

Sample Form #1

DFA 285 A1 –
Food Stamp Application

Application for Food Stamp Benefits

Applicant Information

✓ 1. Please fill out the following personal information for the person requesting food stamp benefits.

Name (Last, First, Middle)	Mickey Mouse
Telephone Number (include area code)	(999) 111-2345
Home Address (Street, P.O. Box, Apt. #)	1234 Disney Street
City, State, Zip Code	Disneyland, CA 95555
Mailing address (if different from above)	SAME
City, State, Zip Code	

2. The food stamp office can provide an interpreter at no cost to you. Would you like an interpreter at your interview? Yes No If "Yes," what language? _____

3. To help us improve our services to you, please complete A, B, and C below. Check all that apply to you. The law says we must record your ethnic group, race, and language. If you do not complete these items, the county will do it for you. This will not affect your eligibility.

- A. ETHNICITY (Everyone must also answer B)
 Are you Hispanic or Latino? Yes No
- B. RACE/ETHNIC ORIGIN - Check all boxes that apply to you. If you do not complete these items, the county will do it for you. This will not affect your eligibility.
- American Indian or Alaskan Native
 - Black or African American
 - 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 Samoan Other (specify) _____
 - White
- C. PRIMARY LANGUAGE:
- English Spanish Lao Tagalog American Sign
 - Cantonese Cambodian Vietnamese Russian Other (specify) _____

✓ 4. Someone in the household is: (check more than one if applicable)

- Disabled Homeless
- Elderly (60 & older) Migrant/ Seasonal Farmworker -
- Without money for food Has your only income stopped? Yes No

5. Do you have a physical or mental condition that requires special help during your interview with a food stamp worker? Yes No

✓ 6. How much is your rent or mortgage this month? \$ 200.00

✓ 7. How much are your utilities this month, if separate from your rent or mortgage? \$ 50.00

I have been informed about getting emergency food stamp benefits within three (3) days.

Signature: Mickey Mouse Date: 5-6-13

County Use Only:

Case Name _____ Case # _____

Application Type: New Recert Date received by County _____

Screened for Expedited Service (ES)? Yes No ES Eligible Yes No

Application for Food Stamp Benefits

Household Information

8. Complete the following information for all persons in the home, including yourself. The County will use this information to determine eligibility only.

Name (Last, First, Middle)	Social Security Number (If none, write none)	Relationship (i.e. son, wife, friend, foster child, etc.)	Circle one	Date of Birth	Do you buy and prepare food with this person? (Circle one)
1. Donald Duck	111-11-1111	stepson	Male/Female	3-4-	Yes / No
2.			Male/Female		Yes / No
3.			Male/Female		Yes / No
4.			Male/Female		Yes / No
5.			Male/Female		Yes / No
6.			Male/Female		Yes / No
7.			Male/Female		Yes / No
8.			Male/Female		Yes / No
9.			Male/Female		Yes / No
10.			Male/Female		Yes / No

Income and Employment

✓ 9. Do you have or will you receive any income this month? Yes No
List all your household income below:

Name of person who gets money	How much each month?
	\$
	\$
	\$
	\$

Resources

✓ 10. How much money do you have? This includes money in bank accounts, in your home, or any other place. \$

County Use Only:

Application for Food Stamp Benefits

Important Information

- The U.S. Department of Agriculture (USDA) prohibits discrimination in all of its programs and activities on the basis of race, color, sex, religion, national origin, or political beliefs. You may file a complaint if you think you have been discriminated against. If you disagree with the decision of the county, an appeal process is available to you.
- The information on this application may be shared with federal, state and local agencies only for the purposes of verifying eligibility for the Food Stamp Program. This process may include confirmation with the U.S. Citizenship and Immigration Services (USCIS) (formerly INS) of the immigration status only of those persons seeking food stamp benefits. Federal law says the USCIS cannot use the information for anything else except cases of fraud.

Signature

I certify under penalty of perjury under the laws of the United States of America and the State of California that the information I have provided on this application is true, correct and complete.

Mickey House

Signature (Adult Household Member or Authorized Representative)

Date

5-6-13

Signature of Witness or Interpreter

Date

Signature of Eligibility Worker

Date

Sample Form #2

MC 210 RV –
Medi-Cal Annual Redetermination Form

MEDI-CAL ANNUAL REDETERMINATION FORM

You must fill out this form and return it to the county to keep your Medi-Cal!

