Solano County Health and Social Services Department

Your General Assistance appointment is scheduled for:

Day: ________________	**Date:** ________________	**Time:** ☐8:00 am ☐12:30 pm
Location: 365 Tuolumne St. Vallejo, CA 94590 on 2nd floor		

General Assistance Questionnaire

1. Are you married? ☐Yes ☐ No

   If yes: Is your spouse living with you? ☐Yes ☐ No
   If yes: You both must apply for General Assistance.

2. Do you have children younger than 18 years old? ☐Yes ☐ No

   If yes: Do they live with you? ☐Yes ☐No

3. Are you pregnant? ☐Yes ☐No

   If yes: When is your Due Date? ______/_______/__________

4. Do you have a source of income? ☐Yes ☐No

5. Do you have resources, such as a bank account?_☐Yes ☐No

   You must provide verification(s), such as a current bank statement.

6. Are you a student? ☐Yes ☐No

   If yes, are you attending ☐High school ☐College ☐ Other
   Name of school:____

7. Do you have a health problem or disability that prevents you from working? ☐Yes ☐No

8. Do you have a photo ID and Social Security Card? ☐Yes ☐No

9. Have you received GA from any County or State in the past 12 months? ☐ Yes ☐No

10. Are you incarcerated, or under house arrest? ☐ Yes ☐ No
    Individuals who are incarcerated / under house arrest can not get General Assistance.

General Assistance is a LOAN PROGRAM and you will have to repay what you receive.

Print Name: ______________________________	Date: ________________________
Address: ________________________________	City/Zip code: __________________
Social Security Number: ____________________	Date of Birth: __________________
Phone No. _______________________________	Message Number: ______________

Solano County Health & Social Services Department

APPLICATION FOR GENERAL ASSISTANCE

Applicant's Name ______________________________ Birthdate ______________________________
(last, first, middle)

Social Security Number ____________________ Telephone Number ______________________

Address ____
(number, street) (city) (zip)

Other Names Used ______________________ Do you intend to reside in Solano County? ☐Yes ☐No

Have you received General Assistance before? ☐Yes ☐ No If so, where and when?________________

Have you ever received CalWORKs or SSI/SSP before? ☐Yes ☐ No If so, where and when?________________

Have you timed out of CalWORKs?________________ ☐Yes ☐ No

Are you attending school or training? ☐ Yes ☐ No If so, where? ______________________

Have you received income this month? ☐ Yes ☐ No If yes, what income and how much? __________

Are you working? ☐ Yes ☐ No If so, where? ______________________

Did you receive a lump sum in the last 2 years? ☐ Yes ☐ No- If yes, what and when?______________________

Race and Ethnic information are optional. This won't affect your eligibility.

Are you of Hispanic, Latino or Spanish Origin? ☐ Yes ☐ No

If yes, do you consider yourself: ☐ Mexican ☐Puerto Rican ☐ Cuban ☐ Other

Race/Ethnic Origin ☐ White ☐ American Indian or Alaskan Native ☐ Black or African American
☐ Asian – if yes check one or more of the following: ☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian
☐ Asian Indian ☐ Laotian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan

---

CERTIFICATION AND PERJURY STATEMENT

I hereby make application for General Assistance in Solano County.

I understand that General Assistance is a loan program and I agree to repay Solano County all General Assistance that I receive that is not offset by participation in the Cal Fresh Employment and Training Program. I understand that this is a bonafide public debt, and I will report changes in my circumstances, within 5 days, to the Solano County Health and Social Services Department and will make arrangements to repay all amounts received when I am self-supporting.

I understand that I must sign a lien on all real property that I own, including my home. I understand that I must sign a lien on any SSI/SSP benefits that I have applied for. If and when my SSI/SSP application is approved, the General Assistance (GA) program will collect the amount of GA benefits I receive from my first SSI/SSP check.

I understand that I must look for work, if I am deemed employable, to receive my General Assistance benefits. I understand that I must provide proof if I am physically/mentally unable to work or to look for work. 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 that it is a crime to obtain or attempt to obtain General Assistance by making false statements or misrepresentations or by intentionally withholding information that would affect the amount of assistance to which I may be entitled. I understand that all information supplied by me may be verified. I understand that I may be prosecuted, fined or given jail time for any of the above activities.

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 is true, correct and complete.

Signature of applicant ______________________________ Date ______________

Signature of witness/interpreter ______________________________ Date______________

GA-1- original scanned in case, copy to applicant
Replaces SAWS1

How do I get and use my benefits?

