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

APPLICATION FOR SOCIAL SERVICES

To the Applicant: All sections of this form must be completed. Information provided is subject to verification.

NOTE: Retain your copy of your completed application. Regarding your Social Security Number, it is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP Section 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

Date of Application:	Case Number (if known):

Section 1 – Personal Information

Name:		Social Security Number:
Street Address:		City:
State:	Zip Code:	Telephone:
Birthdate:	Sex: ☐ Male ☐ Female	

Section 2 – Veteran Information

Are you a Veteran? ☐ Yes ☐ No	Are you a Spouse/Child of a Veteran? ☐ Yes ☐ No .
If YES, give Veteran name and Claim Number:	

Section 3 – SSI/SSP Information

Do you receive SSI/SSP benefits? ☐ Yes ☐ No		
If yes, check your type of living arrangement: ☐ Independent Living	☐ Board and Care	☐ Home of Another
Services being requested:		