

Sendy Perez Assessor 516 W. Sycamore St., 2nd Floor Willows CA 95988 Phone: (530) 934-6402 Fax: (530) 934-6571

REHABILITATION — LIVING QUARTERS

This claim is filed for fiscal year 20 _____ 20 ____

Mailing Address (number and street) Corporate ID or LLC Number City, State, Zip Code Corporate ID or LLC Number Organizational Clearance Certificate (OCC) No	This is a Supplemental Affidavit filed with		
Section 1. (dentification of Applicant Mailing Address (number and street) Corporate ID or LLC Number City, State, Zip Code Organizational Clearance Certificate (OCC) No	BOE-267, Claim for Welfare Exemption (First F	Filing)	
Name of Organization Mailing Address (number and street) Corporate ID or LLC Number City, State, Zip Code Crganizational Clearance Certificate (OCC) No(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have an OCC, have you filed a claim for an OCC with the BOE?(Provide copy of certificate with this claim if first filling). If you do not have as expanse tracture in the operations of the facility is operated:	BOE-267-A, Claim for Welfare Exemption (Ann	ual Filing)	
Name of Organization Mailing Address (number and street) Corporate ID or LLC Number City, State, Zip Code Crganizational 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?(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?(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?(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?(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?(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?(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?(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?(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?(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?(Provide copy of certificate with this claim if first filing). If you do not have are an OCC, have you filed a claim for an OCC with the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a separate attachment. A Facility Information I. Number of hours perveek the facility is operated:	Section 1 Identification of Applicant		
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?(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?(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?	Name of Organization		
Organizational Clearance Certificate (OCC) No.	Mailing Address (number and street)		Corporate ID or LLC Number
an OCC, have you filed a claim for an OCC with the BOE?	City, State, Zip Code		
If No, see instructions for information 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 Date Property Acquired Section 4. Rehabilitation: Thrift Shop, Workshop, Manufacturing, or Similar Activities Date Property Acquired Section 3. Rehabilitation: Thrift Shop, Workshop, Manufacturing, or Similar Activities Date Property Acquired Section 4. Facility Information 1. Number of hours per week the facility is operated:			ificate with this claim if first filing). 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: 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 attachment. A Facility Information 1. Number of hours per week the facility is operated:	🗌 Yes 🔲 No		
Address of property (number and street) Date Property Acquired 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 separate attachment. A. Facility Information 1. Number of hours per week the facility is operated: Part-time: Part-time: Longer than 2 years: (ist by number of years) 2. Persons being rehabilitated. Full-time: Part-time: 1 year - 2 years: Longer than 2 years: (ist by number of years) 3. Staff and/or others. Full-time: Part-time: (ist by number of years) B. Total 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: (ist by number of years) 2. Staff and/or others. Full-time: Part-time: 1 year - 2 years: Longer than 2 years: (ist by number of years) 2. Staff and/or others. Full-time: Part-time:	If No, see instructions for information on obtaining an OC	C claim form.	
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 separate attachment. A. Facility Information 1. Number of hours per week the facility is operated: Part-time: Part-time: Part-time: Part-time: Longer than 2 years: (list by number of years) 3. Staff and/or others. Full-time: Part-time: 8 Total number of persons being rehabilitated based on the length of employment:	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 separate attachment. A. Facility Information 1. Number of hours per week the facility is operated: Total number of persons being rehabilitated. Full-time: Persons being rehabilitated. Full-time: identify the number of persons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year: 9 art-time: (list by number of years) 8. 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: (list by number of years) 8. Total number employed off the premises, but in the operations of the facility as of January 1. 1. 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 persons being rehabilitated based on the length of employment: Less than 6 months: Part-time: 2. Staff and/or others. Full-time: Part-time: (list by number of persons being rehabilitated. Number of hours worke	Address of property (number and street)		
Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a separate attachment. A Facility Information 1. Number of hours per week the facility is operated:	City, County, Zip Code		Date Property Acquired
Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a separate attachment. A Facility Information 1. Number of hours per week the facility is operated:			
a separate attachment. A. Facility Information 1. Number of hours per week the facility is operated:			
1. Number of hours per week the facility is operated:	a separate attachment.	illitation program, or describe the rehal	bilitation program and activities in detail on
