

## **STATEMENT OF FACTS**

### **CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI)**

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#### **NOTICE**

Your county welfare office is authorized to collect the information on this form under Section 18940 of the Welfare and Institutions Code and the federal laws that govern the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program. This information is needed to help your county welfare office determine your eligibility for CAPI benefits.

#### **AMERICANS WITH DISABILITIES ACT (ADA) NOTICE**

The federal Americans with Disabilities Act (ADA) and state law protects people with physical, mental, emotional, learning, and developmental disabilities. The ADA also protects people who have health problems.

#### **Do any of these apply to you?**

- ✓ Have a visual, hearing, or speaking impairment
- ✓ Need a sign language interpreter
- ✓ Have difficulty walking, sitting, or standing for a long time
- ✓ Need help filling out or understanding forms or complicated instructions

If you don't know, you can talk about it with us. If you need help in applying for CAPI, please ask a county worker right away!

You have the right to equal access to programs and services. If denied an accommodation, you may file a civil rights complaint or disability grievance with your county welfare office's disability rights coordinator.

#### **What type of help can the county provide to applicants with disabilities?**

Some examples include helping you read and fill out application forms or explaining any notices provided to you. If you tell us you need help applying for benefits, we will work with you to find a way to help you. You do not need to give us a diagnosis or be in treatment to get this help.

#### **Did you know?**

If a disability makes it difficult for you to travel to a county office for an interview, please let a county worker know and the county will come to you. Your county can:

- Interview you at your home, at a skilled nursing facility, at a hospital, or at another convenient location.
- Use video chatting (such as FaceTime or Skype) to conduct interviews remotely.
- Help you get the documents you may need to support your application for CAPI.

#### **LANGUAGE ACCESS NOTICE**

California's Dymally-Alatorre Bilingual Services Act of 1973, Government Code §7290 et seq., requires that application forms and notices be made available in multiple languages. Explanations of benefits, instructions on how to fill out applications, and interviews with county staff must be made available in your preferred language. Please tell a county worker, in person or by telephone, if you would like to be assisted in your language.

Please help us make it easier for you to apply for CAPI by answering the following questions:

- a. Do you need help reading this application?  Yes  No
- b. Do you need help applying for CAPI due to a disability?  Yes  No
- c. Are you deaf or hard of hearing?  Yes  No

If you are deaf or hard of hearing, the county must provide effective communication at no cost to you. What communication method do you require (if any)?

\_\_\_\_\_

- d. What language do you prefer to read?  
\_\_\_\_\_
- e. What language do you prefer to speak?  
\_\_\_\_\_

**INSTRUCTIONS**

CAPI is a state-funded program for non-citizens only. Please print your answers clearly in blue or black ink. This application must be signed and dated by the applicant.

If you need more space, use the “Remarks” section on page 15. Tell your worker if you need help in getting proof or filling out this form.

**COUNTY USE ONLY**

Case Name

Case Number

Worker

Date Received

Linkage

- Aged
- Blind
- Disabled

ID

**SECTION 1: APPLICANT INFORMATION**

- a. Your name (first name, middle initial, last name):  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I don't have a Social Security number.

- b. **Contact Information**

Home Address (street address): \_\_\_\_\_

Apartment #: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Numbers with Area Code:

Cell or Mobile (\_\_\_\_\_) \_\_\_\_\_

Home/Work/Message(\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

**COUNTY USE ONLY**

c. Do you give the county permission to contact you via text message in regard to your CAPI case?  Yes  No

If “yes,” please provide the phone number to which the county should text such messages. (\_\_\_\_\_) \_\_\_\_\_

d. Did you ever use any other names (including maiden name)?  Yes  No

If “yes,” please use the space below to list other names used:

\_\_\_\_\_  
\_\_\_\_\_

e. **Optional:** (This question is optional and your response is confidential.)

