

STATEMENT OF FACTS TO ADD A CHILD UNDER AGE 16

(Supplemental Application and Request for Cash Aid and/or CalFresh)

INSTRUCTIONS:

Fill out this form for a new child in the home and sign the Certification section. If you need more space, attach another sheet of paper. Use one form for each child.

If you get Cash Aid, and you want aid for the new child, this form must be filled out by the parent or California domestic partner or adult caretaker relative.

For CalFresh households which do not get or want to get Cash Aid, this form must be filled out by an adult household member or authorized representative.

CHILD NEEDS AID DUE TO PARENT'S (✓) BELOW

| | | | |
|--------------------------|--------------------------|--------------------------|-------------------------------------|
| DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

1. Parent's or Caretaker Relative's Name _____ Phone () _____

2. Give us all the facts for this child.

| | | | |
|--|---|--|--|
| CHILD'S NAME (FIRST, MIDDLE, LAST) | | PARENT OR CARETAKER RELATIVE'S NAME | |
| SOCIAL SECURITY NUMBER | SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F | OTHER PARENT'S NAME | |
| BIRTHPLACE (CITY/STATE/COUNTRY) | BIRTHDATE (MONTH, DAY, YEAR) | BLIND, DEAF, OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> CalFresh | CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE | | IF CHILD IS UNDER AGE 6, ARE IMMUNIZATION SHOTS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not under age 6 | |

3. Is the child a foster child?
 A. Was the child placed in your home under a dependency order from the court? YES NO
 B. Do you want the foster child and foster care income counted on the CalFresh case? YES NO
 C. Is the child enrolled in a health care plan? YES NO

4. Did the child get cash aid or CalFresh this month? YES NO
 If "YES", complete below:

| | |
|--|-----------------------|
| TYPE OF AID <input type="checkbox"/> Cash Aid <input type="checkbox"/> CalFresh | WHERE (County, State) |
|--|-----------------------|

5. Does the child get or expect to get any income, such as: Earnings, Supplemental Security Income/State Supplementary Payment (SSI/SSP), Social Security Benefits, Child Support, Foster Care Payment, Veterans Benefits, etc. If "YES", complete below: YES NO

| TYPE OF INCOME | AMOUNT (Before Deductions, if any) | WHEN | HOW OFTEN |
|----------------|------------------------------------|------|-----------|
| | \$ | | |

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

6. A. Is the child pregnant or a teen parent? YES NO
 If "YES", Check (✓) status: Pregnant Teen Parent

SCHOOL STATUS, CHECK (✓)
 Has a High School Diploma Has a GED Not Attending School (explain):
 Currently Attending School Other (explain):

B. Has the child received a cash bonus or sanction, or help with child care, transportation, etc, from the Cal-Learn Program? YES NO
 If "YES", complete below:

| | |
|----------------|------------------|
| WHERE (COUNTY) | DATE(S) RECEIVED |
|----------------|------------------|

7. Has the parent(s) of this child been in the United States (U.S.) military? YES NO
 If "YES", complete below:

| NAME OF PARENT | PARENT A U.S. CITIZEN | BRANCH OF SERVICE | DATES OF SERVICE | HONORABLE DISCHARGE |
|----------------|--|-------------------|------------------|--|
| | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |

8. Complete below if you want CalFresh for this child and the child is not a citizen of the U.S.

A. How many years total has this child and/or his/her parents lived in the U.S.?

B. While living in the U.S., in how many of the years did this child and/or the child's parents earn money by working in the U.S.?

C. While living outside the U.S., how many total years did this child and/or the child's parents work in the U.S. or for a U.S. company?

COUNTY USE ONLY

| | | | |
|--|--------|--|------------------------------|
| CASE NAME | | | |
| CASE NUMBER | | | |
| WORKER NAME AND NUMBER | | | |
| DATE RECEIVED | | | |
| AU | Non-AU | MFG Child <input type="checkbox"/> Yes <input type="checkbox"/> No | CF Non-HH Excl. Member Code: |
| Work Registration/Exemption Codes: WtW: _____ CF: _____ | | | |
| VERIF: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> Citizen <input type="checkbox"/> SAVE <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> Immun. | | | |
| Alien Reg. No. | | D.O.E. | |

3A. Request dependency order
 3B. CA and FC Elig/CR Chooses:
 Child: CA FC
 CR: CA None Kin-GAP
 3C. Medi-Cal Fee for Service

Verification provided

Verification provided
 FC Income Counted on CF Case YES NO
 CA Eligible for Higher MAP

| Income | | (✓) if exempt | |
|----------|--------|---------------|----|
| Unearned | Earned | CA | CF |

