

REQUEST FOR RESTORATION OF CALFRESH BENEFITS AFTER ADMINISTRATIVE DISQUALIFICATION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

┌ _____ ┐
└ _____ ┘

┌ _____ ┐
└ _____ ┘

I was disqualified from receiving CalFresh benefits from _____ to _____.

_____ I live in the same CalFresh household where I previously received benefits and the county did not restart them after the end date of my disqualification period.

_____ I live in a new household that receives CalFresh. I request to be added to that CalFresh household. The household's information is as follows:

Case Name: _____

Case number: _____

Address: _____

_____ I live in a new household that does not receive CalFresh. Please send me an application for CalFresh benefits at the following address:

Return this form to your welfare office, at the address listed above.