Case Number <i>(optional)</i> 123456		Social Security Number <i>(optional)</i> 551-23-4567	
Print Your Full Name <i>(if you have not moved, put address label here if one is provided)</i> JANE DOE		Birth Date <i>(optional)</i> (mm/dd/yyyy) 1-2-34	
Current Street Address, Apartment Number <input type="checkbox"/> <i>(check here if address is new)</i> 8889 E. Nowhere		City/State LAND, CA	Zip Code 93000
Mailing Address <i>(if different from above)</i>		City/State	Zip Code

Use ink and **PRINT** your answers. Make sure you sign and date the form. Use the postage paid envelope to return it. If you need more space, attach a separate sheet to this form. If you have any questions or need help filling out this form, call your worker at the telephone number listed on the Annual Redetermination Notice.

Section 1. Income

(a) Do you or any family member in the home get money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts, or interest or dividends?

Yes No

If yes, complete below and list each source of income on a separate line.

Attach most recent pay stubs showing income before taxes or deductions, benefit or award letters, checks received or signed statement from employer, or last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person with Income <i>(include first and last name)</i>	Source of Income	Income Amount <i>(before any deductions)</i>	How Often Paid <i>(weekly, monthly, twice a month)</i>	Hours Worked <i>(per week or month)</i>
JACK DOE	WAGE Earnings	\$7.25 hr	Weekly	10 HRS wtkly.

(b) Do you or any family member in the home get rent, utilities, food, or clothing entirely free?

Yes No

If yes, who? _____

What was free? _____

(c) Was the free rent, utilities, food, or clothing received in exchange for work done?

Yes No

Section 2. Expenses and Deductions

Do you or any family member in the home pay for child or adult care, health insurance or Medicare premiums, court-ordered child support or alimony, or educational expenses?

Yes No

If yes, complete below and list each expense/deduction on a separate line.

Attach proof of expenses/deductions.

Name of Person with Expense/Deduction <i>(include first and last name)</i>	Type of Expense or Deduction	Amount of Payment	Paid to Whom	How Often Paid <i>(weekly, monthly, twice a month)</i>

Section 3. Other Health Insurance

(a) Did you or any family member have a change in, or get new health, dental, vision, or Medicare coverage or insurance within the last 12 months?

Yes No

If yes, who has the coverage/insurance? Donald Dink Jack Doe

Which type of coverage/insurance? _____

(b) Is any family member living in the home receiving kidney dialysis-related services?

Yes No

If yes, who? _____

(c) Has any family member living in the home received an organ transplant within the last 2 years?

Yes No

If yes, who? _____

Section 4. Living Situation

(a) Did anyone move into or out of your home, move in with someone else, get married, or have a baby within the last 12 months? *(Examples: newborn, child, or adult moved in or out of the home, absent parent returns home.)*

Yes No

If yes, complete below:

Name <i>(include first and last name)</i>	Relationship to You	What Changed?	Date Changed

(b) Does anyone in the home want Medi-Cal who is not already receiving it?

Yes No

If yes, who? _____

(c) If a new baby is in home, where was the baby's place of birth? _____ | _____ | _____
City State Country

Section 4. Living Situation *continued*

(d) Did anyone in the home get inpatient care in a nursing facility or medical institution?

Yes No

If yes, who? _____

(e) Is anyone in the home pregnant?

Yes No

If yes, who? _____

Number of babies expected _____ Due date: _____

Section 5. Real or Personal Property

(a) Indicate the total amount of cash and uncashed checks held by any family member in the home \$ 0

(b) Does anyone have a checking or savings account, life insurance, long-term care insurance, motor vehicle, court-ordered settlement or judgement, stocks, bonds, retirement funds, trusts where money or property is held for the benefit of any family member in the home, real estate, motor vehicles for a business, business accounts or property, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), or oil or mineral rights?

Yes No

(c) Did you or any family member in the home sell or give away any money or property in the past 12 months, or have any of the items listed in this section been spent or used as security for medical costs?

Yes No

Note: If you have answered "yes" to questions (b) or (c), you will also have to fill out a property supplement form, submit the form to the county and provide verification.

Section 6. Immigration or Citizenship Status Change

Has there been a change in immigration or citizenship status for anyone in the home that has Medi-Cal or wants Medi-Cal within the last 12 months? *(If your immigration status has changed, you might qualify for full scope Medi-Cal benefits.)*

Yes No

If yes, list the name(s) below and send proof of new status.

Name of Person <i>(include first and last name)</i>	Status Change <i>(send proof of status)</i>

Section 7. Blindness/Disability/Incapacity

(a) Do you or any family member in the home have a physical or emotional condition that makes it difficult to work, take care of personal needs, or take care of your children?

