STATEMENT OF FACTS FOR IN-HOME SUPPORTIVE SERVICES

Note: *Your eligibility for In-Home Supportive Services (IHSS), under Welfare and Institutions Code Section 12300, will be determined by the information you provide on this form.*

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1. APPLICANT INFORMATION

NAME (FIRST, MIDDLE, LAST) | BIRTHDATE

HOME ADDRESS | CITY | ZIP CODE

MAILING ADDRESS (IF DIFFERENT) | HOME PHONE ( ) | MESSAGE PHONE ( )

PLACE OF BIRTH | SOCIAL SECURITY NUMBER | MEDI-CAL CARD NUMBER

ARE YOU:
☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

MARITAL STATUS:
☐ SINGLE ☐ MARRIED (Date___/___/___) ☐ SEPARATED (Date___/___/___) ☐ WIDOWED (Date___/___/___) ☐ DIVORCED (Date___/___/___)

COMPLETE THE FOLLOWING:

NAME OF SPOUSE OR PARENT(S) *(IF YOU ARE UNDER 18 YEARS OF AGE)*

IS SPOUSE/PARENT(S):
☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

SPOUSE/PARENT(S) SOC. SEC. NO. | SPOUSE/PARENT(S) ADDRESS *(IF DIFFERENT THAN APPLICANT'S)*

2. DO YOU RESIDE IN CALIFORNIA WITH THE INTENTION TO CONTINUE RESIDING HERE?

☐ YES ☐ NO

3. ARE YOU A CITIZEN OF THE UNITED STATES?

(IF "YES", GO TO "ITEM 4")

☐ YES ☐ NO

(A.) IF YOU ARE NOT A UNITED STATES CITIZEN, ARE YOU LAWFULLY ADMITTED TO PERMANENT RESIDENCE OR LEGALLY PERMITTED TO REMAIN IN THE U S.?

☐ YES ☐ NO

(B.) WHAT IS YOUR ALIEN REGISTRATION NUMBER?

(C.) WHAT IS NAME OF SPONSOR?

(D.) WHAT IS SPONSOR'S ADDRESS?

4. WHAT IS YOUR LIVING ARRANGEMENT?

MY HOME IS A: ☐ HOUSE ☐ APARTMENT ☐ ROOM ☐ ROOM & BOARD ☐ TRAILER/ MOTOR HOME ☐ OTHER

IN WHICH I: ☐ OWN/ AM BUYING ☐ RENT ☐ LIVE COST FREE ☐ RECEIVE BOARD AND CARE

LANDLORD'S NAME | AMOUNT OF RENT, BOARD AND/OR MORTGAGE PAID $_____/MONTH

ADDRESS | CITY | ZIP CODE

5. ARE THERE OTHERS LIVING IN THE HOUSEHOLD?

(IF "YES", GIVE THE INFORMATION BELOW:)

☐ YES ☐ NO

NAME	RELATIONSHIP	AGE

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6. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN REAL PROPERTY OTHER THAN YOUR HOME? *(If "YES", GIVE THE INFORMATION BELOW: OR ON PAGE 4 PARAGRAPH 21.)* ☐ YES ☐ NO

ADDRESS	CITY	COUNTY

STATE	ZIP CODE	PARCEL NUMBER

ASSESSED VALUE	TOTAL AMOUNT OWED ON MORTGAGE(S)	MONTHLY PAYMENT
$	$	$

ANNUAL TAXES	ANNUAL INSURANCE	ANNUAL ASSESSMENTS
$	$	$

HOW IS PROPERTY UTILIZED?	IF USED AS RENTAL, INDICATE AMOUNT OF RENT.	ARE TAXES INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

OTHER PROPERTY EXPENSES	IS INSURANCE INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

7. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN MOTOR VEHICLES (CARS, TRUCKS, MOTORCYCLES, BOATS, MOTORHOMES)? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

MAKE AND MODEL	YEAR	ESTIMATED VALUE	CHECK IF USED FOR WORK	CHECK IF USED FOR MEDICAL TRANS.	MODIFIED FOR DISABLED PERSON?

8. WHAT IS THE VALUE OF YOUR LIQUID RESOURCES?
(IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE RESOURCES OF PARENT(S) RESPONSIBLE FOR CHILD, INDICATE IF ANY RESOURCE IS EXCLUSIVELY FOR BURIAL EXPENSES FOR YOU OR YOUR IMMEDIATE FAMILY.)