**Ethnicity:** Are you of Hispanic, Latino or Spanish origin?

Yes  No  Decline to state

If you answered “yes” to the above, do you consider yourself:

- Mexican  Puerto Rican  Cuban
- Guatemalan  Salvadoran  Honduran
- Other (please specify): \_\_\_\_\_

f. **Optional:** (This question is optional and your response is confidential.)

**Race/Ethnic Origin:** Please check all that apply.

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

g. *A response to this question is required from all applicants for cash aid. Your response is confidential.*

What is your sex?  Female  Male  
 Transgender: male to female  
 Transgender: female to male

h. **Optional:** (This question is optional and your response is confidential.)

How do you identify your gender identity? Please check one:

- Female  Male  Transgender: male to female
- Transgender: female to male  Another gender identity
- Non-Binary (neither male nor female)  Decline to state

**COUNTY USE ONLY**

- i. **Optional:** (This question is optional and your response is confidential.)  
What sex was listed on your original birth certificate? Please check one:  Female  Male  Decline to state
- j. **Optional:** (This question is optional and your response is confidential.)  
How do you identify your sexual orientation? Please check one:  
 Straight or heterosexual  Gay or lesbian  Bisexual  Queer  
 Another sexual orientation  Unknown  Decline to state
- k. Are you homeless?  Yes  No  
("Homeless" means you do not have a regular place to sleep at night or you sleep in a temporary location such as a shelter or motel room or you sleep in a place not meant for human habitation, such as a car, train or bus station, airport or abandoned building, or you sleep outdoors or you are temporarily "doubled up" with other people because you are unable to pay for your own place to live.)
- l. Do you intend to remain in California?  Yes  No

**SECTION 2: HEALTH**

- a. Do you have any physical or mental health problems or are you blind?  Yes  No  
Examples include high blood pressure, heart problems, diabetes, arthritis, osteoporosis, vision problems, depression, etc.
- b. If you answered "yes" to the above, please briefly explain:  
Health Problem #1 – Date Problem Began: \_\_\_\_\_  
Describe Health Problem #1: \_\_\_\_\_  
\_\_\_\_\_  
Health Problem #2 – Date Problem Began: \_\_\_\_\_  
Describe Health Problem #2: \_\_\_\_\_  
\_\_\_\_\_  
Health Problem #3 – Date Problem Began: \_\_\_\_\_  
Describe Health Problem #3: \_\_\_\_\_  
\_\_\_\_\_
- c. Are you a victim of abuse?  Yes  No  
If "yes," was the abuser your sponsor or your sponsor's spouse?  Yes  No  
"Abuse" means assaultive or coercive behavior, including physical, sexual and psychological abuse, economic control, stalking, isolation, threats, and other types of coercive behaviors.

- Current Medi-Cal or SSA Disability Determination
- DDSD Referral Completed
- Disabled
- Blind
- Presumptive Disability
- SSI Referral Completed

- APS Referral?  
 Yes  No  N/A

**SECTION 3: MARITAL STATUS**

- a. What is your marital status?  
 Single/Never Married    Married    Divorced  
 Widowed    Separated

If you are not currently married, please go to **Section 4** below.

- b. Your spouse’s name (first name, middle initial, last name):  
\_\_\_\_\_

Your spouse’s date of birth: \_\_\_\_\_

- c. Did your spouse ever use any other names (including maiden name)?       Yes    No  
If “**yes**,” please use the space below to list other names used:  
\_\_\_\_\_

- d. Are you and your spouse living together?       Yes    No

- e. If you answered “**no**” to the above, please list the date that you and your spouse began living apart:  
\_\_\_\_\_

- f. If you do not live with your spouse, please list your spouse’s address (number and street, city and zip code):  
\_\_\_\_\_

- g. Is your spouse applying for CAPI?       Yes    No

**COUNTY USE ONLY**

**Spouse:**

Linkage:

- Aged
- Blind
- Disabled

ID:

Spouse Eligible?

- Yes    No

**SECTION 4: IMMIGRATION STATUS - GENERAL**

- a. Are you a United States citizen?       Yes    No  
If you answered “**yes**” to the above, please go to the end of the application and sign your name.

