CalFresh Intake for Seniors (60+) and or Disabled

Name: _____ Date of Birth: _____

Does your shelter expense (rent/mortgage) exceed 50% of your net income? ☐Yes ☐No

Dependent Care Deduction: Do you seek care for a child with disability or adult to:

☐accept or continue employment/seek employment?

☐comply with Food Stamp Employment & Training (FSET) requirements?

☐pursue education or training for employment preparation (**Welfare-to-Work** activities)?

(***note: receipts with names of the dependent & the person who paid for the care are needed***)

Excess Medical Expenses ($35+): Please check the corresponding box that applies to you:

- ☐ Costs of medical & dental care, including co-payment for visits
- ☐ Hospitalization or nursing care (note: household can deduct entire amount that is not reimbursable by any public or private insurance coverage. A hospital bill is considered a one-time medical expense. The household can either have a one-time-only deduction or have a one-time-only deduction or have the expense averaged out over the remaining months of its certification period.
- ☐ Prescription medication & medical supplies (special bandages, glucose strips, etc.)
- ☐ Over-the-counter medication (including insulin and vitamins), when approved by health professional
- ☐ Health and hospitalization insurance premiums (excluding the costs of health and accident or income maintenance policies)
- ☐ Medical premiums or Medi-Cal share of cost
- ☐ Dentures, hearing aids, and prosthetics
- ☐ Costs for obtaining/maintaining service animal including costs of food and veterinarian bills
- ☐ Reasonable transportation and lodging expenses needed to obtain medical treatment
- ☐ Special telephone equipment for a person with disabilities
- ☐ Prescription eyeglasses and contact lenses
- ☐ Attendant services performed by someone outside of the household (even if that person is a relative) and meals provided to the “attendant” (i.e., meals for the caretaker being paid to take care of the elderly or the disabled person)
- ☐ Psychotherapy

If you marked any of the boxes above, you may be asked by your County to provide proof. The more documentation you provide at the intake assistance the sooner you will find out the status of your application.

CalFresh Intake Form

Please fill in your contact information below. The information you provide is confidential and will assist in submitting your CalFresh application to the DHA*.

Name: _____ Date of Birth: _____

Home Address: _____ Homeless? YES NO

E-mail address: _____ Best time/day to contact you? _____

Phone #: _____ Language (Preferred/ fluent): _____ Military Status: _____

SSN #: _____ CIRCLE ONE, I am a: U.S. Citizen Non-Citizen Naturalized Sponsored

Income Type:

Earned	Unearned	Information
Work/ Self-Employed: (Company name):	Social Security Retirement:	How often paid? Weekly/Twice A Month/Monthly or Other
Work/ Self-Employed: (Company name):	Disability:	Gross or total earnings from last 30 days:
Work/ Self-Employed: (Company name):	Other:	Is this income expected to continue? If no, why?

Bank Account(s): YES NO Name of Bank: _____ Checking: $_____ Savings: $_____
Own Property? YES or NO Mortgage payment: _____ Value: _____ How much owed?: _____
Enrolled in college or vocational school? YES NO Full time Part time # of units ____ Work Study Program? YES NO
Enrolled in Low Income Home Energy Assistance Program (LIHEAP)? Discount on SMUD or PG&E bill(s) YES NO

1. How many people do you prepare meals for and eat with in your household? _____
2. Have you received? CalFresh and/or Medi-Cal YES or NO Name used: _____
   What County? _____ Approximate dates: _____
3. Please complete the boxes below that apply to your household:

Type of Bill	Amount	Frequency	Does anyone outside of the home assist with this bill?	If yes, name and amount.
Rent/Mortgage				
PG&E				
SMUD				
Water/Garbage/Sewer				
Telephone/Cell				
Childcare				
Child Support				

Important: Please complete the back of this page with all household member(s) information.

Helped by	Date	☐ DHA ☐ CAFB
Staff	Event	

CalWin	Date	Time
CalWin Conf #		
Oasis	Date	Case#

What is the race and/or ethnicity the applicant identifies as?

_____

Household member CIRCLE ONE: Spouse, Child, Parent or Other: ________________ Birthdate: ________________

Name: ____ Male Female Military Status: ___________________

SSN #: __________________ CIRCLE ONE: U.S. Citizen Non-Citizen Naturalized Sponsored

Does this household member receive earned or unearned income? ____ If yes, what kind/how often? __________________

Have they received? CalFresh and/or Medi-Cal YES or NO Name used: ___________________________

What County? ______________________________ Approximate dates: ______________________________

Enrolled in college or vocational school? YES NO Full Time Part time # of units ___ Work Study Program? YES NO

Household member CIRCLE ONE: Spouse, Child, Parent or Other: ________________ Birthdate: ________________