Verified:
 Referred to Cal-Learn Program
 CW 25
 QR 25A

CW 5 YES NO
 Date Initiated _____

CF: Honorable Discharge YES NO

| | | | | | | | | |
|--|-----------------------|-----------------------------|---------------|---|--|-----|----|--|
| 9. Does the child own any property or have resources, such as: cash, land, bank accounts, trust funds, savings bonds, Native American per capita payments or trust funds, or other items? If "YES", complete below: | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | COUNTY USE ONLY | | | |
| TYPE OF RESOURCE | ACCOUNT/POLICY NUMBER | NAME, ADDRESS OF BANK, ETC. | CURRENT VALUE | <input type="checkbox"/> Verification provided <input type="checkbox"/> CA Restricted Account <input checked="" type="checkbox"/> Check if exempt <input type="checkbox"/> CA <input type="checkbox"/> CF | | | | |
| 10. Does the child have Medicare or health insurance, such as Blue Cross, Kaiser, CHAMPUS, etc., which is paid for by a parent or parent's employer? If "YES", list insurance coverage: | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Verification provided Health Coverage Code: | | | |
| 11. If the child has been charged as an adult with a felony, is the child hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for that felony crime or attempted felony crime? | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 12. Has the child been found by a court of law to be in violation of probation or parole? | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 13. A. If you can get cash aid, eligible members of your family under age 21 may be able to get some health examinations through the Child Health and Disability Prevention Program (CHDP). | | | | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> </tr> </table> | | YES | NO | <input type="checkbox"/> CHDP brochure and explanation given <input type="checkbox"/> CHDP Referral <input type="checkbox"/> Date: |
| | YES | NO | | | | | | |
| <ul style="list-style-type: none"> • Do you want more facts about CHDP services?..... • Do you want free CHDP medical or dental services?..... • Do you need help making appointments or getting to the doctor or dentist?..... | | | | | <input type="checkbox"/> Referred for Immunization | | | |
| B. Do you want more facts about immunization services? | | | | | <input type="checkbox"/> Other services referral | | | |
| C. Do you want facts about non-discrimination, alcohol/drug counseling, past medical expenses, and other special needs? | | | | | <input type="checkbox"/> Pregnant | | | |
| D. Does anyone who is pregnant need to find a doctor, get medical transportation, and/or other help? | | | | | <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum | | | |
| E. Is anyone breastfeeding a child? If "YES", was the birth within the last 12 months? | | | | | <input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning info given Date Referred: | | | |
| F. Do you want to get facts or services from a Family Planning Clinic to help you plan your family size and prevent unplanned pregnancies? | | | | | | | | |

CERTIFICATION

I understand that:

- If I give wrong facts or fail to report all facts or situations on purpose that affect my eligibility and aid payments, I may be fined, jailed/imprisoned, or both. I can be fined up to \$10,000 for cash aid and \$250,000 for CalFresh. I can be sent to jail/prison for up to 3 years for cash aid and 20 years for CalFresh. And benefits for cash aid and CalFresh 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.
- My case can be picked for reviews to prove eligibility; and I must cooperate fully with county, state, and federal personnel in any quality control review.
- The facts I give will be checked out by local, state, and federal personnel.
- The county will send facts to the U.S. Citizenship and Immigration Services (USCIS) for proof of immigration status.
- The facts the county gets from USCIS may affect eligibility for cash aid and CalFresh.
- The facts I give will be checked with tax, welfare, employment agencies, school districts, and the Social Security Administration to prove the child's eligibility for cash aid and/or CalFresh and to prove that I am getting the right amount of cash aid or CalFresh. And the social security number will be matched with law enforcement agency records for arrest warrants.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on this Statement of Facts is true, correct, and complete.

WHO MUST SIGN THIS FORM: For Cash Aid, you and your aided spouse, Registered Domestic Partner, or the other parent (of cash aided children), if living in the home.
 For CalFresh, an adult household member or authorized representative.

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| SIGNATURE OF CARETAKER RELATIVE AND/OR ADULT CALFRESH HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE | DATE |
| SIGNATURE OF CASH-AIDED SPOUSE OR DOMESTIC PARTNER OR OTHER PARENT (OF CASH-AIDED CHILD) IF LIVING IN THE HOME | DATE |
| SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM | DATE |

COUNTY USE ONLY

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|--|------------------------------------|---------------------|------------------------|--|--|
| <input type="checkbox"/> INELIGIBLE (Reason) | | | | IMMUNIZATION <input type="checkbox"/> Informing (CW 101 / TEMP CW 101A) Regs Met: <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| <input type="checkbox"/> ELIGIBLE | Eligibility Conditions Met - Date: | Authorization Date: | Effective Date of Aid: | | |
| Signature of County Worker | | | Date | Signature of Supervisor | |
| | | | | Date | |