BOE-267-R (P1) REV. 07 (06-11)

# WELFARE EXEMPTION SUPPLEMENTAL AFFIDAVIT, REHABILITATION — LIVING QUARTERS

Phil Ting, Assessor-Recorder
Office of the Assessor-Recorder
City and County of San Francisco
1 Dr. Carlton B. Goodlett Place, Room 190
San Francisco, CA 94102
(415) 554-5596

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)

## 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?

☐ 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)

City, County, Zip Code | Date Property Acquired

## Section 3. Rehabilitation

Provide a copy of the organization's formal rehabilitation program, or describe the rehabilitation program and activities in detail on a separate attachment.

**A. Thrift shop, workshop, manufacturing, or similar activities.**

1. Number of hours per week the facility is operated: _____

*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:
   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: _____

**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:
   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: _____

**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: _____

| 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)* on _____ *(date)* | DAYTIME TELEPHONE ( ) | EMAIL ADDRESS |

**THIS DOCUMENT IS SUBJECT TO PUBLIC INSPECTION**

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

1. Persons being rehabilitated.
   Salaries and wages: _____ Number of persons involved: _____
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?**

☐ 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 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.

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.