- b. Would you like information on how to become a United States citizen and assistance with the citizenship process?       Yes    No

- c. Have you or your spouse (or former spouse) ever served in the U.S. military?       Yes    No

- d. What is your Alien Registration Number? \_\_\_\_\_

- e. Where was your port of entry? \_\_\_\_\_

Resident Card on File?  
 Yes    No    N/A

Resident Card Expired?  
 Yes    No    N/A

If Yes: Current status verified on SAVE?

- Yes    No

**COUNTY USE ONLY**

- f. Are you lawfully admitted for permanent residence in the United States?  Yes  No
- g. If you answered “yes” to the above, please list the date of your admission for permanent residence and go to **Section 5**.
- h. If you answered “no” to the above, please briefly explain your current immigration status with the United States Citizenship and Immigration Services (USCIS). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- i. Through what date will USCIS allow you to remain in the United States? Please list date or “indefinitely,” as applicable. \_\_\_\_\_

**SECTION 5: IMMIGRATION STATUS – SPONSORSHIP**

- a. Do you have a sponsor?  Yes  No  
If you answered “no” to the above, please go to **Section 6**.  
Note: The income of your sponsor and your sponsor’s spouse will generally be deemed to you for a period of ten years. ([WELFARE AND INSTITUTIONS CODE §18940\(B\)](#)). This could potentially cause you to exceed CAPI income limits and make you ineligible to receive CAPI. However, if your sponsor provides you with little or no support and you are therefore unable to obtain shelter and food, you may be eligible for an indigence exception to the sponsor deeming rule. Please Note: We will not count any housing subsidies or food stamps when determining whether you are unable to obtain shelter and food. To apply for an indigence exception, completion of form SOC 809 (CAPI Indigence Exception Statement) will be required. For help and further explanations, please ask your case worker.
- b. Please list the name, address and telephone number of your sponsor. If you have more than one sponsor, please provide this information for each of your sponsors.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- c. Are any of your sponsors deceased?  Yes  No  
If you answered “yes” to the above, please list the name of your deceased sponsor. \_\_\_\_\_
- d. Are any of your sponsors disabled?  Yes  No  
If you answered “yes” to the above, please list the name of your disabled sponsor. \_\_\_\_\_

- Sponsored?  
 Yes  No
- Affidavit of Support:  
 Form I-134  
 Form I-864
- Sponsor Verifications:  
 Deceased  
 Disabled
- USCIS documentation on file?  Yes  No
- SOC 809 completed?  
 Yes  No  N/A
- SOC 813 approved?  
 Yes  No  N/A
- If NO, SOC 860 mailed to sponsor(s) and applicant?  
 Yes  No
- Abuse exception to sponsor deeming (see question #2c)?  
 Yes  No  N/A

**SECTION 6: RESIDENCY**

- a. Are you hiding or running from the law for a felony, attempted felony, or a parole or probation violation?  Yes  No  
If you answered “yes” to the above, please go to the end of the application and sign your name.
- b. On what date did you first make your home in the United States?  
\_\_\_\_\_
- c. Have you lived outside of the United States since then?  Yes  No  
If you answered “yes” to the above, please list the dates that you were outside the United States (month/day/year you left and month/day/year you returned). \_\_\_\_\_
- d. Have you been outside of the United States within the past 30 days?  Yes  No  
If you answered “yes” to the above, please list the date that you left the United States and the date on which you returned. \_\_\_\_\_

