EF-267-R-R09-0521-09000205-1 BOE-267-R (P1) REV. 09 (05-21)

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



JON DEVILLE, ASSESSOR 360 FAIR LN.

EL DORADO COUNTY

PLACERVILLE, CA 95667 TEL. 530-621-5739

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)	a)	
BOL-207-A, Glain for Wellare Exemption (Annual Film)	9)	
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 o	of 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)
Address of property (number and street)		/ tooosoor of a doo, / tooosoment (4amber(e)
City, County, Zip Code		Date Property Acquired
attachment. A. Facility Information. 1. Number of hours per week the facility is operated: Total number of pers 2. Persons being rehabilitated. Full-time: Part	the length of employment:	Longer than 2 years:
3. Staff and/or others. Full-time: Part-time:		(list by number of years)
B. Total number employed off the premises, but in the ope	erations of the facility as of	January 1.
	-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:	
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 stat	tements that accompany the claim.
1. Persons being rehabilitated.	sons involved:	, , , , , , , , , , , , , , , , , , ,
Staff and/or others. Number of hours worked: Number of per	sons involved:	
FOR ASSESSOR'S USE ONLY	Whom shoul	Id we contact during normal business
		rs for additional information?
Received by(Assessor's designee)	NAME	
of on		
(county or city) (date)	DAYTIME TELEPHONE	EMAIL ADDRESS

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	d wages paid during the time period included in the fina	ncial statements that accompany the claim.	
1. Persons be Salaries ar	eing rehabilitated. nd wages: Number of persons involved:		
2. Staff and/o Salaries ar			
	son, management firm, or entity other than the organizat No If YES, provide the operator's name and mailing addre		
Amount of sa	lary or fee: \$ Attach a copy of the contra	act or other document that indicates the basis for the s	alary or fee.
	for persons being rehabilitated and/or living quarters for No If YES, explain the necessity and complete section 4,	•	
Section 4. Hou	using — Living Quarters		
A. Total numb	er of persons who were housed on the premises the last	t night in December. Include persons who may be to	emporarily away.
-	Total number of persons being rehabilitated		
-	2. Number of unoccupied beds available for persons to be reha		
-	Number of staff members necessary to care for those persor Attach a list describing the jobs performed and the number of		
-	Number of other staff members		
-	5. Number of other persons who are not directly connected with		
B. Length of s	tay of persons being rehabilitated who were housed on 1. Number of persons	the premises 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 pe		
	s being rehabilitated pay, donate, or perform fund production No If YES, indicate which and explain in sufficient detail to	_	
from, their	embers who care for those being rehabilitated pay, donat salary? No If YES, indicate which and explain in sufficient detail to	•	in lieu of, or
	aff members pay, donate, or perform work for their room ☐ No If YES, indicate which and explain in sufficient detail to		
F. Do the othe board?	r persons not directly connected with the rehabilitation	program pay, donate, or perform work for their r	oom and/or
☐ Yes	No If YES, indicate which and explain in sufficient detail to	o determine the monthly fee per person.	
	CERTIFICA	TION	
	clare) under penalty of perjury under the laws of the State of Cali any accompanying statements 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. 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.

