WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT, REHABILITATION — LIVING QUARTERS

This claim is filed for fiscal year 20 _____ 20 ____

CHRISTINA WYNN SACRAMENTO COUNTY ASSESSOR INSTITUTIONAL EXEMPTIONS SECTION 3636 American River Drive, Suite 200 Sacramento, CA 95864-5952 Phone (916) 875-0720 FAX (916) 854-9181 https://assessor.saccounty.gov

This is a Supplemental Affidavit filed with

- BOE-267, Claim for Welfare Exemption (First Filing)
- BOE-267-A, Claim for Welfare Exemption (Annual Filing)

Section 1. Identification of Applicant

Name of Organization

City. State, Zip Code Organizational Clearance Certificate (OCC) No. (Provide copy of certificate with this claim if first filing). If you do not an OCC, have you filed a claim for an OCC with the BOE? Yes No. Yes No. Address of property (number and street) Address of property (number and street) City. County, Zip Code Cate Property Acquired Section 3. Rehabilitation; Thrift Shop, workshop, manufacturing, or similar activities. Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep attachment. A. Facility Information. 1. Number of hours per week the facility is operated: 2. Persons being rehabilitated Full-time: 2. Persons being rehabilitated Full-time: 2. Partime: 3. Staff and/or others. Full-time: 4. Part-time: 4. Part-time: 4. Part-time: 5. Otal number of persons being rehabilitated based on the length of employment: 4. Leas than 6 months: 5. Bottal number of persons being rehabilitated based on the length of employment: 4. Staff and/or others. Full-time: 6. Partime: 7. Cotal number of persons being rehabilitated based on the length of employment: 4. Staff and/or others. Full-time: 7. Partime: 7. Cotal number of persons being rehabilitated based on the length of employment: 4. Staff and/or others. Full-time: 7. Partime: 7. Cotal number of persons being rehabilitated based on the facility as of January 1 7. Partime: 7. Cotal number of hours worked during the time period included in the financial statements that accompany the claim. 7. Partime: 7. Cotal number of hours worked fulling: 7. Number of persons being rehabilitated based on the length of employment: 7. Less than 6 months: 7. Border there: 7. Votion there: 7. Number of hours worked fulling the time period included in the financial statements that accompany the claim. 7. Partime: 7. Cotal number of hours worked fulling the time period included in the finan	City, State, Zip Code	
an OCC, have you filed a claim for an OCC with the BOE? Yes No Ko, see instructions for information on obtaining an OCC claim form. Section 2. Identification of Property Address of property (number and street) Address of property (number and street) City, County, Zip Code Date Property Acquired Section 3. Rehabilitation; Thrift shop, workshop, manufacturing, or similar activities. Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep attachment. A Facility Information. Number of hours per week the facility is operated: Total number of persons employed on the premises on January 1 Persons being rehabilitated. Full-time: Section 3. Staff and/or others. Full-time: Section of persons being rehabilitated. Full-time: Section of the premises, but in the operations of the facility as of January 1. Section of persons being rehabilitated. Full-time: Section of onces or years: Section of northers.		
an OCC, have you filed a claim for an OCC with the BOE? Yes No No, see instructions for information on obtaining an OCO claim form. Section 2. Identification of Property Address of property (number and street) City, County, Zip Code Date Property Acquired Section 3. Rehabilitation; Thrift shop, workshop, manufacturing, or similar activities. Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep attachment. A Facility Information. 1. Number of hours per week the facility is operated: Total number of persons employed on the premises on January 1 2. Persons being rehabilitated. Full-time: Part-time: (list by number of years) 3. Staff and/or others. Full-time: Part-time: (list by number of years) 4. Staff and/or others. Full-time: Part-time: (list by number of years) 4. Staff and/or others. Full-time: Part-time: (list by number of years) 4. Staff and/or others. Full-time: Part-time: (list by number of years) 4. Staff and/or others. Full-time: Part-time: (list by number of years) 4. Staff and/or others. Full-time: Part-time: (list by number of years) 4. Staff and/or others. Full-time: Part-time: (list by number of years) 5. Staff and/or others. Full-time: Part-time: (list by number of years) 5. Staff and/or others. Full-time: Part-time: (list by number of years) 5. Staff and/or others. Full-time: Part-time: (list by number of years) 5. Staff and/or others. Full-time: Part-time: (list by number of years) 5. Staff and/or others. Full-time: Part-time: (list by number of years) 5. Staff and/or others. Stars being rehabilitated. Mumber of persons involved: (list by number of years) 6. Total number of hours worked: Number of persons involved: (list by number of years) 7. Staff and/or others. Staff and/or others. Staff and/or others. Staff and/or others involved: (list by number of years) 7. Staff and/or others. Number of persons involved: (list by numbe		
INo, see instructions for information on obtaining an OCO claim form. Section 2. Identification of Property Address of property (number and street) Assessor's Parcel/Assessment Numb City, County, Zip Code Date Property Acquired Section 3. Rehabilitation: Thrift shop, workshop, manufacturing, or similar activities. Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep attachment. A. Facility Information.		of certificate with this claim if first filing). If you do not have