**COUNTY USE ONLY**

Lawfully admitted permanent resident?  
 Yes  No

Passport viewed and copy on file?  
 Yes  No

Month aid begins:  
\_\_\_\_\_

**SECTION 7: LIVING ARRANGEMENTS**

- a. Check the applicable block to show where you live now:
  - House  Nursing Home  Apartment
  - Mobile Home  Jail  Room (private home)
  - Hospital  Homeless Shelter  Other Institution
  - Residential Care Facility
  - Room (hotel/commercial establishment)
  - Shelter for Battered Women
  - Other (describe): \_\_\_\_\_
- b. Are you currently receiving In-Home Supportive Services (IHSS)?  Yes  No  
If you answered “no” to the above, do you need assistance in personal care or other domestic related tasks (such as feeding, dressing, bathing, taking medication, moving around, house cleaning, meal preparation, laundry, grocery shopping, etc.), or accompaniment to medical appointments because you are unable to perform these tasks independently?
  - Yes, and I would like the county to help me obtain assistance with personal care/domestic related tasks.
  - Yes, and I am currently receiving the assistance I need from:
    - My spouse
    - A relative, legal guardian or conservator
    - Other (describe) \_\_\_\_\_
  - No, I do not need assistance with personal care/domestic related tasks.

IHSS referral?  
 Yes  No

NMOHC?  
 Yes  No

**COUNTY USE ONLY**

c. Do you have adequate cooking and food storage facilities available where you live?  Yes  No

Cooking Facilities?  
 Yes  No

d. Do you live alone?  Yes  No

e. If you do not live alone, please provide information about each person who lives with you, including your spouse. Please list the name of each person who lives with you, their relationship to you, their date of birth, and whether the person receives public assistance. "Public assistance" includes BIA, CalWORKs, SSI/SSP, General Assistance/General Relief, VA pension, etc. *If a person who lives with you receives CalFresh/SNAP or CFAP food assistance only, please check "No" for that person.* There is room below for you to enter information about up to five people who live with you. If more than five people live with you, please list five of them below and the rest of them in the Remarks section on page 15.

Person #1's name: \_\_\_\_\_

Person #1's relationship to you: \_\_\_\_\_

Person #1's gender and date of birth: \_\_\_\_\_

Does Person #1 receive public assistance (such as BIA, CalWORKs, CAPI, SSI/SSP, GA/GR, VA Pension)?  Yes  No

Person #2's name: \_\_\_\_\_

Person #2's relationship to you: \_\_\_\_\_

Person #2's gender and date of birth: \_\_\_\_\_

Does Person #2 receive public assistance (such as BIA, CalWORKs, CAPI, SSI/SSP, GA/GR, VA Pension)?  Yes  No

Person #3's name: \_\_\_\_\_

Person #3's relationship to you: \_\_\_\_\_

Person #3's gender and date of birth: \_\_\_\_\_

Does Person #3 receive public assistance (such as BIA, CalWORKs, CAPI, SSI/SSP, GA/GR, VA Pension)?  Yes  No

Person #4's name: \_\_\_\_\_

Person #4's relationship to you: \_\_\_\_\_

Person #4's gender and date of birth: \_\_\_\_\_

Does Person #4 receive public assistance (such as BIA, CalWORKs, CAPI, SSI/SSP, GA/GR, VA Pension)?  Yes  No

Person #5's name: \_\_\_\_\_

Person #5's relationship to you: \_\_\_\_\_

Person #5's gender and date of birth: \_\_\_\_\_

Does Person #5 receive public assistance (such as BIA, CalWORKs, CAPI, SSI/SSP, GA/GR, VA Pension)?  Yes  No



**COUNTY USE ONLY**

- f. How do you pay for your shelter expenses?  
 Pay rent to landlord    Sublet    Pay mortgage  
 Own the property    I live here for free
- g. How much is your monthly rent or mortgage payment? \$ \_\_\_\_\_
- h. Does anyone who lives with you pay rent or make monthly mortgage payments?       Yes    No

Rental liability/ownership verified?  
 Yes    No

SOC 453?  
 Yes    No

**SECTION 8: RESOURCES/PROPERTY**

- a. Does your name or your spouse’s name appear on the title of any vehicle?       Yes    No

Exempt vehicle?  
 Yes    No

Vehicles include cars, trucks, boats, motorcycles, motor homes, etc.

- b. If you answered “yes” to the above question, for each vehicle that you or your spouse own, please list the owner’s name, a description of the vehicle (year, make and model), the purpose for which the vehicle is used (for work, to get to medical appointments, etc.), the vehicle’s current market value, and the amount owed on the vehicle.

