CalFresh Referral Form

RIVER CITY FOOD BANK
P.O. Box 160204
Sacramento, CA
95816
916-446-2627

Referring Organization: _____ **Date:**_____

Worker/Volunteer Name_____**Phone#**_____

Please fill in your contact information below. The information you provide is confidential and will help us determine if anyone in your household **might be eligible** to apply for CalFresh.

Name:	**Spoken Language:**
Phone:	**Best time to call:**
Email Address:	
Address: **City, Zip code:**	

1. How many people live in your household?

Children (0-21years old)_____Adults (22-59 years old)_____Older Adults (>60 years old)

2. How many household members are citizens or permanent residents?____
3. How many people do you prepare and eat meals with in your household?____
4. Are there any household members that receive Supplemental Security Income {SSI} or State Supplemental Payments {SSP)? (YES/NO) If yes, how many?_____
5. Please tell us about your household income:

	Name	Relationship to you	Source of Income	Gross amount per month
1				$
2				$
3				$

6. Do you pay rent or mortgage? (circle one) If yes, how much per month? $_____
7. Is your rent/mortgage& utility bills for this month more than your monthly household income? Yes or no
8. Do you pay for child care? If yes, how much per month? $ _____
9. If you are a senior or disabled, do you have any out of pocket monthly medical costs? Yes or no?
10. Is anyone in the household paying child support? Yes or no If yes, how much per month?____

Please fax completed form to River City Food Bank at

(916) 446-4241 or email to calfresh@rivercityfoodbank.org

Questions? Contact Amy at 916-233-4075

APPLICANT/RECIPIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION TO COMMUNITY-BASED ORGANIZATION (CBO) IN BENEFITSCAL

Case # _____

To: (Name of County that information is being requested from) Sacramento

I, (Applicant/Recipient Name) _____

whose contact information is

(Applicant/Recipient Mailing Address) _____

☐ I don't have a mailing address

(Applicant/Recipient Phone Number) _____

☐ I don't have a phone number

give you permission to release to (name of CBO) River City Food Bank- CalFresh Outreach Dept.

specific information on the following program(s) (select all that apply):

- ☑ CalFresh
- ☐ Medi-Cal
- ☐ CalWORKs

*(Not required) for Medi-Cal, you may select the person(s) at the chosen CBO above that you allow information to be shared with. If you do not choose anyone, any employee of the CBO identified above may have access to your information. _____

*If Medi-Cal is checked, please select the reason for sharing this information:

- ☐ Assist in applying for and/or keeping public benefits
- ☐ A specific case issue
- ☐ At the request of the individual
- ☐ Other: _____

I ask the following specific information be released to the CBO identified above (select all information you want to share):

- ☑ Notices of Action (NOAs)
- ☑ Verification Requests from your County Worker
- ☑ Benefit Award
- ☑ Program Status
- ☑ Termination Reason(s)
- ☑ Upcoming SAR 7 and Renewal Due Dates

How long do you want the information you marked above to be shared with the CBO? This time period begins the date this form is signed. Please note: any new specific information marked above that becomes available during this time period will also be made available to the CBO (select one option).

- ☑ 365 calendar days
- ☐ Number of days (less than 365 days): _____ days

You can also share with the CBO what has happened in the past, except for any of your previous NOAs and Verification Requests from your County Worker. **What length of your case history, as available in BenefitsCal and limited to the information you marked above (except for NOAs and Verification Requests from your County Worker), do you request be shared with the CBO (select one option)?**

- ☑ The past 60 days
- ☐ No case history

I understand that by signing this authorization (permission) form that I agree to and understand the following:

- Whether I completed this form or not has no effect on my eligibility for benefits.
- I authorize (give permission) for the use and/or disclosure of my information as described above for the programs and reason listed above. I understand that this authorization is voluntary.
- I have the right to revoke (cancel) this authorization at any time by contacting the County listed above in person or by mail, phone, or electronically. The authorization will end on the date the County gets my request to cancel.
- The CBO is prohibited from re-disclosing (sharing) the information except with my written authorization, or as specifically required or permitted by law.
- I have the right to get a copy of this signed form.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- This authorization is effective (starts) the date that I sign this form.
- This form was filled out completely and was read by me (or read to me) before signing.
- **By signing this form, I cancel any previous release of information I signed with the CBO and/or person(s) named in this form. The CBO and/or person(s) listed on this form are only given permission to see the information that I have chosen above.**

SS #

Applicant/Recipient Name – Print Name	Birth Date
Signature of Applicant/Recipient or Authorized Representative X	Date

FOR CALWORKS AND MEDI-CAL ONLY

Signature of Parent/Guardian (If applicant/recipient is a minor)	Date