CalFresh and General Assistance (GA) Cash aid:

- The County will mail or give you a plastic Electronic Benefit Transfer (EBT) card. Benefits will be put on the card when your application is approved. Sign your card when you get it. You will set up a Personal Identification Number (PIN) to get cash from ATMs or to buy food and/or other items.

- If your EBT card is lost, stolen, or destroyed, call (877) 328-9677 right away. Also, you may call the County right away. Make sure your authorized representative also knows how to report a lost or stolen EBT card or PIN. Any benefits taken from your account before you report the EBT card or PIN lost or stolen will **NOT** be replaced.

- You can use your CalFresh benefits to buy almost all foods, as well as seeds and plants to grow your own food. You cannot buy alcohol, tobacco, pet food, some types of cooked food, or anything that is not food (like soap, toothpaste, or paper towels).

- CalFresh benefits are accepted at most grocery stores and other places that sell food. GA cash aid can be used at most stores and most ATMs. Some ATMs may charge a fee. There may also be a fee if you use an ATM to get cash after three withdrawals. For a list of locations near you that accept EBT please go to: https://www.ebt.ca.gov or https://www.snapfresh.org. You can also find out where you can get cash without paying a fee.

- CalFresh benefits are only for you and your household members. Your GA cash aid is only for you and the members of your family who were approved for GA cash benefits. Your GA cash aid is to help meet the basic needs of your family (housing, food, clothing, etc.). Keep your benefits safe. Do not give out your PIN number. Do not keep your PIN number with your EBT card.

- Any use of your EBT card by you a household member, your authorized representative, or anyone you voluntarily give your EBT card and PIN to will be considered approved by you and any benefits taken from your account will **NOT** be replaced.

Solano County Health & Social Services Department

Applicant Clearance Form

First Name	Last Name	☐ Male ☐ Female	Date of Birth:
Previous (other) Name(s)			

List all persons living in the home					
Name/Social Security Number (SSN)	Requesting Aid?	Date of Birth (DOB)	Sex	Race/Ethnicity	Relationship to Applicant
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic: Race/Ethnic:	

List Absent Parent Name	DOB	Child's Name
		(More space on other side)

COUNTY USE ONLY

☐Call-In ☐Fairfield ☐ICT ☐Mail-In ☐ Online ☐Outstation/Out of Office ☐ Vacaville ☐Vallejo ☐Walk-In

MEDS: ☐ **Yes** ☐ **No Record** **Initials:**	**Case#**	**App#**	

Evaluator:

Initials/Worker #: **DATE:**

ES CF?	**IN CW?**	**MC Need?**	**Customer Request:**
Y N	**Y N**	**Y N**	☐**Face to Face Interview** ☐ **Phone Interview**

Beginning Date of Aid: ________________ ☐ Retro MediCal - Month/s and Year: ____________________

☐ Create new case ☐ Add to current case number: ____________ ☐ Companion case number: ____________

☐ Assign to Intake Rotation ☐ Assign to Eligibility worker number: ____________

☐ Packet mailed by Eligibility worker ☐ Clerical to mail packet

Additional notes for Clerical:

Solano County Health & Social Services Department

Applicant Clearance Form

Household Members, Cont.

List all persons living in the home					
Name/Social Security Number (SSN)	Requesting Aid?	Date of Birth (DOB)	Sex	Race/Ethnicity	Relationship to Applicant
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	
 SSN	Yes ☐ No ☐	Month/Day/Yr	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No Race/Ethnic:	

Notes for Eligibility Worker:

Solano County Health and Social Services Department

Employment and Eligibility Services Division

Name:____________________ Date:____________

INTAKE SUPPLEMENTAL QUESTIONNAIRE:

(to be filled by ALL clients completing an application for ALL programs)

** Please answer ALL questions: *Please check one

Question		
1. As of today's date, are you 60 years or older?	Yes	No
A. For Medi-Cal Applications only - Are you under 64 years old?	Yes	No
2. Are you declared disabled by Social Security?	Yes	No
3. Are you receiving Social Security Disability benefits?	Yes	No
4. Do you have Medi-Care? (Red, White and Blue card?)	Yes	No
5. Do you have a previous ODAS worker? (ODAS = Older and Disabled Adult Services)	Yes	No

Date of Birth ____________________ Case #. ____________________

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

AUTHORIZATION FOR REIMBURSEMENT OF INTERIM ASSISTANCE INITIAL CLAIM OR POSTELIGIBILITY CASE

NAME		SOCIAL SECURITY NUMBER
ADDRESS	CITY/TOWN	ZIP CODE
COUNTY IA AGENCY Solano County Health and Social Services		GR CODE 05580

For the purpose of this Authorization Form:

The term "State" means the California county interim assistance (IA) agency (s) that the California Department of Social Services has an interim assistance reimbursement agreement with and that paid you public assistance.