**2nd Vehicle:**  
Market Value:  
\$ \_\_\_\_\_  
Encumbrances:  
\$ \_\_\_\_\_  
Equity Value:  
\$ \_\_\_\_\_

Name of owner of Vehicle #1: \_\_\_\_\_

Description of Vehicle #1 (year, make and model): \_\_\_\_\_

Purpose for which Vehicle #1 is used: \_\_\_\_\_

Current market value of Vehicle #1: \_\_\_\_\_

Amount owed on Vehicle #1: \_\_\_\_\_

Name of owner of Vehicle #2: \_\_\_\_\_

Description of Vehicle #2 (year, make and model): \_\_\_\_\_

Purpose for which Vehicle #2 is used: \_\_\_\_\_

Current market value of Vehicle #2: \_\_\_\_\_

Amount owed on Vehicle #2: \_\_\_\_\_

- c. Do you or your spouse own or are either of you buying any life insurance policies?       Yes    No

CSV?  
 Yes    No  
Amount: \$ \_\_\_\_\_

If you answered “yes” to the above question, please provide the following information about each of your life insurance policies:

Name of owner of Policy #1: \_\_\_\_\_

Name of person insured by Policy #1: \_\_\_\_\_

Name of insurance company for Policy #1: \_\_\_\_\_

Policy number for Policy #1: \_\_\_\_\_

Face value of Policy #1: \_\_\_\_\_

COUNTY USE ONLY

Cash surrender value of Policy #1: \_\_\_\_\_

Date that Policy #1 was purchased: \_\_\_\_\_

Are there any loans against Policy #1?  Yes  No

Name of owner of Policy #2: \_\_\_\_\_

Name of person insured by Policy #2: \_\_\_\_\_

Name of insurance company for Policy #2: \_\_\_\_\_

Policy number for Policy #2: \_\_\_\_\_

Face value of Policy #2: \_\_\_\_\_

Cash surrender value of Policy #2: \_\_\_\_\_

Date that Policy #2 was purchased: \_\_\_\_\_

Are there any loans against Policy #2?  Yes  No

- d. Do you (or your spouse, if you are married) own, either alone or jointly with another person, any life estates or ownership interest in an unprobated estate?  Yes  No

If you answered "yes" to the above question, please provide the owner's name, a description of the item (life estate or unprobated estate), its resale value, and the amount owed on the item.

Name of owner of Item #1: \_\_\_\_\_

Description of Item #1: \_\_\_\_\_

Resale value of Item #1: \_\_\_\_\_

Amount owed on Item #1: \_\_\_\_\_

Name of owner of Item #2: \_\_\_\_\_

Description of Item #2: \_\_\_\_\_

Resale value of Item #2: \_\_\_\_\_

Amount owed on Item #2: \_\_\_\_\_

- e. Do you or your spouse own, or do either of your names appear (either alone or jointly) on any of the following items either inside or outside of the United States?

Cash (at home, with you, or anywhere else)

**You:**  Yes  No      **Your Spouse:**  Yes  No

Checking Accounts

**You:**  Yes  No      **Your Spouse:**  Yes  No

Savings Accounts

**You:**  Yes  No      **Your Spouse:**  Yes  No

Credit Union Accounts

**You:**  Yes  No      **Your Spouse:**  Yes  No

Certificates of Deposit

**You:**  Yes  No      **Your Spouse:**  Yes  No

**COUNTY USE ONLY**

Notes

**You:**  Yes  No

**Your Spouse:**  Yes  No

Bonds

**You:**  Yes  No

**Your Spouse:**  Yes  No

Money Market Accounts

**You:**  Yes  No

**Your Spouse:**  Yes  No

Stocks

**You:**  Yes  No

**Your Spouse:**  Yes  No

IRAs

**You:**  Yes  No

**Your Spouse:**  Yes  No

Other items that can be turned into cash

**You:**  Yes  No

**Your Spouse:**  Yes  No

f. Provide the following information for any **“yes”** answers above:

Owner’s Name: \_\_\_\_\_

Name of Item: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Name of Bank or Financial Institution: \_\_\_\_\_

Account Number: \_\_\_\_\_

Owner’s Name: \_\_\_\_\_

Name of Item: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Name of Bank or Financial Institution: \_\_\_\_\_

Account Number: \_\_\_\_\_

Owner’s Name: \_\_\_\_\_

Name of Item: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Name of Bank or Financial Institution: \_\_\_\_\_

Account Number: \_\_\_\_\_

Information in Item f verified?

Yes  No

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

g. Do you or your spouse own any land or buildings, or does either of your names appear on the title of ANY property either inside or outside of the United States, other than at the address where you currently live? **You:**  Yes  No **Your Spouse:**  Yes  No

If **“yes”** to either, please provide the following information:

**Property #1:** Type of Property: \_\_\_\_\_

Location of Property: \_\_\_\_\_

Value: \$ \_\_\_\_\_

**Property #2:** Type of Property: \_\_\_\_\_

Location of Property: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Information in Item g verified?

Yes  No

**COUNTY USE ONLY**

h. Have you or your spouse sold, transferred title, disposed of or given away any money or property, including money or property in foreign countries, within 36 months of this application filing date, and after December 14, 1999? **You:**  Yes  No **Your Spouse:**  Yes  No

Property sold for less than market value?

Yes  No

If "yes" to either, please provide the following information:

Date and transfer verified?

Description of Property: \_\_\_\_\_

Yes  No

Current Market Value: \$ \_\_\_\_\_ Date of Transaction: \_\_\_\_\_

Reason for Transaction: \_\_\_\_\_

Period of ineligibility

Name, address and telephone number of buyer or person who received property: \_\_\_\_\_

Beginning Date:

Relationship to applicant: \_\_\_\_\_

Ending Date:

Sales price or other agreement: \_\_\_\_\_

i. Do you or your spouse have any money set aside for burial expenses? **You:**  Yes  No **Your Spouse:**  Yes  No

Money set aside for burial expenses:

If "yes" to either, please provide the following information:

Exempt?

Owner: \_\_\_\_\_

Yes  No

Description (Type of Asset, Name of Organization): \_\_\_\_\_

Amount over \$1,500

Value: \$ \_\_\_\_\_ Date set aside: \_\_\_\_\_

For whose burial (relationship)? \_\_\_\_\_

Owner: \_\_\_\_\_

Description (Type of Asset, Name of Organization): \_\_\_\_\_

Value: \$ \_\_\_\_\_ Date set aside: \_\_\_\_\_

For whose burial (relationship)? \_\_\_\_\_

j. Do you or your spouse own any cemetery plots, crypts, caskets, vaults or urns? **You:**  Yes  No **Your Spouse:**  Yes  No

Burial Asset #1:

Revocable

Irrevocable

Burial Asset #1 Owner: \_\_\_\_\_

Description: \_\_\_\_\_

Burial Asset #2:

Value: \$ \_\_\_\_\_ For whose burial (relationship)? \_\_\_\_\_

Revocable

Irrevocable

Burial Asset #2 Owner: \_\_\_\_\_

Description: \_\_\_\_\_

Value: \$ \_\_\_\_\_ For whose burial (relationship)? \_\_\_\_\_

**COUNTY USE ONLY**

**SECTION 9: INCOME**

a. Have you or your spouse received, or do you expect to receive income from any of the following sources?

