

Additional Writing Space

Additional Writing Space

DO NOT COMPLETE - COUNTY USE ONLY

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

Is the household's gross income less than \$150 and is the total of cash on hand, checking and savings accounts \$100 or less?

Yes No

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

Yes No

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

Yes No

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

Yes No



HEALTH COVERAGE FROM JOBS

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

First, tell us about the job (employer) who offers coverage.

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

EMPLOYER Information

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

10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB? 11. PHONE NUMBER (IF DIFFERENT FROM EMPLOYER'S PHONE NUMBER) 12. EMPLOYER'S EMAIL ADDRESS (EMPLOYER'S REPRESENTATIVE)

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

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

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

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

Name: Name: Name:

Tell us about the health plan offered by this employer.

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

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

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

- a. How much would the employee have to pay in premiums for this plan? \$ b. How often? Weekly Bi-weekly Twice a month Monthly Quarterly Yearly The employee doesn't offer wellness programs.

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

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

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

 **Appendix B QUESTIONS FOR AMERICAN INDIAN AND ALASKAN NATIVE INDIVIDUALS**

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

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

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

	AI/AN Person 1	AI/AN Person 2								
1. Name (First name, Middle name, Last name)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">First</td> <td style="width: 50%; text-align: center;">Middle</td> </tr> <tr> <td colspan="2" style="text-align: center;">Last</td> </tr> </table>	First	Middle	Last		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">First</td> <td style="width: 50%; text-align: center;">Middle</td> </tr> <tr> <td colspan="2" style="text-align: center;">Last</td> </tr> </table>	First	Middle	Last	
First	Middle									
Last										
First	Middle									
Last										
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes , tribe name _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes , tribe name _____ <input type="checkbox"/> No								
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> no	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , is this person eligible to get services from the Indian Health Services, tribal health program, urban Indian health programs or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> no								
4. Certain money may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> • Per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations) • Money from selling things that have cultural significance 	<input type="checkbox"/> Yes - if yes, please complete information below: <input type="checkbox"/> None to report \$ _____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____	<input type="checkbox"/> Yes - if yes, please complete information below: <input type="checkbox"/> None to report \$ _____ How often? (daily, weekly, bi-weekly, monthly, yearly, etc.) _____								



ASSISTANCE WITH COMPLETING THIS APPLICATION

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

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or Suite number
4. City	5. State	6. Zip code
7. Phone number ()		
8. Organization name (if applicable)		9. I.D. Number (if applicable)

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

10. Your signature	11. Date
--------------------	----------

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

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

1. Application start date (mm/dd/yyyy)
2. First name, Middle name, Last name, & Suffix
3. Organization name
4. I.D. number (if applicable)