Yes No

If yes, who? _____

(b) Was the physical, mental, or health condition a result of an injury or accident?

Yes No

If yes, explain _____

Section 8. Other Health Program Information and Referrals

- (a) Check this box if you do **not** want your child's information shared with the low-cost Healthy Families Program if your child gets Medi-Cal with a share of cost.
- (b) Do you want information on the no-cost health program for children under 21 (*Child Health and Disability Prevention Program, also known as CHDP?*) Yes No
- (c) Do you want information on the no-cost supplemental food program for pregnant or breast feeding women and children under 5 (*Women, Infants, and Children Program, also known as WIC?*) Yes No
- (d) Do you want information on the Personal Care Services Program, an in-home care program for aged, blind, or disabled persons (also known as In-Home Supportive Services)? Yes No

Section 9. Signature and Certification

Person completing this form must read and sign below.

- I have received and read a copy of the *Important Information for Persons Requesting Medi-Cal* form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219 form.
- I certify that I will report all income, property, and/or other changes that may affect Medi-Cal eligibility within ten days of the change.
- I understand that all of the statements, including benefit and income information, that I have made on this form, may be subject to investigation and verification.
- I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature <i>Jane Doe</i> <i>Mickey Mouse</i>	Date 5-6-13
Daytime or Message Telephone Number 555 551-52-53	Home Telephone Number <input type="checkbox"/> (check here if new number)

Signature of Witness (if signed by a mark), Interpreter or Person Assisting

— County Use Only —

Referrals

- HF
- CHDP

- WIC
- PCSP

Follow-up Forms

- MC 13
- MC 210 PS
- DDSD Packet

Other:

Sample Form #3

QR 7 –
Eligibility/Status Report

ELIGIBILITY/STATUS REPORTPLEASE SIGN THE FORM AFTER 05/2013 1ST AND RETURN IT BY THE 5TH OF THE MONTH.
SUBMIT MONTHKatie Mouse
445 Mouse House Ave
Disneyland, CA 93702**NEED HELP? CALL YOUR WORKER.**Worker Name: Peter Smith
Worker Phone: 559-600-1377

BAR CODE:

Please Stop My Benefits For: Cash Aid Food Stamps Medi-Cal at the end of this month. Sign and date the last page. Return the form to your worker. You can reapply at any time.**PART 1: Please tell us what happened in** 04 2013
REPORT MONTH YEAR1. Did you or anyone get any income or money from any source this MONTH? If "YES", list below and YES NO
ATTACH PROOF.**Earnings:** Babysitting, interest or dividends, rental income, salary, self-employment, sick pay, tips, vacation pay, etc. **Any Government Benefits:** State Disability Indemnity (SDI), Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), other government disability or retirement, rental assistance, unemployment, veteran's retirement, Worker's Compensation (UIB), etc. **Other Benefits:** Child/spousal support, insurance or legal settlements, other private disability or retirement, railroad retirement, strike benefits, etc. **Other:** Cash, gifts, loans, scholarships, etc. **Income In-Kind:** Such as earned housing, free housing/utilities/clothing/food, etc.

Who got the income? Self	From? Rental	Gross amount	\$ 1,000.00	\$	\$	\$	\$
		Date received	4/5/13				
Who got the income?	From?	Gross amount	\$	\$	\$	\$	\$
		Date received					
Who got the income?	From?	Gross amount	\$	\$	\$	\$	\$
		Date received					

1a. Number of hours worked or in training in this MONTH:

Who worked?	Where?	Total Hours	Who worked?	Where?	Total Hours
Who trained?	Where?	Total Hours	Who trained?	Where?	Total Hours

1b. If the income or money reported above will change in the next three months after the SUBMIT MONTH, please explain and ATTACH PROOF.

Name of person	Source of income or money	Why will it change?	How much will you get?		
			First Month	Second Month	Third Month
			\$	\$	\$
			\$	\$	\$

Questions 2, 3, 4, and 5 may help you get more Food Stamps2. Medical Costs: Did anyone who gets Food Stamps and is disabled or 60 years or older pay medical costs? YES NO
If "YES", list the amount paid below and ATTACH PROOF of payment.

Who paid?	Who gets care?	Amount
		\$

3. Dependent Care: Did anyone who gets Food Stamps pay for the care of a child, disabled person, or other dependent while working, seeking work, or attending school or training? YES NO
If "YES", list the amount paid below and ATTACH PROOF of payment.