Name: ____ Male Female Military Status: ___________________

SSN #: __________________ CIRCLE ONE: U.S. Citizen Non-Citizen Naturalized Sponsored

Does this household member receive earned or unearned income? ____ If yes, what kind/how often? __________________

Have they received? CalFresh and/or Medi-Cal YES or NO Name used: ___________________________

What County? ______________________________ Approximate dates: ______________________________

Enrolled in college or vocational school? YES NO Full Time Part time # of units ___ Work Study Program? YES NO

Household member CIRCLE ONE: Spouse, Child, Parent or Other: ________________ Birthdate: ________________

Name: ____ Male Female Military Status: ___________________

SSN #: __________________ CIRCLE ONE: U.S. Citizen Non-Citizen Naturalized Sponsored

Does this household member receive earned or unearned income? ____ If yes, what kind/how often? __________________

Have they received? CalFresh and/or Medi-Cal YES or NO Name used: ___________________________

What County? ______________________________ Approximate dates: ______________________________

Enrolled in college or vocational school? YES NO Full Time Part time # of units ___ Work Study Program? YES NO

Household member CIRCLE ONE: Spouse, Child, Parent or Other: ________________ Birthdate: ________________

Name: ____ Male Female Military Status: ___________________

SSN #: __________________ CIRCLE ONE: U.S. Citizen Non-Citizen Naturalized Sponsored

Does this household member receive earned or unearned income? ____ If yes, what kind/how often? __________________

Have they received? CalFresh and/or Medi-Cal YES or NO Name used: ___________________________

What County? ______________________________ Approximate dates: ______________________________

Enrolled in college or vocational school? YES NO Full Time Part time # of units ___ Work Study Program? YES NO

Confirmation #:

COUNTY OF SACRAMENTO

Phone #:

AUTHORIZATION FOR RELEASE OF INFORMATION

Case Name
Case Number
Worker Name
Worker Number
Worker Telephone
Date

TO:

I, _____, residing at _____
Applicant/Client Name — Applicant/Client Address (#, street, city, zip)

_____, hereby authorize you to release to
Applicant/Client Address continued (#, street, city, zip)

Sacramento Food Bank & Family Services/ Lorena Carranza

specific information requested by this agency which I cannot provide concerning: CalFresh application status.

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 X	Birth Date	Maiden Name of Mother
Birthplace N/A	SSN Last 4 digits _ _ _ _	Date
Signature of Spouse of Applicant/Client	SSN	Date
Birthplace of Spouse	Birthdate	Maiden Name of Spouse's Mother

- Your Rights and Responsibilities:

  When you apply for CalFresh benefits, you have rights and responsibilities. Your most important right is to be treated fairly without regard to race, color, national origin, political beliefs, religion, gender, age, or disability. If you think you have been discriminated against, you may file a complaint by:

  - Contacting your county's civil rights coordinator
  - Call (916) 654-2107 or 866-741-6241 (toll free)
  - Write to: California Department of Social Services
    Civil Rights Bureau, M.S. 8-16-70
    P.O. Box 94243
    Sacramento, CA 94244-2430
  - If you get Calfresh benefits only, write to:
    U.S. Department of Agriculture
    Food and Consumer Service
    P.O. Box 944243
    Civil Rights Office
    550 Kearny Street
    San Francisco, CA 94108-2518

- Your Rights are to:
  - Receive an application when you ask for it.
  - Turn in your application the same day you receive it.
  - Receive your CalFresh benefits (or be notified that you are not eligible for the program) within 30 days after you turn in your application.
  - Receive expedited CalFresh benefits within three (3) days if you are eligible and have little or no money.
  - Have a fair hearing if you disagree with any action taken on your case.

- Your Responsibilities are to:
  - Answer all questions completely and honestly when you apply for CalFresh benefits. Sign your name to certify, under penalty of perjury, that all your answers are true.
  - Provide proof that you are eligible.
  - Promptly report changes in household circumstances to the CalFresh office.
  - Not put your money or possessions in someone else's name in order to be able to get CalFresh benefits.
  - Not make changes on any CalFresh cards or documents.
  - Not sell, trade, or give away your CalFresh benefits, or any CalFresh cards or documents.
  - Use CalFresh benefits only to buy eligible items.

*__The information you are providing today on this CalFresh Intake Form will only be used to complete your online CalFresh application to the Department of Human Assistance (DHA). By signing, you are allowing this information to be input on your behalf. You will receive this original signed copy during the intake process or it will be mailed back to you.__

CalFresh Applicant: _____ Date: _____
(print name) (signature)

SFBFS Staff: _____ Date: _____
(print name) (signature)

If you have any questions regarding the submission of your online CalFresh application, please do not hesitate to contact Sacramento Food Bank & Family Services at (916)-925-3240 or (916)-456-1980. Thank you for allowing us to assist you today.