



P.O. Box 160204
 Sacramento, CA
 95816
 916-446-2627

CalFresh Referral Form

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 adierlam@rivercityfoodbank.org
 Questions? Contact Amy at 916-233-4075**

AUTHORIZATION FOR RELEASE OF INFORMATION

Case Name
Case Number
Worker Name
Worker Number
Worker Telephone
Date

111

I, _____, residing at _____
Applicant/Client Name **Applicant/Client Address**

_____ hereby authorize you to release to _____
Applicant/Client City/State/Zip Code
River City Food Bank, Amy Dierlam, Amalia Canseco Cruz (916) 233-4075 specific information
Name of Agency, Institution, Individual Provider

requested by this agency which I cannot provide concerning:

*** Worker Note (To be entered as- Limited authority to check application and renewal status)***

***No client correspondence to be sent to this representative ***

River City Food Bank may discuss all of my Cal Fresh case details & work with the county to resolve any issues regarding my case on my behalf.

phone number:

email address:

This form was completed in its entirety (or read to me) prior to signing. I understand that I have the right to receive a copy of this authorization upon my request.

Copy requested and received: Yes No Initial

This release is valid for 12 months from the signature date of the client or until revoked by the client.

Signature of Applicant/Client	Birth Date	Maiden Name of Mother
Birthplace	SSN	Date
Signature of Spouse of Applicant/Client	SSN	Date
Birthplace of Spouse	Birthdate	Maiden Name of Spouse's Mother