Total number of persons employed on the premises on January 1. 2. Persons being rehabilitated. Full-time: Part-time: Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years: 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) B. 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: Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years: (list by number of years) 2. Staff and/or others. Full-time: 9 art-time: (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: (list by number of years) 2. Staff and/or others. Number of persons involved: . 1. Persons being rehabilitated. Number of persons involved: . 2. Staff and/or others. Number of persons involved: . 2. Staff and/or others. Number of persons involved: . 2. Staff and/or others.	A. Facility Information		
2. Persons being rehabilitated. Full-time: Part-time: Part-time: Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years: (list by number of years) 3. Staff and/or others. Full-time: Part-time: (list by number of years) 8. Total number employed off the premises, but in the operations of the facility as of January 1. I. Persons being rehabilitated. Full-time: Part-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: Longer than 2 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: 2. Staff and/or others. For hours worked during the time period included in the financial statements that accompany the claim. 1. Persons being rehabilitated. Number of persons involved:	1. Number of hours per week the facility is operated:		
Identify the number of persons being rehabilitated based on the length of employment: Longer than 2 years:			anuary 1.
Less than 6 months:			
(list by number of years) 3. Staff and/or others. Full-time: Part-time: B. 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 years) 2. Staff and/or others. Full-time: Part-time: 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: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of nours worked: Number of persons involved: Number of hours worked: Number of persons involved: Number of nours worked: Number of persons involved:		0 1 3	Longer then Overse
3. Staff and/or others. Full-time: Part-time: B. 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:	Less than 6 months: 6 months - 1 yea	ar: 1 year - 2 years:	
1. Persons being rehabilitated. Full-time: Part-time: Image: Part-time: Image: Part-time: 1. bersons being rehabilitated based on the length of employment: Less than 6 months: 6 months - 1 year: 1 year - 2 years: Longer than 2 years: 2. Staff and/or others. Full-time: Part-time: 1 year - 2 years: Longer than 2 years: 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. Staff and/or others. 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:	3. Staff and/or others. Full-time: Part-ti	ime:	
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: (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: 2. Staff and/or others. Number of persons involved: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of persons involved: Number of hours worked: Number of persons involved: Port ASSESSOR'S USE ONLY Whom should we contact during normal business hours for additional information? NAME DayTIME TELEPHONE EMAIL ADDRESS	B. Total number employed off the premises, but in	the operations of the facility as of Janu	uary 1.
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: Number of hours worked: Number of persons involved: 2. Staff and/or others. Number of persons involved: 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) NAME of (county or city) (date) DAYTIME TELEPHONE EMAIL ADDRESS			
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 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: 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: 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:	Less than 6 months: 6 months - 1 yea	ar: 1 year - 2 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	2. Staff and/or others. Full-time: Part-ti	me:	(list by number 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			
2. Staff and/or others. Number of hours worked:		beriod included in the financial stateme	nts that accompany the claim.
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) NAME of on On OAYTIME TELEPHONE EMAIL ADDRESS	Number of hours worked: Number	er of persons involved:	
Received by (Assessor's designee) NAME of on On (county or city) (date)		er of persons involved:	
Received by (Assessor's designee) hours for additional information? of on OAYTIME TELEPHONE EMAIL ADDRESS	FOR ASSESSOR'S USE ONLY	Whom should we	contact during normal business
of on (date) OAYTIME TELEPHONE EMAIL ADDRESS		hours for	additional information?
of on date) DAYTIME TELEPHONE EMAIL ADDRESS	Received by(Assessor's designee)		
(county or city) (date) DAYTIME TELEPHONE EMAIL ADDRESS		NAME	
			EMAIL ADDRESS
		()	
THIS DOCUMENT IS SUBJECT TO PUBLIC INSPECTION			PECTION



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

- 1. Persons being rehabilitated. Number of persons involved: Salaries and wages: 2. Staff and/or others.
- 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? □ No If YES, indicate which and explain in sufficient detail to determine the monthly fee per person. Yes
- 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? No If YES, indicate which and explain in sufficient detail to determine the monthly fee per person. Yes

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 other persons	not directly	connected	with the rehabilitation program pay, donate, or perform work for their room 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.						
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: 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

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.

