PPOCs: Please send the completed request to CER@CalSAWS.org and cc your RM. Submission 02/12/2025 Date Title Create a Verification of Benefits form that includes FC, ARC, AAP, and KG programs. Region #: 1 **County Name: Santa Clara County** Submitter: **Phone**: 408-755-7516 Email: Brenda.ulloa@ssa.sccgov.org Brenda Ulloa/Trisha Miura Program(s) Impacted: Adoptive Services \boxtimes arc CalFresh Cal-Learn CalWORKS / RCA CAPI Child Care **CMSP** Foster Care GA/GR GAIN/REP/WTW **GROW** Kin-GAP Medi-Cal / RMA Other – specify Area(s) Impacted: Call Center Central Print Case Assignment Correspondence Eligibility Fiscal / Collections Hearings **Imaging Lobby Management** Reports Resource Data Bank Schedule Appt Security Self Service Portal Special Investigation Task Mgmt Time Limits Training Interface(s) - specify County Operational (ex. Business Reply Mail (BRM), EBT Printers, Change of Address, Opt In/Out, etc.) – specify

Other – specify
Justification / Request Summary:
Issue: Eligibility may have the need to request Verification of benefits form CSF142 for foster care (FC), Approved Relative Caregiver (ARC), Adoption Assistance Program (AAP), and Kin-GAP (KG) cases. Currently the CSF 142 does not include these programs so the form can't be generated from CalSAWS. EW's who need to provide a verification of benefits for one of the above mentioned programs are currently using our internal form which must be completed manually and printed locally.
Proposed Recommendation: Create a Verification of benefits specific to Foster Care programs: Foster Care (FC), Approved Relative Caregiver (ARC), Adoption Assistance Program (AAP), and Kin-GAP (KG). Include functionality of pre-population, editing of the data and allow for both central and local print options.
The following is the form currently used.

Santa Clara County		Social Services Agency
VERIFICATION O	OF COUNTY	Your agency address is: La direccion de su oficina es: Địa chỉ văn phòng phụ trách hồ sơ quý vị: 373 W Julian Street San Jose, CA 95110
DATE:		
TO WHOM IT MAY CONCERN:		
Our records indicate that (NAME/S)		
CASE NAME:	CAS	E NO:
	□ ARC □ Foster Care □ Gener	
	Adult: Child: To:	
☐ Medi-Cal: F	From: To:	\$per month
☐ Other: F	from: To:	\$ per month
Date case discontinued:	Date case to be discontinued	:
f more information is needed, please s ndicating the exact nature of informat	submit a written request signed by the client giv ion required.	ring permission to release the information and
ELIGIBILITY WORKER	WORKER NO.	TELEPHONE NUMBER
Scan: Foster Care F7 CSF 142	Page 1 of 1	SCD 1521 FC_EN (09/17

CalSAWS Response:				
CER Tracking #: (automatically generate by	SCR#			
JIRA)				
Rejected By:	Date:			
Rejection Reason(s) or other Comments:				