STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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.

COUNTY USE ONLY

CASE NAME

CASE NUMBER

WORKER NAME AND NUMBER

DATE RECEIVED

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

CHILD NEEDS AID DUE TO PARENT'S (✔) BELOW: DEATH | DISABILITY | ABSENCE | UNEMPLOYMENT

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 (✔) ☐ M ☐ F	OTHER PARENT'S NAME
BIRTHPLACE (CITY/STATE/COUNTRY)	BIRTHDATE (MONTH, DAY, YEAR) / BLIND, DEAF, OR DISABLED ☐ YES ☐ NO
TYPE OF AID REQUESTED (✔) ☐ Cash Aid ☐ CalFresh	CITIZEN/NONCITIZEN STATUS (✔) ☐ U.S. Citizen/National ☐ Noncitizen: Sponsored ☐ YES ☐ NO
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE	IF CHILD IS UNDER AGE 6, ARE IMMUNIZATION SHOTS UP TO DATE? ☐ YES ☐ NO ☐ Not under age 6

AU ☐ | Non-AU ☐ | MEG Child ☐ Yes ☐ No | CF Non-HH Excl. Member Code:

Work Registration/Exemption Codes: WtW: | CF:

VERIF: ☐ Blind/Deaf/Disabled ☐ SSN ☐ Citizen ☐ SAVE ☐ Eligible Noncitizen ☐ Immun.

Alien Reg. No. | D.O.E.

3. Is the child a foster child? ☐ YES ☐ NO
- 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

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

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

TYPE OF AID	WHERE (County, State)
☐ Cash Aid ☐ CalFresh	

☐ Verification provided

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:

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

Income		(✔) if exempt	
Unearned ☐	Earned ☐	CA ☐	CF ☐

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):

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

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

CW 5 ☐ YES ☐ NO
Date Initiated _____

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
	☐ YES ☐ NO			☐ YES ☐ NO

CF: Honorable Discharge ☐ YES ☐ NO

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

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

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

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

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: ☐ **YES** ☐ **NO**

TYPE OF RESOURCE	ACCOUNT/POLICY NUMBER	NAME, ADDRESS OF BANK, ETC.	CURRENT VALUE
			$

COUNTY USE ONLY
☐ Verification provided
☐ CA Restricted Account
(✔) Check if exempt
☐ CA ☐ 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: ☐ **YES** ☐ **NO**

☐ 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? ☐ **YES** ☐ **NO**

12. Has the child been found by a court of law to be in violation of probation or parole? ☐ **YES** ☐ **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).

	YES	NO
• 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?		
B. Do you want more facts about immunization services?		
C. Do you want facts about non-discrimination, alcohol/drug counseling, past medical expenses, and other special needs?		
D. Does anyone who is pregnant need to find a doctor, get medical transportation, and/or other help?		
E. Is anyone breastfeeding a child?		
If **"YES",** was the birth within the last 12 months?		
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?		

☐ CHDP brochure and explanation given
☐ CHDP Referral Date:
☐ Referred for Immunization
☐ Other services referral
☐ Pregnant
☐ Parent or Guardian of child under 5
☐ Breastfeeding ☐ Postpartum
☐ WIC referral
☐ Family Planning info given Date Referred:

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.

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

☐ INELIGIBLE (Reason)

☐ ELIGIBLE | Eligibility Conditions Met - Date: | Authorization Date: | Effective Date of Aid:

IMMUNIZATION
☐ Informing (CW 101 / TEMP CW 101A)
Regs Met: ☐ YES ☐ NO

Signature of County Worker	Date	Signature of Supervisor	Date