Address of property (number and street) Assessor's Parcel/Assessment Numb Address of property (number and street) Date Property Acquired Dity, County, Zip Code Date Property Acquired Section 3. Rehabilitation: Thrift shop, workshop, manufacturing, or similar activities. Date Property Acquired Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep strachment. A. Facility Information. 1. Number of hours per week the facility is operated: Total number of persons being rehabilitated. Full-time: Part-time: Less than 6 months: 6 months - 1 year 1 year - 2 years: Longer than 2 years: (ist by number of years) 6 months - 1 year 1 year - 2 years: Longer than 2 years: 3. Staff and/or others. Full-time: Part-time: (ist by number of years) 3. Staff and/or others. Full-time: Part-time: It year - 2 years: Longer than 2 years: Identify the number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year 1 year - 2 years: Longer than 2 years: 2. Staff and/or others. Full-time: Part-time: [ist by number of years) 2. Staff and/or othours worked during the time period included in the financial state		
City, County, Zip Code Date Property Acquired Section 3. Rehabilitation: Thrift shop, workshop, manufacturing, or similar activities. Date Property Acquired Section 3. Rehabilitation: Thrift shop, workshop, manufacturing, or similar activities. Date Property Acquired Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep attachment. A. Facility Information. 1. Wumber of hours per week the facility is operated: Part-time: Part-time: Longer than 2 years: Longer than 2 years:	Section 2. Identification of Property	
Section 3. Rehabilitation: Thrift shop, workshop, manufacturing, or similar activities. Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep attachment. A. Facility Information. 1. Number of hours per week the facility is operated: If all number of persons being rehabilitated. Facility information: 2. Persons being rehabilitated. Facility information: 3. Staff and/or others. Full-time: Part-time: Class than 6 months: 6 months - 1 year: 1 year: 1 year: 2 resons being rehabilitated. 8. Total number of persons but in the operations of the facility as of January 1. 1. Persons being rehabilitated. 1 year: 1 year: 2 years: Conger than 2 years: (list by number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year 2 staff and/or others. Full-time: Part-time: (list by number of years) 6 months - 1 year 2 staff and/or others. Number of persons being rehabilitated. Number of hours worked during the time period included in the financial statements that accompany the cl	Address of property (number and street)	Assessor's Parcel/Assessment Number(s
Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a sep stractment. A. Facility Information. 1. Number of hours per week the facility is operated: Part-time: Part-time: Part-time: Longer than 2 years: Longer than 2 years: (list by number of years) 3. Staff and/or others. Full-time: Part-time: Longer than 2 years: (list by number of years) 3. Staff and/or others. Full-time: Part-time:	City, County, Zip Code	Date Property Acquired
Attachment. A. Facility Information. 1. Number of hours per week the facility is operated:	Section 3. Rehabilitation: Thrift shop, workshop, manufacturing, or similar activities	S. Constant and the second
1. Number of hours per week the facility is operated:		pilitation program and activities in detail on a separa
Interpretation Interpretation Persons being rehabilitated. Full-time: Part-time: Identify the number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year. 1 year - 2 years: Longer than 2 years: (list by number of years) 3. Staff and/or others. Full-time: Part-time:		\frown T
Persons being rehabilitated. Full-time: Part-time: Longer than 2 years: Longer than 2 years: (<i>ist by number of years</i>) Staff and/or others. Full-time: Part-time: B. Total number employed off the premises, but in the operations of the facility as of January 1. Persons being rehabilitated. Full-time: Part-time: B. Total number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year Part-time: B. Total number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year 1 year - 2 years: Longer than 2 years: 2. Staff and/or others. Full-time: Part-time: C. Total number of hours worked during the time period included in the financial statements that accompany the claim. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of persons involved: 2. Number of nours worked:		es on January 1
Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years: Longer than 2 years: (list by number of years) 3. Staff and/or others. Full-time: Part-time: (list by number of years) 8. Total number employed off the premises, but in the operations of the facility as of January 1. Persons being rehabilitated. Full-time: Part-time: 8. Total number of persons being rehabilitated. Full-time: Part-time: (list by number of years) 2. Staff and/or others. 6 months - 1 year 1 year - 2 years: Longer than 2 years: (list by number of years) 2. Staff and/or others. 6 months - 1 year Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Number of persons involved: (list by number of persons involved: 2. Staff and/or others. Number of persons involved:		
(list by number of years) 3. Staff and/or others. Full-time: Part-time: Part-time: Part-time: Part-time: Part-time: Longer than 2 years: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) 2. Staff and/or others. Wumber of persons involved: (list by number of years) 2. Staff and/or others. Number of persons involved: (list by number of hours worked: Number of persons involved: (list by number of hours worked: Number of persons involved: (Assessor's USE ONLY Number of persons involved: NAME		