The term "SSI/SSP benefits" means "Supplemental Security Income/State Supplementary Payment" benefits under Title XVI of the Social Security Act.

What actions am I authorizing when I sign this authorization and I check the "Initial Claim Only" block?

☐ Initial Claim Only

You are authorizing the Commissioner of the Social Security Administration (SSA) to reimburse the State for some or all of the money the State gives you while SSA decides if you are eligible to receive SSI/SSP benefits. If you become eligible, SSA pays the State from the retroactive SSI/SSP benefits due you. The reimbursement covers the time from the first month you are eligible to receive SSI/SSP benefits through the first month your monthly SSI/SSP benefit begins.

If the State cannot stop the last payment made to you, SSA can reimburse the State for this additional payment amount.

What actions am I authorizing when I sign this authorization and I check the "Posteligibility Case Only" block?

☐ Posteligibility Case Only

You are authorizing the Commissioner of the Social Security Administration (SSA) to reimburse the State for some or all of the money the State gives you while SSA decides if your SSI/SSP benefits can be reinstated after being terminated or suspended. If your SSI/SSP benefits resume, SSA pays the State from the retroactive SSI/SSP benefits due you. The reimbursement overs the time from the day of the month the reinstatement is effective through the first month your monthly SSI/SSP benefit resumes.

If the State cannot stop the last payment made to you, SSA can reimburse the State for this additional payment amount.

How can the State use this form when blocks for initial claims and posteligibility cases are part of the form?

The State can use this form for one case situation at a time, either an initial claim or a posteligibility case: If both blocks are checked the form is not valid. You and the State must sign and date a new form with only one block checked.

What kind of State payment qualifies for reimbursement by SSA?

SSA can reimburse a State for a payment that is paid only from State or local funds. The State cannot be reimbursed for payments made wholly or partially from Federal funds.

How does SSA determine how much of my SSI/SSP money to pay the State?

SSA decides the amount of payment based on two considerations. First, SSA looks at the amount of money claimed by the State, and second, SSA looks at the amount of your retroactive SSI/SSP money available to pay the State. SSA can reimburse the State for a payment made in a month only when you receive a State payment and an SSI/SSP payment for the same month. SSA will not pay the State more money than you have for the SSI/SSP retroactive period.

How long is this authorization effective for the State and me if I checked the "Initial Claims Only" block?

This authorization is in effect for you and the State for twelve (12) months. The 12 months begin with the date SSA receives the authorization from the State and end 12 months later. However, for a State using an electronic system, the 12 months begin with the date the State notifies SSA through an electronic system that the State has received the authorization and end 12 months later. You and a State representative must sign and date the authorization for the authorization to be valid.

Exceptions apply to this rule. The State must send SSA the authorization within a certain time frame. SSA must receive the form within 30 calendar days of the date you signed the authorization. If the form is late, SSA will not accept the form as a valid authorization. For the State using an electronic system, SSA must receive the authorization information within 30 calendar days of the state matching your SSI record with your state record. If the information is late, SSA will not accept the information sent by the State. SSA will not pay any of your retroactive SSI/SSP benefits to the State. SSA will send you any SSI/SSP money that may be due you, based on SSA's regular payment rules.

Can the authorization stay effective longer than the 12-month period? Can the authorization end before or after the 12-month period ends?

The authorization can stay effective longer than the 12-month period, if you

- apply for SSI/SSP benefits before the State has the authorization form, or
- apply within the 12-month period the authorization is effective, or
- file a valid appeal of SSA's determination on your initial claim.

The period of the authorization can end before the 12-month period ends, or end after the 12-month period ends when any of these actions take place:

- SSA makes the first SSI/SSP payment on your initial claim; or
- SSA makes a final determination on your claim; or
- the State and you agree to terminate this authorization.

The authorization period will end with the day of the month any of these actions take place.

How long is this authorization effective for the State and me if I check the "Posteligibility Case Only" block?

This authorization is in effect for you and the State for twelve (12) months. The 12 months begin with the date SSA receives the authorization from the State and end 12 months later. However, for a State using an electronic system, the 12 months begin with the date the State notifies SSA through an electronic system that the State has received the authorization and end 12 months later. You and a State representative must sign and date the authorization for the authorization to be valid.

