EF-267-R-R09-0521-36000299-1 BOE-267-R (P1) REV. 09 (05-21)

WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT, REHABILITATION — LIVING QUARTERS



Josie Gonzales Assessor-Recorder-County Clerk

San Bernardino County 222 W. Hospitality Lane, 4th Floor San Bernardino, CA 92415-0311 arc.sbcounty.gov 909-387-8307 or 1-877-885-7654

This claim is filed for fiscal year 20 — 20		909-367-6307 01 1-677-665-7654
This is a Supplemental Affidavit filed with		
☐ BOE-267, Claim for Welfare Exemption (First Filing)		
☐ BOE-267-A, Claim for Welfare Exemption (Annual Filin	g)	
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.	(Provide copy of	certificate with this claim if first filing). If you do not have
an OCC, have you filed a claim for an OCC with the BOE?	(oo. ansatto vitar and oranii ii inot iiii igyi. ii you uo iiot iiu io
☐ 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 pers 2. Persons being rehabilitated. Full-time: Part Identify the number of persons being rehabilitated based on Less than 6 months: 6 months - 1 year:	the length of employment:	
3. Staff and/or others. Full-time: Part-time:		(list by number of years)
B. Total number employed off the premises, but in the op	erations of the facility as of	January 1.
1. Persons being rehabilitated. Full-time: Part		
Identify the number of persons being rehabilitated based on Less than 6 months: 6 months - 1 year:		Longor than 2 years:
Less than o months o months - 1 year	1 year - 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	ncluded in the financial state	ements that accompany the claim.
Persons being rehabilitated. Number of hours worked: Number of persons.	rsons involved:	
Staff and/or others. Number of hours worked: Number of per	rsons involved:	
FOR ASSESSOR'S USE ONLY	Whom should	I we contact during normal business
Received by	1	s for additional information?
(Assessor's designee)	NAME	
ofon(date)	DAYTIME TELEPHONE	EMAIL ADDRESS
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D. Salaries and wages paid during the time 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:		
E. Does a person, management firm, or entity other than the organization fi Yes No If YES, provide the operator's name and mailing address:	ling this claim operate the facility?	
Amount of salary or fee: \$ Attach a copy of the contract or	other document that indicates the basis for the sala	ary or fee.
F. Is housing for persons being rehabilitated and/or living quarters for staff Yes No If YES, explain the necessity and complete section 4, House		
Section 4. Housing — Living Quarters		
A. Total number of persons who were housed on the premises the last nigh	t in December. Include persons who may be tem	porarily away.
Total number of persons being rehabilitated		
2. Number of unoccupied beds available for persons to be rehabilitate	ed	
Number of staff members necessary to care for those persons beir Attach a list describing the jobs performed and the number of persons		
4. Number of other staff members		
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 p 1. Number of persons	remises the last night in December.	
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 war Yes No If YES, indicate which and explain in sufficient detail to dete		
 D. Do staff members who care for those being rehabilitated pay, donate, or from, their salary? Yes No If YES, indicate which and explain in sufficient detail to determine the sufficient detail to detail the sufficient detail to detail the sufficient detail the sufficient detail to detail the sufficient det	•	lieu of, or
E. Do other staff members pay, donate, or perform work for their room and/ Yes No If YES, indicate which and explain in sufficient detail to dete		
F. Do the other persons not directly connected with the rehabilitation progr board?	, ,	om and/or
☐ Yes ☐ No If YES, indicate which and explain in sufficient detail to dete	rmine the monthly fee per person.	
CERTIFICATION	l	
I certify (or declare) under penalty of perjury under the laws of the State of California any accompanying statements or documents, is true, correct, and c	omplete to the best of my knowledge and belief.	erein, 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. 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.