3. Staff and/or others. Full-time: Part-time: 3. Total number employed off the premises, but in the operations of the facility as of January 1. 1. Persons being rehabilitated. Full-time: Part-time: Longer than 2 years: (list by number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year: 1 year - 2 years: Longer than 2 years: (list by number of years) 2. Staff and/or others. Full-time: Part-time: 2. Total number of hours worked during the time period included in the financial statements that accompany the claim. 1. Persons being rehabilitated. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked:	Less than 6 months:6 months - 1 year: 1 year - 2 years:	Longer than 2 years:
B. Total number employed off the premises, but in the operations of the facility as of January 1. 1. Persons being rehabilitated. Full-time:	2. Ota # an allow attacks and Full times.	(list by number of years)
1. Persons being rehabilitated. Full-time: Part-time: Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years: Less than 6 months: 6 months - 1 year. 1 year - 2 years: Longer than 2 years: (list by number of years) (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) C. Total number of hours worked during the time period included in the financial statements that accompany the claim. 1. Persons being rehabilitated. Number of persons involved: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of persons involved: Number of hours worked: Number of persons involved: Yourge of hours worked: Number of persons involved: Number of hours worked: Number of persons involved: ProR ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? Name DayTIME TELEPHONE EMAIL ADDRESS	3. Staff and/or others. Full-time: Part-time:	
1. Persons being rehabilitated. Full-time: Part-time: Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years: Less than 6 months: 6 months - 1 year. 1 year - 2 years: Longer than 2 years: (list by number of years) (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) C. Total number of hours worked during the time period included in the financial statements that accompany the claim. 1. Persons being rehabilitated. Number of persons involved: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of persons involved: Number of hours worked: Number of persons involved: Yourge of hours worked: Number of persons involved: Number of hours worked: Number of persons involved: ProR ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? Name DayTIME TELEPHONE EMAIL ADDRESS	3. Total number employed off the premises, but in the operations of the facility as c	of January 1.
Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years: (list by number of years) Less than 6 months: 6 months - 1 year: 1 year - 2 years: Longer than 2 years: (list by number of years) 2. Staff and/or others. Full-time: Part-time:		
2. Staff and/or others. Full-time: Part-time: (list by number of years) C. Total number of hours worked during the time period included in the financial statements that accompany the claim. 1. Persons being rehabilitated. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: Number of additional information?		
2. Staff and/or others. Full-time: Part-time: C. Total number of hours worked during the time period included in the financial statements that accompany the claim. 1. Persons being rehabilitated. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of hours worked: Number of persons involved: 2. Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of additional information? 2. DAYTIME TELEPHONE 2. DAYTIME TELEPHONE EMAIL ADDRESS	Less than 6 months: 6 months - 1 year: 1 year - 2 years:	Longer than 2 years:
C. Total number of hours worked during the time period included in the financial statements that accompany the claim. 1. Persons being rehabilitated. Number of hours worked:		(list by number of years)
1. Persons being rehabilitated. Number of hours worked: 2. Staff and/or others. Number of hours worked: Number of hours worked: Number of persons involved: FOR ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? Received by (Assessor's designee) of (county or city) (date) DayTIME TELEPHONE EMAIL ADDRESS	2. Staff and/or others. Full-time: Part-time:	
1. Persons being rehabilitated. Number of hours worked: 2. Staff and/or others. Number of hours worked: Number of hours worked: Number of persons involved: FOR ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? Received by (Assessor's designee) of (county or city) (date) DayTIME TELEPHONE EMAIL ADDRESS	Total number of hours worked during the time period included in the financial st	atomonts that accompany the claim
Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of persons involved: Number of hours worked: Number of persons involved: FOR ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? Received by		atements that accompany the claim.
Number of hours worked: Number of persons involved: FOR ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? Received by (Assessor's designee) NAME of on Oddate DAYTIME TELEPHONE EMAIL ADDRESS	5	
FOR ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? Received by		
Received by (Assessor's designee) NAME of on On (county or city) (date)	Number of hours worked: Number of persons involved:	
Received by (Assessor's designee) NAME of on On (county or city) (date) DAYTIME TELEPHONE () EMAIL ADDRESS	FOR ASSESSOR'S USE ONLY Whom sho	uld we contact during normal business
of on (county or city) (date) (date) DAYTIME TELEPHONE EMAIL ADDRESS ()		-
of on (date) DAYTIME TELEPHONE EMAIL ADDRESS	(Assessor's designes)	
(county or city) (date) DAYTIME TELEPHONE EMAIL ADDRESS		
()		EMAILADDRESS
THIS DOCUMENT IS SUBJECT TO PUBLIC INSPECTION		
THIS DOCUMENT IS SUBJECT TO PUBLIC INSPECTION		