Gifts/Support

**You:**  Yes  No      **Your Spouse:**  Yes  No

Social Security

**You:**  Yes  No      **Your Spouse:**  Yes  No

Veteran’s Administration

**You:**  Yes  No      **Your Spouse:**  Yes  No

Supplemental Security Income (SSI)

**You:**  Yes  No      **Your Spouse:**  Yes  No

Unemployment Benefits

**You:**  Yes  No      **Your Spouse:**  Yes  No

State Disability

**You:**  Yes  No      **Your Spouse:**  Yes  No

Workers’ Compensation

**You:**  Yes  No      **Your Spouse:**  Yes  No

Other Pensions/Annuities

**You:**  Yes  No      **Your Spouse:**  Yes  No

CalWORKs

**You:**  Yes  No      **Your Spouse:**  Yes  No

General Assistance/Relief

**You:**  Yes  No      **Your Spouse:**  Yes  No

Rental Income

**You:**  Yes  No      **Your Spouse:**  Yes  No

Insurance Payments

**You:**  Yes  No      **Your Spouse:**  Yes  No

Interest/Dividends

**You:**  Yes  No      **Your Spouse:**  Yes  No

Alimony/Child Support

**You:**  Yes  No      **Your Spouse:**  Yes  No

Other Income

**You:**  Yes  No      **Your Spouse:**  Yes  No

Section 9a info verified?

Yes  No

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

Wages verified?

Yes  No

Paid:

Daily

Weekly

Bi-Weekly

Monthly

Twice Monthly

Fluctuating

Tax return?

Yes  No

Year of tax return:

IRWE?

Yes  No

For each “yes” answer above, please provide the following information:

Person Receiving: \_\_\_\_\_ Type: \_\_\_\_\_

Gross amount: \$ \_\_\_\_\_ How often received: \_\_\_\_\_

Person Receiving: \_\_\_\_\_ Type: \_\_\_\_\_

Gross amount: \$ \_\_\_\_\_ How often received: \_\_\_\_\_

**COUNTY USE ONLY**

Person Receiving: \_\_\_\_\_ Type: \_\_\_\_\_  
Gross amount: \$ \_\_\_\_\_ How often received: \_\_\_\_\_

Person Receiving: \_\_\_\_\_ Type: \_\_\_\_\_  
Gross amount: \$ \_\_\_\_\_ How often received: \_\_\_\_\_

- b. Do you or your spouse receive or do you expect to receive any wages?  
**You:**  Yes  No      **Your Spouse:**  Yes  No

If “yes” to either, please provide the following information:

Person working: \_\_\_\_\_  
Employer’s name, address and telephone number:  
\_\_\_\_\_

Gross wage amount: \$ \_\_\_\_\_ How often paid: \_\_\_\_\_  
Dates of employment: \_\_\_\_\_

Person working: \_\_\_\_\_  
Employer’s name, address and telephone number:  
\_\_\_\_\_

Gross wage amount: \$ \_\_\_\_\_ How often paid: \_\_\_\_\_  
Dates of employment: \_\_\_\_\_

- c. Have you or your spouse been, or do you or your spouse expect to be self-employed in the current year?  
**You:**  Yes  No      **Your Spouse:**  Yes  No

If “yes” to either, please provide the following information:

Type of business: \_\_\_\_\_  
Dates of self-employment (from/to): \_\_\_\_\_

Last year’s gross income: \$ \_\_\_\_\_

Last year’s net income/loss: \$ \_\_\_\_\_

This year’s gross income: \$ \_\_\_\_\_

This year’s net income/loss: \$ \_\_\_\_\_

Type of business: \_\_\_\_\_  
Dates of self-employment (from/to): \_\_\_\_\_

Last year’s gross income: \$ \_\_\_\_\_

Last year’s net income/loss: \$ \_\_\_\_\_

This year’s gross income: \$ \_\_\_\_\_

This year’s net income/loss: \$ \_\_\_\_\_

- d. If you or your spouse is under age 65 and disabled, do either of you have any special expenses related to your illness or injury that are necessary for you to work?  
**You:**  Yes  No      **Your Spouse:**  Yes  No

If “yes”, describe in “Remarks” under **Section 10**.

Wages verified?  
 Yes  No

Paid:  
 Daily  
 Weekly  
 Bi-Weekly  
 Monthly  
 Twice Monthly  
 Fluctuating

Tax return?  
 Yes  No

Year of tax return:

IRWE?  
 Yes  No

e. Are you or your spouse currently receiving CalFresh benefits (Food Stamps)?