Exceptions apply to this rule. The State must send SSA the authorization within a certain time frame. SSA must receive the form within 30 calendar days of the date you signed the authorization. If the form is late, SSA will not accept the form as a valid authorization. For a State using an electronic system, SSA must receive the authorization information within 30 calendar days of the State matching your SSI record with your State record. If the information is late, SSA will not accept the information sent by the State. SSA will not pay any of your retroactive SSI/SSP benefits to the State. SSA will send you any SSI/SSP money that may be due you, based on SSA's regular payment rules.

Can the authorization stay effective longer than the 12-month period? Can the authorization end before or after the 12-month period ends?

The authorization can stay in effect longer than the 12-month period if you file a valid appeal. You must file your appeal within the time frame SSA requires.

The period of the authorization can end before the 12-month period ends, or can end after the 12-month period ends when any of these actions take place:

- SSA makes the first SSI/SSP payment on your posteligibility case after a period of suspension or termination; or
- SSA makes a final determination on your appeal; or
- the State and you agree to terminate this authorization.

The authorization period will end with the day of the month any of these actions take place.

Can SSA use this authorization form to protect my filing date for SSI/SSP benefits?

SSA can use this form to protect your filing date if you checked the "Initial Claims Only" block. When you sign this form, you are saying that you have the intention of filing for SSI/SSP benefits if you have not already applied for benefits.

You have sixty (60) days from the date the State receives this form to file for SSI/SSP benefits. Your eligibility to receive SSI/SSP benefits can be as early as the date you sign this authorization if you file within the 60-day time period. If you file for SSI/SSP benefits after the 60-day time period, this form will not protect your filing date. Your filing date will be later than the date you sign this form.

How do I appeal the State's decision if I do not agree with the decision?

You can disagree with a decision the State made during the reimbursement process. You will receive the State notice telling you how to appeal the decision. You cannot appeal to SSA if you disagree with any State decision.

Within 10 working days after the State receives the reimbursement money from SSA, the State must send you a notice. The notice will tell you three things: (1) the amount of the payments the State paid you; (2) that SSA will send you a letter explaining how SSA will pay the remaining SSI/SSP money (if any) due you, and (3) about your right to a hearing with the State, including how to request the State hearing.

SIGNATURE OF INDIVIDUAL RECEIVING INTERIM ASSISTANCE	DATE
SIGNATURE OF STATE REPRESENTATIVE	DATE

If the applicant signs this application with a mark, the signature must have two witnesses who provide their signatures, addresses, and the dates they signed below.

WITNESSED BY:			WITNESSED BY:		
ADDRESS (#, STREET):			ADDRESS (#, STREET):		
CITY	STATE	ZIP	CITY	STATE	ZIP

Solano County Health & Social Services Department

Language Services Needs Request

Customer Notification

Interpreter Confidentiality and Release of Information

:ase Name: ________________________ Case #: ______________________ Date: __________________

:ustomer:

authorize release of my case information as needed while using an interpreter. This release is valid for one year nless I notify the county otherwise. I have been informed of problems that could occur when using an interpreter, and will ask if I am unsure of anything. I also understand that I can request another interpreter at any time.

- ❑ I understand that the Solano County Health and Social Services Department has an obligation to provide me with a bilingual worker, interpreter or other interpretive services in my preferred language.
- ❑ I speak, write and understand the English language and do not need special language services.
- ❑ **I understand that I can leave a voicemail message for my worker in my own language.**
- ❑ My preferred language is ________________, but I would like letters and forms in English.
- ❑ I have brought my own interpreter for today and wish to use him/her instead of using the Health & Social Services language services. I understand that by signing this document, I do not waive my future right to receive services from a bilingual worker, interpreter or other interpreter service provided by Health & Social Services Department.
- ❑ I request that the Solano County Health and Social Services Department provide me with a bilingual worker, interpreter or other interpretive services in my preferred language of ______________________.
- ❑ I would like letters and forms in my preferred language of ______________________.