LIQUID RESOURCES	(✓) IF NONE	ENTER VALUE UNDER OWNER: SELF	SPOUSE/PARENTS	JOINTLY	(✓) FOR BURIAL
CASH ON HAND AND/OR MONEY KEPT IN THE HOME		$	$	$	
CHECKING ACCOUNT		$	$	$	
SAVINGS ACCOUNT, CREDIT UNION TRUST FUNDS		$	$	$	
CHECKS OR CASH IN SAFETY DEPOSIT BOX		$	$	$	
STOCKS, BONDS, OR MUTUAL FUNDS NOTES, MORTGAGES, DEEDS		$	$	$	
IRA, CERTIFICATES OF DEPOSIT, MONEY MARKET		$	$	$	
OTHER *(SPECIFY):*		$	$	$	

9. DO YOU, YOUR SPOUSE OR PARENT(S) (IF APPLICANT IS UNDER 18) HAVE ANY PERSONAL GOODS OR HOUSEHOLD EFFECTS WITH A COMBINED EQUITY VALUE OF MORE THAN $2,000? (E. G., HOUSEHOLD FURNISHINGS, CLOTHING, AND JEWELRY.) *(IF ADDITIONAL SPACE IS NEEDED, SPECIFY IN ITEM 21.)*
(IF "YES", GIVE INFORMATION BELOW:) (EXCLUDE REHABILITATION DEVICES AND EQUIPMENT.) ☐ YES ☐ NO

DESCRIPTION	CURRENT MARKET VALUE	AMOUNT OWED
A.	$	$
B.	$	$
C.	$	$

10. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY LIFE INSURANCE? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

NAME OF OWNER	NAME OF INSURED	NAME AND ADDRESS OF INSURANCE COMPANY

POLICY NUMBER	TOTAL FACE VALUE OF POLICY	CASH SURRENDER VALUE	WHEN WAS THE POLICY PURCHASED	IF THERE IS A LOAN AGAINST THE POLICY WHAT IS THE AMOUNT

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11. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BURIAL FUNDS, INSURANCE, TRUSTS, SPACES OR CONTRACTS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

OWNER OF EACH ITEM	NAME OF EACH ITEM	TOTAL PURCHASE VALUE OF EACH ITEM	HOW MUCH IS OWED ON EACH ITEM	NAME AND ADDRESS OF COMPANY/SOURCE
			$	
			$	

12. HAVE YOU, YOUR SPOUSE OR PARENT(S) (IF A MINOR IS APPLYING) SOLD, TRANSFERRED OR GIVEN AWAY ANY PROPERTY, INCLUDING MONEY, IN THE LAST 36 MONTHS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	DATE OF TRANSFER	ESTIMATED VALUE	AMOUNT RECEIVED
		$	$
		$	$

13. ARE YOU OR YOUR SPOUSE EMPLOYED OR SELF—EMPLOYED? *(IF "YES", GIVE THE INFORMATION BELOW:) (IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER I8 INCLUDE EMPLOYMENT OF PARENT(S).)* ☐ YES ☐ NO

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	
OCCUPATION	GROSS SALARY PER PAY PERIOD $	HOW OFTEN PAID?

IF SELF-EMPLOYED, ATTACH VERIFICATION OF ALL ORDINARY AND NECESSARY BUSINESS EXPENSES, PRINCIPAL PAYMENTS OR ENCUMBRANCES AND PERSONAL INCOME TAX.

14. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BUSINESS EQUIPMENT INVENTORY, OR MATERIAL? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	PURPOSE	ESTIMATED VALUE	AMOUNT OWED
		$	$
		$	$

15. IF YOU ARE BLIND OR DISABLED AND WORKING, DO YOU HAVE ANY WORK—RELATED EXPENSES DUE TO BLINDNESS OR DISABILITY? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

COST OF TRANSPORTATION TO AND FROM WORK	COST OF ITEMS OR SERVICES TO PREPARE FOR WORK	COST OF ITEMS OR SERVICES NEEDED FOR JOB PERFORMANCE
$	$	$

16. LIST INCOME RECEIVED EACH MONTH FROM SOURCES OTHER THAN EMPLOYMENT. IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE INCOME OF PARENT(S) RESPONSIBLE FOR CHILD.

TYPE OF INCOME	(✓) NONE	ENTER MONTHLY AMOUNT RECEIVED BY: SELF	SPOUSE/PARENT(S)	CLAIM NUMBER
A. SOCIAL SECURITY *(RETIREMENT, SURVIVOR, DISABILITY INSURANCE)*		$	$	
B. CASH CONTRIBUTIONS		$	$	
C. STATE DISABILITY/ UNEMPLOYMENT INSURANCE		$	$	
D. VETERAN'S PENSION/COMPENSATION		$	$	
E. V.A. AID AND ATTENDANCE CARE/ HOUSEBOUND ALLOWANCE		$	$	
F. GOVERNMENT PENSION		$	$	
G. PRIVATE AND/OR MILITARY RETIREMENT PENSION		$	$	
H. ALIMONY, CHILD SUPPORT		$	$	
I. RENTAL INCOME		$	$	
J. INTEREST, DIVIDENDS, ROYALTIES		$	$	
K. RAILROAD RETIREMENT PENSION		$	$	
L. WORKER'S COMPENSATION		$	$	
M. AFDC PAYMENTS		$	$	
N. OTHER: *(SPECIFY)*		$	$	

