CLAIM DETERMINATION WORKSHEET

CASE TRANSFER STATUS: ☐ TO ☐ FROM

CASE NUMBER:

CASE NUMBER:

1. CASE NAME	3. HEAD OF HOUSEHOLD *(IF DIFFERENT)*	4. ANOTHER ADULT	5. ANOTHER ADULT
2. CASE NUMBER	SSN	SSN	SSN
6. DATE OF DISCOVERY / 7. CF CASE STATUS: ☐ ACTIVE ☐ DISCONTINUED	ADDRESS *(PO BOX/STREET)*	ADDRESS	ADDRESS
	(CITY, ZIP)	(CITY, ZIP)	(CITY, ZIP)

8. BASIS FOR CLAIM DETERMINATION:

☐ ADMINISTRATIVE ERROR

☐ INADVERTENT HOUSEHOLD ERROR

☐ POTENTIAL IPV

9. EFF. DATE OF DISQUALIFICATION

10. EXPLANATION OF OVERISSUANCE *(IF APPLICABLE, INCLUDE DATE CHANGE OCCURRED AND DATE REPORTED)*

11. SUMMARY OF CALFRESH OVERISSUANCE

ISSUANCE MONTH/YEAR	ACTUAL BASIS FOR ISSUANCE			CORRECT BASIS FOR ISSUANCE			ISSUANCE VERIFICATION			
	HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	ATP / HIR	DMI	OTHER	REDEMPTION
Continue on reverse		11a Total ▶			11b Total ▶					

DOCUMENTATION

12. Total CalFresh overissuance *(subtotal if continued on reverse)* — 11a Minus 11b ▶

13. Claim offsetting lost benefits not restored.

	DATE:	DATE:
A. Total CalFresh overissuance (from 12 above).		
B. Minus lost benefits not restored.		
C. Minus payment received.		
D. Amount of CalFresh claim to be collected.		

ELIGIBILITY WORKER *(SIGNATURE)*	DATE	SUPERVISOR *(SIGNATURE)*	DATE	REVIEW OFFICER *(APPROVAL SIGNATURE)*	DATE

ACTION *(PLANNED/TAKEN)*

14. Summary of CalFresh overissuance (Continuation) > Include all other overissuance months not listed on the front.

ISSUANCE MONTH/YEAR	ACTUAL BASIS FOR ISSUANCE			CORRECT BASIS FOR ISSUANCE			ISSUANCE VERIFICATION			
	HOUSEHOLD SIZE	ADJUSTED INCOME	BONUS/ALLOTMENT	HOUSEHOLD SIZE	ADJUSTED INCOME	BONUS/ALLOTMENT	ATP / HIR	DMI	OTHER	REDEMPTION
Total this page		14a Subtotal ▶			14b Subtotal ▶		DOCUMENTATION			
Total first page		11a Subtotal ▶			11b Subtotal ▶					
15. Total both pages		15a Total (14a + 11a) ▶			15b Total (14b + 11b) ▶					

16. Total CalFresh overissuance ▶ 11a Minus 11b ▶

17. Claim offsetting lost benefits not restored.	DATE:	DATE:
A. Total CalFresh overissuance (from 16 above).		
B. Minus lost benefits not restored.		
C. Minus payment received.		
D. Amount of CalFresh claim to be collected.		

ELIGIBILITY WORKER *(SIGNATURE)*	DATE	SUPERVISOR *(SIGNATURE)*	DATE

DOCUMENTATION