**You:**  Yes  No

**Your Spouse:**  Yes  No

**COUNTY USE ONLY**

CalFresh referral?

Yes  No

**SECTION 10: REMARKS**

Remarks: (Use this area to add to the information you have provided on the previous pages or to provide other information.)

**YOUR AUTHORIZATION AND CERTIFICATION STATEMENT**

I give permission to state and county agencies to check the information I have provided on this form and other CAPI forms, including contacting third parties (e.g., my landlord or my head of household), to verify my living arrangement and my household expenses. I understand that these agencies will compare information provided on this form with records from other county, state and federal agencies to make sure that the correct amount of benefits is paid.

I have read (or someone has read to me) and understand my responsibilities, including my responsibility to report to the county any change in the information I have provided within ten days after the change occurs. I understand that I may incur a penalty if I fail to report any change in my circumstances within ten days.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime that can be punished under state law.

I certify under penalty of perjury that the statements provided on this form are the truth as I know it.

YOUR SIGNATURE/YOUR AUTHORIZED REPRESENTATIVE’S SIGNATURE:

\_\_\_\_\_ DATE: \_\_\_\_\_

FIRST WITNESS, IF MARKED WITH AN “X”: \_\_\_\_\_

SECOND WITNESS, IF MARKED WITH AN “X”: \_\_\_\_\_

Signature of interpreter or person completing form on your behalf:

\_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Telephone number: \_\_\_\_\_ DATE: \_\_\_\_\_



**Important Information – Please Read Carefully****REPORTING RESPONSIBILITIES**

**You must tell us about any change within 10 days after the change occurs. Failure to report any change within 10 days after it occurs could result in a penalty.**

**CHANGES TO REPORT****Where You Live:**

- If you move.
- If you leave the United States for 30 days or more.
- If you are no longer a legal resident of the United States.
- If you are released from a hospital, nursing home, etc.
- If you (or your spouse) leave your household for a calendar month or longer. For example, you enter a hospital or visit a relative.

**How You Live:**

- If someone moves into or out of your household.
- The birth or death of any people with whom you live.
- If the amount of money you pay toward household expenses changes.
- If your marital status changes: You get married, separated, divorced, or your marriage is annulled or you start living together after a separation.

**Income:**

- If the amount of money (or checks or any other type of payment) you receive from someone or someplace goes up or down.
- If you start to receive money (or checks or any other type of payment).
- If you start or stop work.
- If your earnings go up or down.

**Help You Get from Others:**

- If the amount of help (money, food, clothing, or payment of household expenses) you receive goes up or down.
- If someone stops or starts helping you.

**Things of Value that You Own:**

- If the value of your total resources goes over \$2,000 (\$3,000 if you are married and live with your spouse).
- If you sell or give away any things of value.
- If you buy or are given anything of value.

**CHANGES TO REPORT (continued)**

**You are Blind or Disabled:**

- If your condition improves or your doctor says you can return to work.
- If you stop or refuse any vocational rehabilitation services.
- If you go to work.

**Unmarried and Under Age 22:**

- If you are the parent of a child who receives CAPI benefits, you are to report if you or your child has a change in income, a change in marital status, a change in the value of anything the family owns, or if there is a change in residence.
- If the child starts or stops school.

**YOUR UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) STATUS CHANGES OR YOU BECOME A CITIZEN OF THE UNITED STATES.**

I understand my reporting responsibilities and agree to cooperate.

YOUR SIGNATURE/YOUR AUTHORIZED REPRESENTATIVE'S SIGNATURE:

\_\_\_\_\_ DATE: \_\_\_\_\_

FIRST WITNESS, IF MARKED WITH AN "X": \_\_\_\_\_

SECOND WITNESS, IF MARKED WITH AN "X": \_\_\_\_\_

**KEEP FOR YOUR RECORDS**  
**Important Information – Please Read Carefully**

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**CHANGES TO REPORT (continued)**

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