EF-267-R-R07-0611-50000445-1 BOE-267-R (P1) REV. 07 (06-11)



Don H. Gaekle **Stanislaus County Assessor**

1010 Tenth Street, Suite 2400 Modesto, CA 95354-0863 Phone: (209) 525-6461 • Fax: (209) 525-6586 www.stancounty.com/assessor

WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT, **REHABILITATION — LIVING QUARTERS**

This claim is filed for fiscal year 20 — 20		
This is a Supplemental Affidavit filed with		
☐ BOE-267, Claim for Welfare Exemption (First Filing)		
☐ BOE-267-A, Claim for Welfare Exemption (Annual Filing	g)	
Section 1. Identification of Applicant		
Name of Organization		
Mailing Address (number and street)	(Corporate ID or LLC Number
City, State, Zip Code	010	<u> </u>
Organizational Clearance Certificate (OCC) No. an OCC, have you filed a claim for an OCC with the BOE? Yes No If No, see instructions for information on obtaining an OCC claim for the BOE.	5/0	h this claim if <mark>firs</mark> t fili <mark>ng</mark>). If you do not have
Section 2. Identification of Property		
Address of property (number and street)		
City, County, Zip Code		Date Property Acquired
Section 3. Rehabilitation		
Provide a copy of the organization's formal rehabilitation progattachment.	gram, or describe the rehabilitation program	n and activities in detail on a separate
A. Thrift shop, workshop, manufacturing, or similar activity	ties -	
Number of hours per week the facility is operated: Total number of persons	ons employed on the premises on January 1. time:the length of employment:	er than 2 years: (list by number of years)
3. Staff and/or others. Full-time: Part-time:		(iist by number of years)
B. Total number employed off the premises, but in the open serious serious persons being rehabilitated. Full-time: Part-lidentify the number of persons being rehabilitated based on Less than 6 months: 6 months - 1 year:	time:the length of employment:	er than 2 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 in	ncluded in the financial statements that	accompany the claim.
Persons being rehabilitated. Number of hours worked: Number of personal Nu	sons involved:	
Staff and/or others. Number of hours worked: Number of personal Number of Person	sons involved: ———	
FOR ASSESSOR'S USE ONLY	Whom should we contact	during normal business
Received by	hours for addition	nal information?
(Assessor's designee)	NAME	
of on(county or city) (date)	DAYTIME TELEPHONE ()	EMAIL ADDRESS

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D. Salaries and wages paid during the ti	ime period included in the financial statements that accompany the claim.	
Persons being rehabilitated. Salaries and wages:	Number of persons involved:	
Staff and/or others. Salaries and wages:	Number of persons involved:	
	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 s	alary or fee.
	tated and/or living quarters for staff provided?	
-	necessity and complete section 4, Housing - Living Quarters.	
Section 4. Housing — Living Quarters		
	oused on the premises the last night in December. Include persons who may be to	emporarily away.
1. Total number of persons b	peing rehabilitated	
2. Number of unoccupied be	eds available for persons to be rehabilitated	
	necessary to care for those persons being rehabilitated. e jobs performed and the number of persons involved.	
4. Number o <mark>f o</mark> ther staf <mark>f m</mark> en	nbers	
5. Number of other per <mark>so</mark> ns v	who are not directly connected with the rehabilitation program	
B. Length of stay of persons being reha 1. Number of persons	abilitated who were housed on the premises the last night in December.	
less than 6 months		7
6 months - 1 year	/\	
1 year - 2 years	/ 	
2 years or longer (list by n	number of years)	
	ree with the total given above for persons being rehabilitated.	
C. Do persons being rehabilitated pay, of	donate, or perform fund producing work for their room and board? nich and explain in sufficient detail to determine the monthly fee per person.	
	e being rehabilitated pay, donate, or perform work for their room and/or board No If YES, indicate which and explain in sufficient detail to determine the monthly fe	
, J 100		то рог рогости
F. Do other staff members pay donate	or perform work for their room and/or board in lieu of, or from, their salary?	
	nich and explain in sufficient detail to determine the monthly fee per person.	
	nnected with the rehabilitation program pay, donate, or perform work for their in No If YES, indicate which and explain in sufficient detail to determine the monthly fe	
		se per person.
	CERTIFICATION	
I certify (or declare) under penalty of perjury any accompanying stateme	vunder the laws of the State of California that the foregoing and all information contained ents or documents, is true, correct, and complete to the best of my knowledge and belief.	herein, including
NAME	TITLE	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.

SECTION 3. Rehabilitation.

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

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

