

David Peets Alpine County Assessor/Recorder 50 Diamond Valley Rd. P.O. Box 155 Markleeville, CA 9612

This claim is filed for fiscal year 20 ____ - 20 ____

REHABILITATION — LIVING QUARTERS

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

City, State, Zip Code Organizational Clearance Certificate (OCC) No. an OCC, have you filed a claim for an OCC with the BOE? Organizational Clearance Certificate on obtaining an OCC 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 separatechement. A Facility Information. 1. Number of hours per week the facility is operated: I Total number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year: 1 year - 2 years: (list by number of years) 2. Staff and/or others. Full-time: 3. Staff and/or others. Full-time: 4. Part-time: 5. Construction of the premises, but in the operations of the facility as of January 1. 3. Staff and/or others. Full-time: 3. Staff and/or others. Full-time: 4. Part-time: 5. Constructions of the facility of the premises, but in the operations of the facility as of January 1. 3. Staff and/or others. Full-time: 5. Constructions of the facility of the premises, but in the operations of the facility as of January 1. 5. Constructions of the facility of the facility of the ased on the length of employment: 5. Less than 6 months: 5. Constructions of the facility of the premises, but in the operations of the facility as of January 1. 5. Constructions of the facility of the premises, but in the operation of the facility as of January 1.	failing Address (number and street)		Corporate ID or LLC Number
Drganizational Clearance Certificate (OCC) No. (Provide copy of certificate with this claim if first filing). If you do no in OCC, have you filed a claim for an OCC with the BGE? Yes No No, see instructions for information on obtaining an OCC claim form. Section 2. Identification of Property Medress of property (number and strest) Date Property Acquired Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a service activities of prosents employed on the premises on January 1 Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a service activity in the interventies on the premises on January 1 Precisity Information. Facility Information Percenter Percen			
n CCC, have you filed a claim for an OCC with the BOE? Yes No No, see instructions for information on obtaining an OCC claim form. Section 2. Identification of Property Uddress of property (number and siteel) Date Property Acquired City, County, Zip Code City, County, City, City, County, City, Cit	city, State, Zip Code		
TNo, 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 Numl 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 seg stachment. A-Facility Information.		(Provide copy of c	ertificate with this claim if first filing). If you do not
Address of property (number and street) Assessor's Parcel/Assessment Numi City, 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 sequationment. A. Facility Information. 1. Number of hours per week the facility is operated: Total number of persons being rehabilitated. Parl-Imme: Identify the number of persons being rehabilitated based on the length of employment: Less than 6 months: S. Staff and/or others. Full-time: Parl-time: B. Total number of persons being rehabilitated based on the length of employment: Less than 6 months: Less than 6 months: © 6 months - 1 year 1 year - 2 years: Longer than 2 years: 3. Staff and/or others. Full-time: Parl-time: (ist by number of years) 2. Staff and/or others. Full-time: Parl-time: (ist by number of years) 2. Staff and/or others. Full-time: Parl-time: (ist by number of years) 2. Staff and/or others. Number of persons involved: . 2. Staff and/or others. Number of persons involved: . Number of hours wo		n form.	
City, County, Zip Code Date Property Acquired Section 3. Rehabilitation: Thrift shop, workshop, manufacturing, or similar activities. Devide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a seg that activities. Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a seg that activities in detail on a seg that activities in detail on a seg that activities in formation. 1. Number of hours per week the facility is operated:	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 segnitachment. A. Facility Information. 1. Number of hours per week the facility is operated: Tetal 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: 3. Staff and/or others. Full-time: Part-time: 3. Staff and/or others. Full-time: Part-time: 2. Persons being rehabilitated. Full-time: Part-time: 3. Staff and/or others. Full-time: Part-time: 3. Staff and/or others. Full-time: Part-time: 2. Staff and/or others. Full-time: Part-time: 3. Staff and/or others. Full-time: Part-time: 3. Staff and/or others. Full-time: Part-time: 3. Staff and/or others. Full-time: Part-time: 4. Persons being rehabilitated based on the length of employment: Less than 6 months: 1. Persons being rehabilitated full-time: Part-time: 2. Staff and/or others. Full-time: Number of persons involved: 1. Persons being rehabilitated. Numbe	ddress of property (number and street)		Assessor's Parcel/Assessment Number
Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a seguitachment. A. Facility Information. 1. Number of hours per week the facility is operated:	ity, County, Zip Code		Date Property Acquired
