WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT, REHABILITATION — LIVING QUARTERS



Assessor-Recorder
1 Dr. Carlton B. Goodlett Place
City Hall - Room 190

San Francisco, CA 94102-4698

Joaquín Torres

| I his 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 Fili | ing) | |
| 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 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 | m 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 pe 2. Persons being rehabilitated. Full-time: Identify the number of persons being rehabilitated based of Less than 6 months: 1. Number of persons being rehabilitated based of the number of persons being rehabil | ersons employed on the premise art-time: on 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 o | perations of the facility as o | f January 1. |
| Persons being rehabilitated. Full-time: Pa | - | • |
| Identify the number of persons being rehabilitated based o | 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 | included in the financial sta | tements that accompany the claim. |
| 1. Persons being rehabilitated. | ersons involved: | . , |
| 2. Staff and/or others. | | |
| Number of hours worked: Number of p | ersons involved: | |
| FOR ASSESSOR'S USE ONLY | Whom should we contact during normal business | |
| Received by | nou | urs for additional information? |
| (Assessor's designee) | NAME | |
| of on (date) | DAYTIME TELEPHONE | EMAIL ADDRESS |
| | / \ | EMAIL ADDITIES |

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| | d wages paid during the time period included in the financial stat | ements that accompany the claim. | |
|--|--|--|-----------------|
| Persons be Salaries an | ing rehabilitated. d wages: Number of persons involved: | _ | |
| 2. Staff and/o Salaries an | | <u> </u> | |
| | on, management firm, or entity other than the organization filing No If YES, provide the operator's name and mailing address: | this claim operate the facility? | |
| Amount of sal | ary or fee: \$ Attach a copy of the contract or othe | r document that indicates the basis for the sala | ry or fee. |
| | or persons being rehabilitated and/or living quarters for staff pro No If YES, explain the necessity and complete section 4, <i>Housing</i> - | | |
| Section 4. Hou | sing — Living Quarters | | |
| A. Total number | er of persons who were housed on the premises the last night 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 rehabilitated | | |
| _ | Number of staff members necessary to care for those persons being re 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 rehab | | |
| _ | tay of persons being rehabilitated who were housed on the prem 1. Number of persons | ises 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 bein | | |
| | being rehabilitated pay, donate, or perform fund producing work No If YES, indicate which and explain in sufficient detail to determin | | |
| from, their s | mbers who care for those being rehabilitated pay, donate, or perisalary? No If YES, indicate which and explain in sufficient detail to determin | | lieu of, or |
| | aff members pay, donate, or perform work for their room and/or b ☐ No If YES, indicate which and explain in sufficient detail to determin | , , , , , , , , , , , , , , , , , , , | |
| F. Do the other board? | persons not directly connected with the rehabilitation program | pay, donate, or perform work for their roo | om and/or |
| ☐ Yes [| ☐ No If YES , indicate which and explain in sufficient detail to determin | e the monthly fee per person. | |
| | CERTIFICATION | | |
| | are) under penalty of perjury under the laws of the State of California that any accompanying statements or documents, is true, correct, and comp | lete to the best of my knowledge and belief. | rein, including |
| NAME | ТІТ | LE | 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.

