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?____

Complete and Return to calfresh@rivercityfoodbank.org

Or Fax 916-446-4241

Questions? Contact at 916-233-4075

California Health & Human Services Agency | California Department of Social Services

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

To:
SACRAMENTO COUNTY DEPT OF HUMAN ASSISTANCE - CASE #

(Agency or individual for whom information is requested)

I, (name) _____, residing at (address) _____

_____, hereby authorize you to release to the

RIVER CITY FOOD BANK - AMY DIERLAM, AMALIA CRUZ -p.o. box 160204, sacramento, ca

(Name of Agency, Institution, Individual Provider)

specific information requested by this agency which I cannot provide concerning

My CalFresh case including the status, the benefit amount and what budget the county is running, NOA's, termination reasons, upcoming SAR7 and Renewals, and anything pertaining to me getting on CalFresh or staying on CalFresh.

This information is needed for the following purpose:

to help me get on CalFresh or stay on CalFresh.

This form was completed in its entirety and was read by me (or to me) prior to signing.

Signature of Applicant		Date
Birthplace	Birthdate	Maiden Name of Mother
Signature or Name of Spouse		Date
Birthplace of Spouse	Birthdate of Spouse	Maiden Name of Spouse's Mother