Attachment. A. Facility information. 1. Number of hours per week the facility is operated:	ection 3. Rehabilitatio <mark>n: Thrift shop, workshop, man</mark> ufa	ac <mark>turi</mark> ng, <mark>or</mark> similar activities.	
1. Number of hours per week the facility is operated:		rogram, or describe the rehabilita	ation program and activities in detail on a sepa
Persons being rehabilitated. Full-time: Part-time: Longer than 2 years: (list by number of years) Staff and/or others. Full-time: Part-time: Part-time: (list by number of years) Total number employed off the premises, but in the operations of the facility as of January 1. Persons being rehabilitated. Full-time: Part-time: Total number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year Part-time: Conger than 2 years: (list by number of years) Staff and/or others. Full-time: Part-time: Staff and/or others. Full-time: Part-time: Staff and/or others. Full-time: Part-time: Cotal number of hours worked during the time period included in the financial statements that accompany the claim. Persons being rehabilitated. Number of hours worked during the time period included in the financial statements that accompany the claim. Persons worked:	1. Number of hours per week the facility is operated:	rsons employed on the premises o	
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: (list by number of years) 3. Staff and/or others. Full-time: Part-time: (list by number of years) 3. Total number employed off the premises, but in the operations of the facility as of January 1. Persons being rehabilitated. Full-time: Part-time: 2. Staff and/or others. 6 months - 1 year: Part-time: Longer than 2 years: (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: 1 year - 2 years: Longer than 2 years: (list by number of years) 2. Staff and/or others. Full-time: Part-time: (list by number of years) (list by number of years) 3. Staff and/or others. Number of persons involved: (list by number of years) (list by number of years) 2. Staff and/or others. Number of persons involved: Number of hours worked: Number of persons involved: Number of additional information? Received by <t< td=""><td></td><td></td><td>roandary T.</td></t<>			roandary T.
(list by number of years) 3. Staff and/or others. Full-time: Part-time: Part-time: Part-time: Part-time: I. Persons being rehabilitated. Full-time: Part-time: leantify 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) 2. Staff and/or others. Full-time: Part-time: 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:	Identify the number of per <mark>sons being rehabilitated based o</mark>	n the length of employment:	
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: (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: 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 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: 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:	Less than 6 months: 6 months - 1 year:	1 year - 2 years:	
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) 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:	3. Staff and/or others. Full-time: Part-time:		(list by number of 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: (list by number of years) 2. Staff and/or others. Full-time: Part-time:	3. Total number employed off the premises, bu <mark>t i</mark> n the o	p <mark>er</mark> ations of the facility as of Ja	anuar <mark>y 1</mark> .
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: (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:	1. Persons being rehabilitated. Full-time: Pa	art-time:	
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. 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. 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: 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. Number of hours worked: Number of persons involved: 2. Number of nours worked: Number of persons involved: 2. Number of nours for additional information? 2. NAME 3. Other On On On DAYTIME TELEPHONE 3. DAYTIME TELEPHONE 3	Less than 6 months: 6 months - 1 year:	1 year - 2 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 TellePHONE EMAIL ADDRESS	2. Staff and/or others. Full-time: Part-time:		(list by humber of years)
1. Persons being rehabilitated. Number of hours worked: 2. Staff and/or others. 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 stater	nents that accompany the claim.
2. Staff and/or others. Number of hours worked: 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	1. Persons being rehabilitated.		
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 po	ersons involved:	
Received by	FOR ASSESSOR'S USE ONLY	Whom should	we contact during normal business
of on (date) NAME DAYTIME TELEPHONE EMAIL ADDRESS		hours	for additional information?
of on (date) DAYTIME TELEPHONE EMAIL ADDRESS	Keceived by (Assessor's designee)	NAME	
(county or city) (date) DAYTIME TELEPHONE EMAIL ADDRESS			
	of on		
	of on	DAYTIME TELEPHONE	EMAILADDRESS

D. Salaries and wages paid during the time period included in the financ	cial statements that accompany the claim.
--	---

- - 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	er persoi	ns not directly	connected v	vith the re	habilitatio	n program	pay, donate	or perform wo	ork for their roo	om and/or
board?										

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.