______________________________ ______________________________

:ustomer's Printed Name Customer's Signature

nterpreter:

understand and can speak English and ________________, I swear to interpret between the ____________ ınguage and the English language as literally and as accurately as possible without changing, adding to or detracting ·om the facts. I understand the content of material/information being translated is confidential and all information is) be treated with strict privacy according to the confidentiality requirements of Welfare and Institutions (W&I) Code ection 10850, and HIPAA (Health Insurance Portability & Accountability Act)

______________________________ ______________________________

ıterpreter's Printed Name Interpreter's Signature

County Employee Completes This Section

taff Member:

have informed the customer of potential problems that could occur while using an interpreter. I have also explained) the interpreter, the importance of keeping all information confidential. If I feel improper translation is occurring, I /ill ask another staff member who is bilingual in the ____________ language, to ensure/confirm the information is eing interpreted accurately.

- ❑ The services of a bilingual worker or interpreter were not needed.
- ❑ I am certified Bilingual worker in the language chosen by the client.
- ❑ Bilingual services were provided by: (check one) Certified bilingual staff CTS Language Link Kelly Temp Interpreter Client provided interpreter One time use of a child under the age of 13 due to an emergency situation.

______________________________ ______________________________

taff Member's Printed Name Staff Member's Signature

'ou may file a complaint with the Civil Rights Coordinator if you were denied services of a bilingual worker or interpreter, r if you were not given forms or letters in your preferred language. You may do this by telephoning the Civil Rights :oordinator, Stephan Betz at (707) 784-8500.

Case Name: ______________________ Case #: ______________________
Additional Interpreters assisted on this Date: ______________________

______
Customer's Initials

Interpreter:
I understand and can speak English and ______________. I swear to interpret between the ________ language and the English language as literally and as accurately as possible without changing, adding to or detracting from the facts. I understand the content of material/information being translated is confidential and all information is to be treated with strict privacy according to the confidentiality requirements of Welfare and Institutions (W&I) Code Section 10850, and HIPAA (Health Insurance Portability & Accountability Act).

______________________ ______________________
Interpreter's Printed Name Interpreter's Signature

______
Customer's Initials

Interpreter:
I understand and can speak English and ______________. I swear to interpret between the ________ language and the English language as literally and as accurately as possible without changing, adding to or detracting from the facts. I understand the content of material/information being translated is confidential and all information is to be treated with strict privacy according to the confidentiality requirements of Welfare and Institutions (W&I) Code Section 10850, and HIPAA (Health Insurance Portability & Accountability Act).

______________________ ______________________
Interpreter's Printed Name Interpreter's Signature

______
Customer's Initials

Interpreter:
I understand and can speak English and ______________. I swear to interpret between the ________ language and the English language as literally and as accurately as possible without changing, adding to or detracting from the facts. I understand the content of material/information being translated is confidential and all information is to be treated with strict privacy according to the confidentiality requirements of Welfare and Institutions (W&I) Code Section 10850, and HIPAA (Health Insurance Portability & Accountability Act).

______________________ ______________________
Interpreter's Printed Name Interpreter's Signature

Instructions: Complete the back of the 48-12-324 when using additional interpreters during the same visit. If additional interpreters are used, explain to the client why additional interpreters are assisting and have the client(s) initial for each additional interpreter.

File: Original-Top Upper Right
Copies-Client, Interpreter

Solano County Health & Social Services Department

lental Health Services
ublic Health Services
ubstance Abuse Services
'lder & Disabled Adult Services

Employment and
Eligibility Services
Children's Services
Administrative Services

Gerald Huber, Director

Employment and Eligibility Services Division
Angela Shing, Deputy Director

'75 Beck Avenue, Mail Station 5-150
airfield, California 94533

Office: 707-553-5173
Fax: 707-553-5827

Text Messaging Authorization Form

Would you like to receive text message reminders from Solano County Health & Social Services about your benefits? Solano County H&SS is offering a reminder service for periodic reports and yearly renewals by text message to your cell phone. This service is optional. You will continue to receive notices by mail whether or not you choose to receive text messages reminders.

Solano County H&SS will not share your contact information with outside partners, nor contact you by text message without your consent.

Please be advised of the following:

- Communication providers and anyone with access to your cell phone may be able to see your text messages.
- You may be charged for these text messages depending on your service plan.

You can stop receiving these messages from Solano County at any time by:

- Text *STOP* in response to any message (this option may take up to 45 days to be processed).
- Call your worker or the number listed on your notices and ask them to disable the feature.

By signing below, you give Solano County H&SS permission to contact you about periodic reports, renewals, and other important program information via cell phone text message.

I would like to receive ***text*** messages & reminders from Solano County H&SS

☐ YES ☐ NO

I understand that these services are optional and that I can stop participating at any time.

Cell Phone # ______________________ Case # (If known ______________

Printed Name ______________________ Date of Birth ______________

Signature ______________________ Date ______________