- 1. Persons being rehabilitated.

 Salaries and wages:

 Number of persons involved:

- 2. Staff and/or others. Salaries and wages: _____ Number of persons involved:
- E. Does a person, management firm, or entity other than the organization filing this claim operate the facility?
 - Yes No If YES, provide the operator's name and mailing address:

Amount of salary or fee: \$_____ Attach a copy of the contract or other document that indicates the basis for the salary or fee.

F. Is housing for persons being rehabilitated and/or living quarters for staff provided?

Yes No If YES, explain the necessity and complete section 4, *Housing - Living Quarters*.

Section 4. Housing — Living Quarters

A. Total number of persons who were housed on the premises the last night in December. Include persons who may be temporarily away.

- 1. Total number of persons being rehabilitated
- 2. Number of unoccupied beds available for persons to be rehabilitated
 3. Number of staff members necessary to care for those persons being rehabilitated.
 Attach a list describing the jobs performed and the number of persons involved.
- 4. Number of other staff members
- 5. Number of other persons who are not directly connected with the rehabilitation program
- B. Length of stay of persons being rehabilitated who were housed on the premises the last night in December.

1. Number of persons
less than 6 months
6 months - 1 year
1 year - 2 years
2 years or longer (list by number of years)

- 2. Total. This figure must agree with the total given above for persons being rehabilitated.
- C. Do persons being rehabilitated pay, donate, or perform fund producing work for their room and board?
 - Yes No If YES, indicate which and explain in sufficient detail to determine the monthly fee per person.
- D. Do staff members who care for those being rehabilitated pay, donate, or perform work for their room and/or board in lieu of, or from, their salary?
 - Yes INO If YES, indicate which and explain in sufficient detail to determine the monthly fee per person.

E. Do other staff members pay, donate, or perform work for their room and/or board in lieu of, or from, their salary? Yes No If YES, indicate which and explain in sufficient detail to determine the monthly fee per person.

F. Do the oth board?	ier perso	ns not directl	y connected	with the rel	habilitation pro	ogram pay, do	onate, or perform	n work for their ro	om and/or
	—								

Yes No If YES, indicate which and explain in sufficient detail to determine the monthly fee per person.

CERTIFICATION

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing and all information contained herein, including any accompanying statements or documents, is true, correct, and complete to the best of my knowledge and belief.

TITLE NAME DATE

SIGNATURE



INSTRUCTIONS FOR FILING WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT REHABILITATION – LIVING QUARTERS

FILING OF AFFIDAVIT

This affidavit is required under the provisions of sections 251 and 254.5 of the Revenue and Taxation code and must be filed when seeking exemption on property that involves rehabilitation of persons and/or living quarters. A separate affidavit must be filed for each location. This affidavit supplements the claim for welfare exemption and must be filed with the county assessor by February 15 to avoid a late filing penalty under section 270. If you do not complete and file this form, you may be denied the exemption.

FISCAL YEAR

The fiscal year for which an exemption is sought must be entered correctly. The proper fiscal year follows the lien date (12:01 a.m., January 1) as of which the taxable or exempt status of the property is determined. For example, a person filing a timely claim in February 2011 would enter "2011-2012" on line four of the claim; a "2010-2011" entry on a claim filed in February 2011 would signify that a late claim was being filed for the preceding fiscal year.

SECTION 1. Identification of Applicant.

Identify the name of the organization seeking exemption on the property, corporate identification number (or limited liability number if the organization is a limited liability company), and mailing address.

SECTION 2. Identification of Property.

Identify the location of the property, county in which the property is located, and the date the property was acquired by the organization. Also identify the assessor's parcel number or assessment number of the property.

SECTION 3. Rehabilitation: Thrift shop, Workshop, Manufacturing, or Similar Activities.

Provide a copy of the organization's formal rehabilitation program or describe the rehabilitation program and activities in detail on a separate sheet of paper. As requested in this section of the claim form, provide information on persons being rehabilitated and staff (and/or others) at the store or other facility for which you are claiming exemption.

SECTION 4. Housing – Living Quarters.

Complete this section of the claim form if the organization provides housing for the persons being rehabilitated and/or the organization provides living quarters for staff. As requested in this section, provide information on persons who are housed by the organization on the premises and if those persons housed pay, donate, or perform work for their room and/or board.

OBTAINING CLAIM FORMS FROM THE STATE BOARD OF EQUALIZATION (BOE)

Claim form BOE-277, *Claim for Organizational Clearance Certificate – Welfare Exemption*, is available on the BOE's website (www.boe.ca.gov) or you may request the form by contacting the Welfare Exemption Section at 1-916-274-3430.

