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 <u>LOAN PROGRAM</u> 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

SHADED AREAS ARE FOR COUNTY USE ONLY

Today's Date: _____

Last Name **First Name** **MI**	☐ Male ☐ Female	Hispanic, Latino, or Spanish ☐ Yes ☐ No	Race/Ethnic	
Previous (other) Name(s)				
Applicant Address:		Mailing address/office:		
Applicant Phone #:	Message Phone:	Requesting Aid Yes ☐ No ☐ In the Home Yes ☐ No ☐	Date Arrived in County	
Homeless ☐ Yes ☐ No	Address Permanent: ☐ Yes ☐ No	Mailing Address same: ☐ Yes ☐ No		
SSN:	CIN:	Primary Language ___English_____ Forms _____English_____	Interpreter Needed Yes ☐ No ☐	

Are you currently receiving aid or have you ever received, any form of cash, food, or medical aid in another county or state? ☐ **Yes** ☐ **No If yes, date last received:** _____ **From where:** _____

Check the program(s) that you are applying for

☐ **CalWORKs** ☐ **CF** ☐ **MC- CMSP** ☐ **Retro MC - Retro Mo/Yr** _____ ☐ **FC** ☐ **GA** ☐ **IHSS**

Medical Expenses in Last 3 months Yes ☐ **No** ☐

List additional persons living in the home

Name/Social Security Number (SSN)	**Requesting Aid?**	**DOB** / CIN	**Sex**	**Race/Ethnicity**	**Relationship to Applicant**
	Yes ☐ No ☐	DOB	☐ M	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN	☐ F	Race/Ethnic:	
	Yes ☐ No ☐	DOB	☐ M	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN	☐ F	Race/Ethnic:	

List Absent Parent Information	**DOB**	**Child's Name**

COUNTY USE ONLY (Clerical)

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

MEDS: ☐ **No Record** ☐ **Down**		**Clearing Initials:**	**Case #**	**App#**
EBS/ERS Name:		**Appointment Info:**		
App Reg Clerk Initials & Worker #:		**App Reg Date:**		

Household Members, Cont.

List additional household members who are requesting benefits and are the parent/minor child of someone requesting benefits.					
Name	Requesting Aid?	DOB / CIN	Sex	Race/Ethnicity	Relationship to Applicant
	Yes ☐ No ☐	DOB	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN		Race/Ethnic:	
	Yes ☐ No ☐	DOB	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN		Race/Ethnic:	
	Yes ☐ No ☐	DOB	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN		Race/Ethnic:	
	Yes ☐ No ☐	DOB	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN		Race/Ethnic:	
	Yes ☐ No ☐	DOB	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN		Race/Ethnic:	
	Yes ☐ No ☐	DOB	☐ M ☐ F	Hispanic, Latino, or Spanish ☐ Yes ☐ No	
SSN		CIN		Race/Ethnic:	

Eligibility Worker's comments/notes:

For Clerical:

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:

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

1. As of today's date, are you 60 years or older?	Yes	No
a. For Medi-Cal Applications only - Are you 64 years or older?	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

Solano County Health & Social Services Department

Language Services Needs Request

Customer Notification
Interpreter Confidentiality and Release of Information

Case Name: _____ Case #: _____ Date: _____

Customer:

I authorize release of my case information as needed while using an interpreter. This release is valid for one year unless I notify the county otherwise. I have been informed of problems that could occur when using an interpreter, and I 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 _____.

_____ _____
Customer's Printed Name Customer's Signature

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

County Employee Completes This Section

Staff Member:

I have informed the customer of potential problems that could occur while using an interpreter. I have also explained to the interpreter, the importance of keeping all information confidential. If I feel improper translation is occurring, I will ask another staff member who is bilingual in the _____ language, to ensure/confirm the information is being 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
- ❑ Language Link
- ❑ Client provided interpreter ☐ One time use of a child under the age of 13 due to an emergency situation.

_____ _____
Staff Member's Printed Name Staff Member's Signature

You may file a complaint with the Civil Rights Coordinator if you were denied services of a bilingual worker or interpreter, or if you were not given forms or letters in your preferred language. You may do this by sending an email to the Civil Rights Coordinator, Niccore Tyler at: HSSCivilRights@SolanoCounty.com .

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.

Solano County Health & Social Services Department

Mental Health Services
Public Health Services
Substance Abuse Services
Older & Disabled Adult Services

Employment and
Eligibility Services
Children's Services
Administrative Services

Gerald Huber, Director

Employment and Eligibility Services Division
Marla Stuart, Deputy Director

275 Beck Avenue, Mail Station 5-150
Fairfield, California 94533

Office & Fax: 707-784-8050

Text Messaging Authorization Form

Would you like to receive text message reminders from Solano County Health & Social Services about your benefits and appointments? Solano County H&SS is offering a reminder service by text message to your cell phone. This service is optional. You will continue to receive notices by mail whether you choose to opt-in or opt-out of receiving text message 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, appointments, 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**

Revised 05/10/2018