Who paid?	Who gets care?	Amount
		\$

COUNTY USE SECTION

4. Child Support: Did anyone who gets Food Stamps pay court-ordered child support? YES NO
 If "YES", list the amount paid below and ATTACH PROOF of payment.

Who paid?	Amount \$	Who paid?	Amount \$

5. If the information in Question 2, 3, or 4 will change in the next three months after the SUBMIT MONTH, check the box(es) below, please explain and ATTACH PROOF.

Medical Costs	Who pays?	Amount \$	Who gets care?	What changed?	When will it change?
<input type="checkbox"/>					
Dependent Care	Who pays?	Amount \$	Who gets care?	What changed?	When will it change?
<input type="checkbox"/>					
Court-Ordered Child Support	Who pays?	Amount \$	For whom?	Attach new court order	When will it change?
<input type="checkbox"/>					

PART 2: What Has Happened SINCE Your Last Report?

6. Did anyone get, buy, sell, trade, or give away any property [land, home, cars, bank accounts, money payments (such as: lottery or casino winnings, retroactive social security, tax refunds), other]? If "YES", list all items below and ATTACH PROOF. YES NO

Who owns, sold, traded, or gave away?	Type of Property	When?	Value \$	<input type="checkbox"/> Bought	<input type="checkbox"/> Sold	<input type="checkbox"/> Won	<input type="checkbox"/> Gift Received	<input type="checkbox"/> Traded	<input type="checkbox"/> Gave Away

Checking Account Opened Closed Balance \$ Savings Account Opened Closed Balance \$

7. Has anyone moved into or out of your home, or did you move in with someone else? YES NO
 If "YES", complete below.

Full name of person	Relationship to you	Moved in or out?	When?

8. Has anyone in your family been convicted of a drug related felony for possession, use, or distribution; avoiding or running from any felony prosecution, custody, or confinement; or in violation of probation or parole? YES NO
 If "YES", name: _____ Where convicted? _____ Date of conviction: _____

9. Have any of the following or any other changes happened to anyone in your home? YES NO
 If "YES", check the box(es) below and ATTACH PROOF.

- Family Change** (Married, divorced, separated, registered a California Domestic Partnership (DP), have a non-California DP, ended a DP, became pregnant, had a baby, or no longer pregnant?)
- Disability** (Became disabled or recovered from a disability or major illness?)
- Work** (Started or stopped working, refused a job or training, number of hours worked or in training went up or down, or went out on strike?)
- Immigration** (Citizenship or immigration status change, or got a new card, form, or letter from USCIS (INS)?)
- Insurance** (Started, stopped, or changed health, dental, or life insurance benefits, including MEDICARE?)
- Custody** (Any change in the amount of time you care for/have custody of your children?)
- In-Home Supportive Services** (Started or stopped getting services?)
- School Attendance**
 - **For Cash Aid Only - Student age 6 - 18** stopped or started attending school regularly?
 - **Age 16 or older student** started or stopped school/college? (You may be able to claim costs for books, school transportation, etc.)
- Other**

If you checked "YES" for any of these, please fill out below. Attach a separate sheet of paper if needed:

Name of person(s)	Relationship to you	What happened?	When

ADDRESS CHANGE Fill in this section **ONLY** if you have moved or have a new mailing address. If you are getting Food Stamps, you may be asked to provide proof of your new shelter costs.

NEW Home Address (Number, Street Name, Avenue, Blvd., Etc.) Apt. No	City	State	Zip Code	New Phone Number ()

Date Moved	NEW Mailing Address (If different from Home Address)	City	State	Zip Code

Do you have housing costs at this new address? YES NO If yes, how much? \$ _____

Do you have to pay heating/cooling costs separate from your housing cost? YES NO If yes, how much? \$ _____

CERTIFICATION - FRAUD WARNING

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I may also be charged with committing a felony if more than \$400 in Cash Aid, and/or Food Stamps is wrongly paid out as a result of such an action. I have received a copy of the Instructions and Penalties for the Eligibility/Status Report for Cash Aid and Food Stamps.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE MONTH THIS REPORT IS FOR OR IT WILL BE CONSIDERED INCOMPLETE. I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW:	For Cash Aid: you and your aided spouse, domestic partner, and the other parent (of cash-aided children) if living in the home. For Food Stamps: the head of household, a responsible household member, or the household's authorized representative.		
SIGNATURE OR MARK	DATE SIGNED	HOME PHONE	CONTACT/CELL PHONE
	5/3/13	(559) 555-5555	()
SIGNATURE OF SPOUSE, DOMESTIC PARTNER, OR OTHER PARENT OF CASH AIDED CHILD(REN)	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE SIGNED