EF-267-R-R09-0521-24000275-1 BOE-267-R (P1) REV. 09 (05-21)

WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT, REHABILITATION — LIVING QUARTERS



MERCED COUNTY MATT H. MAY, ASSESSOR

2222 M STREET MERCED, CA 95340 TELEPHONE (209) 385-7631 FAX (209) 725-3956 www.co.merced.ca.us\assessor

This claim is filed for fiscal year 20 — 20	www.co.merced.ca.us\assessor		
This is a Supplemental Affidavit filed with			
☐ BOE-267, Claim for Welfare Exemption (First Filing)			
☐ BOE-267-A, Claim for Welfare Exemption (Annual Filin	ng)		
Section 1. Identification of Applicant			
Name of Organization			
Mailing Address (number and street)		Corporate ID or LLC Number	
City, State, Zip Code			
Organizational Clearance Certificate (OCC) No an OCC, have you filed a claim for an OCC with the BOE?	(Provide copy of o	certificate with this claim if first filing). If you do not have	
☐ Yes ☐ No			
If No, see instructions for information on obtaining an OCC claim	form.		
Section 2. Identification of Property			
Address of property (number and street)		Assessor's Parcel/Assessment Number(s)	
City, County, Zip Code		Date Property Acquired	
A. Facility Information. 1. Number of hours per week the facility is operated: Total number of per. 2. Persons being rehabilitated. Full-time: Identify the number of persons being rehabilitated based on Less than 6 months: 1. Number of persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. Number of persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on Less than 6 months: 1. One was a second or persons being rehabilitated based on the less than 6 months: 1. One was a second or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated based on the less than 6 months or persons being rehabilitated b	sons employed on the premises on t-time: the length of employment:		
3. Staff and/or others. Full-time: Part-time:			
B. Total number employed off the premises, but in the op	erations of the facility as of J	anuary 1.	
Persons being rehabilitated. Full-time: Par			
Identify the number of persons being rehabilitated based on			
Less than 6 months: 6 months - 1 year:	1 year - 2 years:	Longer tnan 2 years: (list by number of years)	
2. Staff and/or others. Full-time: Part-time:		, , ,	
C. Total number of hours worked during the time period i	included in the financial state	ments that accompany the claim.	
Persons being rehabilitated. Number of hours worked: Number of pe	rsons involved:		
Staff and/or others. Number of hours worked: Number of pe	rsons involved:		
FOR ASSESSOR'S USE ONLY	Whom should we contact during normal business		
Received by		for additional information?	
(Assessor's designee)	NAME		
of on	DAYTIME TELEPHONE	EMAIL ADDRESS	
, , ,	,	LIVIAILADDINEGO	

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D. Salaries a	nd wages paid during the time	period included in the financial	statements that accompany t	the claim.		
	Persons being rehabilitated. Salaries and wages: Number of persons involved:					
2. Staff and Salaries	or others. and wages:	Number of persons involved:				
E. Does a per	_	ity other than the organization fi rator's name and mailing address:	ling this claim operate the fac	cility?		
Amount of s	alary or fee: \$	Attach a copy of the contract or	other document that indicates the	e 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, <i>Housing - Living Quarters</i> .						
Section 4. Ho	ousing — Living Quarters					
A. Total num	ber of persons who were hous	ed on the premises the last nigh	t in December. Include persons	s who may be temporarily away.		
	Total number of persons being	g rehabilitated				
	2. Number of unoccupied beds a	vailable for persons to be rehabilitate	ed			
	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 member	rs .				
	5. Number of other persons who	are not directly connected with the r	ehabilitation 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 numb	per of years)				
	2. Total. This figure must agree v	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 No 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?	_	eted with the rehabilitation progrand explain in sufficient detail to dete				
CERTIFICATION						
		ler the laws of the State of California or documents, is true, correct, and c	omplete to the best of my knowle	dge and belief.		
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. 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.

