QUARTERLY REPORT
For Cash Aid and CalFresh

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

THIS REPORT IS FOR THE MONTH OF

COMPLETE, SIGN AND RETURN THIS FORM BY THE 5TH OF THE MONTH AFTER THE **REPORT** MONTH

(Bar Code)

CASE NAME:
CASE NUMBER:
FILE/UNIT NUMBER:
WORKER PHONE:

NEED HELP? CALL YOUR WORKER

MAIL BACK TO ADDRESS:

ADDRESSEE:

- ✓ **You must report all of the income received in the Report Month of _____.**
- ✓ If you do not send in a complete QR 7 report, including but not limited to, answering all questions and attaching proof when the question says to attach proof, your benefits may be delayed, changed, or stopped. **Attach a separate sheet of paper if needed.** Facts you report may result in your benefits going up, down or stopped.
- ✓ For CalWORKs and CalFresh, you must notify the county within **10 days** of any change that may affect your eligibility for, or the amount of your benefits. **This includes contacting your Worker when your income goes above this amount $_____ for your AU size of _____. For GR, you must report your changes within 5 days.**
- ✓ If you get CalFresh benefits, answer for everyone in your household. If you do not get CalFresh benefits, answer for everyone on cash aid, including children, parents, stepparents, your spouse, and anyone absent temporarily from the home.

Request to Stop Benefits (if you fill in this part, sign and date the back of this form. You can reapply at any time.)
I ask that my: ☐ Cash Aid ☐ CalFresh ☐ Medi-Cal ☐ State CMSP be stopped on the last day of: _____ (MONTH/YEAR)

PART 1: Please tell us what happened in _____ _____
REPORT MONTH YEAR

1. Did you or anyone get any income or money from any source this MONTH? If "YES", list below and ATTACH PROOF ☐ **YES** ☐ **NO**

Earnings: Babysitting, interest or dividends, rental income, salary, self-employment, sick pay, tips, vacation pay, etc. **Any Government Benefits:** State Disability Indemnity (SDI), Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), other government disability or retirement, rental assistance, unemployment, veteran's retirement, Worker's Compensation (UIB), etc, . **Other Benefits:** Child/spousal support, insurance or legal settlements, other private disability or retirement, railroad retirement, strike benefits, etc. **Other:** Cash, gifts, loans, scholarships, etc. **Income In-Kind:** Such as earned housing, free housing/utilities/clothing/food, etc.

Who got the income?	From?	Gross amount	$	$	$	$	$
		Date received					
Who got the income?	From?	Gross amount	$	$	$	$	$
		Date received					

1a. Number of hours worked or in training in this MONTH:

Who worked?	Where?	Total Hours	Who worked?	Where?	Total Hours
Who trained?	Where?	Total Hours	Who trained?	Where?	Total Hours

1b. If the income or money reported above will change in the next three months after the SUBMIT MONTH, please explain and ATTACH PROOF.

Name of person	Source of income or money	Why will it change?	How much will you get?		
			First Month	Second Month	Third Month

Questions 2, 3, 4, and 5 may help you get more CalFresh benefits

2. Medical Costs: Did anyone who gets CalFresh benefits and is disabled or 60 years or older pay medical costs? ☐ **YES** ☐ **NO**
If "Yes", list the amount paid below and **ATTACH PROOF** of payment.

Who paid?	Who gets care?	Amount $

3. Dependent Care: Did anyone who gets CalFresh benefits pay for the care of a child, disabled person, or other dependent while working, seeking work, or attending school or training? ☐ **YES** ☐ **NO** If "YES", list the amount paid and attach proof.

Who paid?	Who gets care?	Amount $

COUNTY USE ONLY EW Initials: CHANGE ( ) NO CHANGE ( ) Date:

REPORT WELFARE FRAUD
CALL HOTLINE (800) 349-9970

4. Child Support: Did anyone who gets CalFresh benefits pay court-ordered child support? ☐ YES ☐ NO
If "YES", list the amount paid below and **ATTACH PROOF** of payment.