17. HAVE YOU, YOUR SPOUSE OR YOUR PARENT(S) APPLIED FOR OR DO YOU EXPECT TO START RECEIVING INCOME FROM ANY OF THE SOURCES LISTED IN "ITEM 16"? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW:)

TYPE OF INCOME	PLACE APPLIED	DATE APPLIED	DATE EXPECTED

18. HAVE YOU, YOUR SPOUSE OR YOUR PARENTS HAD MEDICAL EXPENSES WITHIN THE LAST 3 MONTHS AND WANT MEDI-CAL FOR THOSE EXPENSES? ☐ YES ☐ NO

19. (A.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE ANY NON-CASH GIFTS OR CONTRIBUTIONS OF RENT, FOOD, CLOTHING OR OTHER ITEMS OF NEED? ☐ YES ☐ NO

(B.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE NON-CASH COMPENSATION IN RETURN FOR WORK? ☐ YES ☐ NO

(IF "YES" TO "(A)" OR "(B)", GIVE THE INFORMATION BELOW:)

ITEM CONTRIBUTED	FREQUENCY OF RECEIPT	CASH EQUIVALENT
		$
		$

20. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE HEALTH OR HOSPITALIZATION INSURANCE (INCLUDING PAID BY AN EMPLOYER)? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW:)

INSURANCE CARRIER (CHECK APPLICABLE(S))	PERSON(S) INSURED
☐ MEDICARE *(CLAIM NO.)*	
☐ CHAMPUS	
☐ VETERAN'S ADMINISTRATION COVERAGE	
☐ KAISER	
☐ ROSS—LOOS	
☐ BLUE SHIELD	
☐ BLUE CROSS	
☐ PREPAID HEALTH PLAN	
☐ HEALTH MAINTENANCE ORGANIZATION *(SPECIFY:)*	
☐ OTHER CARRIER *(SPECIFY:)*	

21.

ITEM NUMBER	ADDITIONAL INFORMATION (ATTACH ADDITIONAL SHEETS IF NECESSARY)

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EXPECTED INCOME

How Verified:

a. _____

b. _____

c. _____

IN-KIND INCOME

30-775.11

How Verified: _____

_____

_____

_____

_____

PREMIUM PAYMENTS

Amount Paid: $ _____

How often: _____

How Verified: _____

_____

_____

_____

_____

SOC 310 VERIFICATION

☐ ELIGIBLE ☐ INELIGIBLE

REASON (IF INELIGIBLE):

SOCIAL SERVICE WORKER:

DATE:

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I HEREBY STATE BY MY SIGNATURE THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

I AGREE TO TELL THE COUNTY DEPARTMENT OF SOCIAL SERVICES WITHIN 10 DAYS IF THERE ARE ANY CHANGES IN MY INCOME, POSSESSIONS. OR EXPENSES, OR IN THE NUMBER OF PERSONS IN MY HOUSEHOLD, OR IF ANY CHANGE OF ADDRESS. AND I AGREE TO MEET ALL OTHER RESPONSIBILITIES EXPLAINED IN THE "MEDI–CAL RESPONSIBILITIES CHECKLIST" I HAVE RECEIVED.

I UNDERSTAND THAT I MAY BE ASKED TO PROVE MY STATEMENTS, BUT THAT THE COUNTY IS REQUIRED BY LAW TO KEEP THEM CONFIDENTIAL.

I UNDERSTAND THAT IF I AM DISSATISFIED WITH ANY ACTIONS TAKEN BY THE COUNTY DEPARTMENT OF SOCIAL SERVICES, I HAVE THE RIGHT TO A STATE HEARING.

I UNDERSTAND THAT I MUST DISPOSE OF ANY EXCESS RESOURCES WITHIN A SIX–MONTH PERIOD IN THE CASE OF REAL PROPERTY AND WITHIN THREE MONTHS IN THE CASE OF PERSONAL PROPERTY AND REPAY ANY OVERPAYMENTS WITH THE PROCEEDS OF THE DISPOSED PROPERTY.

I UNDERSTAND THAT IF I AM ELIGIBLE FOR IHSS SERVICES, I WILL BE PROVIDED A MEDI–CAL CARD AT NO SHARE–OF–COST TO ME IF I PAY THE IHSS SHARE OF COST I AM OBLIGATED TO PAY.

I UNDERSTAND THAT FEDERAL AND STATE LAW REQUIRE THE RECOVERY OF ALL MEDI-CAL BENEFITS RECEIVED AFTER AGE 55 FROM THE ESTATE OF A MEDI–CAL BENEFICIARY IF THERE IS NO SURVIVING SPOUSE, MINOR CHILDREN, OR PERMANENTLY AND TOTALLY DISABLED CHILDREN.

I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF WITNESS *(REQUIRED IF APPLICANT SIGNED BY MARK)*	DATE
SIGNATURE OF PERSON ACTING FOR APPLICANT (RELATIONSHIP: PARENT, GUARDIAN, CONSERVATOR)	DATE	SIGNATURE OF PERSON HELPING APPLICANT COMPLETE FORM	DATE