Who paid?	Amount $	Who paid?	Amount $

5. If the information in Question 2, 3, or 4 will change in the next three months after the SUBMIT MONTH, check the box(es) below, please explain and **ATTACH PROOF.**

Medical Costs	Who pays?	Amount $	Who gets care?	What changed?	When will it change?
Dependent Care	Who pays?	Amount $	Who gets care?	What changed?	When will it change?
Court-Ordered Child Support	Who pays?	Amount $	For whom?	Attach new court order	When will it change?

PART 2: What Has Happened *SINCE* Your Last Report?

6. Did anyone get, buy, sell, trade, or give away any property [land, home, cars, bank accounts, money payments (such as: lottery or casino winnings, retroactive social security, tax refunds), other]? If "YES", list all items below and **ATTACH PROOF.** ☐ YES ☐ NO

Who owns, sold, traded, or gave away?	Type of Property	When?	Value $	☐ Bought	☐ Sold	☐ Won
				☐ Gift Received	☐ Traded	☐ Gave Away

Checking Account ☐ Opened ☐ Closed Balance $ | Savings Account ☐ Opened ☐ Closed Balance $

7. Has anyone moved into or out of your home, or did you move in with someone else? ☐ YES ☐ NO

Full name of person	Relationship to you	Moved in or out?	When?

8. Has anyone in your home been convicted of a drug-related felony for possession, use or distribution; avoiding or running from any felony prosecution, custody, or confinement; or in violation of probation or parole? ☐ YES ☐ NO
If "YES", name: Where convicted? Date of conviction:

9. Have any of the following or any other changes happened to anyone in your home? ☐ YES ☐ NO
If "YES", list below and **ATTACH PROOF.** Attach a separate sheet of paper if needed.

☐ **Family Change** [Married, divorced, separated, registered as a California Domestic Partnership (DP), have a non-California DP, ended a DP, became pregnant, had a baby, or no longer pregnant?]

☐ **Disability** (Became disabled or recovered from a disability or major illness?)

☐ **Work** (Started or stopped working, refused a job or training, number of hours worked or in training went up or down, or went out on strike?)

☐ **Immigration** (Citizenship or immigration status change, or got a new card, form, or letter from USCIS/INS?)

☐ **Insurance** (Started, stopped, or changed health, dental, or life insurance benefits, including MEDICARE?)

☐ **Custody** (Any change in the amount of time you care for/have custody of your children?)

☐ **In-Home Supportive Services** (Started or stopped getting services?)

☐ **School Attendance**
- **For Cash Aid Only – Student age 6-18** stopped or started attending school regularly?
- **Age 16 or older student** started or stopped school/college. (You may be able to claim costs for books, school transportation, etc.)

☐ **Other:**

Name of person (s)	Relationship to you	What happened?	Date of change

ADDRESS CHANGE

Fill in this section **ONLY** if you have moved or have a new mailing address. If you are getting CalFresh benefits, you may be asked to provide proof of your new shelter costs.

NEW Home Address (Number, Street Name, Avenue, Blvd., Etc.) Apt. No.	City	State	Zip Code	New Phone Number ( )

Date Moved	NEW Mailing Address (if different from Home Address)	City	State	Zip Code

Do you have housing costs at this new address? ☐ YES ☐ NO If yes, how much $

Do you have to pay heating/cooling costs separate from your housing cost? ☐ YES ☐ NO If yes, how much? $

CERTIFICATION – FRAUD WARNING

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I may also be charged with committing a felony if more than $400 in Cash Aid, and/or CalFresh benefits is wrongly paid out as a result of such action. I have received a copy of the Instructions and Penalties for the Eligibility/Status Report for Cash Aid and CalFresh.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE MONTH THIS REPORT IS FOR OR IT WILL BE CONSIDERED INCOMPLETE.
I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW: **For Cash Aid:** you and your aided spouse, domestic partner, and the other parent (of cash-aided children) if living in the home.
CalFresh benefits: the head of household, a responsible household member or the household's authorized representative.

SIGNATURE OR MARK	DATE SIGNED	HOME PHONE ( )	CONTACT/CELL PHONE ( )
SIGNATURE OF SPOUSE, DOMESTIC PARTNER OR OTHER PARENT OF AIDED CHILD(REN)	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR OTHER PERSON COMPLETING FORM	DATE SIGNED