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):
06/22/2025	

Section 1 – Personal Information

Name:		Social Security Number:
Wei Jin Li		123456789
Street Address:		City:
789 Main Lane Apt 5		Fremont
State:	Zip Code:	Telephone:
CA	94538	510-555-1111
Birthdate:	Sex: [X] Male [ ] Female	

Section 2 – Veteran Information

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

Section 3 – SSI/SSP Information

Do you receive SSI/SSP benefits? [X] Yes [ ] No
If yes, check your type of living arrangement: [X] Independent Living [ ] Board and Care [ ] Home of Another
Services being requested: House cleaning, meal assistance, supervision

Please use black or blue ink because it is easy to read and copies best. Please print your answers.
If you need more space to answer a question(s), attach additional sheets of paper to provide the information. Please be sure to identify which question you are writing about on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST)	OTHER NAMES (MAIDEN, NICKNAMES, ETC.)	SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS)
Wei Jin Li	Wesley	123456789

HOME ADDRESS OR DIRECTIONS TO YOUR HOME	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
789 Main Lane Apt 5	Apt 5	Fremont	Alameda	CA	94538
MAILING ADDRESS (IF DIFFERENT FROM ABOVE	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
789 Main Lane Apt 5	Apt 5	Fremont	Alameda	CA	94538

I want to get information about this application by email. ☑ Yes ☐ No

I want to get messages about my case by email. ☑ Yes ☐ No

HOME PHONE	WORK/ALTERNATE/MESSAGE PHONE	EMAIL ADDRESS
510-555-1111	510-555-2222	grandpa.lee@example.com

What programs are you applying for?
☑ CalFresh ☐ Cash Aid ☑ Health Coverage

Do you have a disability and need help applying? ☑ Yes ☐ No

Are you homeless? ☐ Yes ☑ No If **yes,** please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)? Chinese
What language do you prefer to speak (if not English)? Cantonese

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

Is your household's gross income less than $150 and cash on hand, checking and savings accounts of $100 or less?	☐ Yes ☐ No	Have your utilities been shut off or do you have a shut-off notice?	☐ Yes ☑ No
Is your household's combined gross income and liquid resources less than the combined rent/mortgage and utilities?	☐ Yes ☐ No	Will your food run out in 3 days or less?	☐ Yes ☑ No

Is anyone pregnant? ☐ Yes ☐ No

Does anyone in your household have a personal emergency? ☐ Yes ☐ No If **yes**, check box: ☐ Pregnancy ☐ Immediate Medical Need ☐ Child Abuse ☐ Domestic Abuse ☐ Elder Abuse ☐ Other emergency which threatens health or safety. Explain:

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- My answers to the questions are true and complete to the best of my knowledge.
- Any answers I may give for my application process will be true and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1).
- I read, or had read to me, the Program Rules and Penalties (Program Rules Pages 2 - 4).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility is fraud and that I may be subject to penalties under federal law if I provide false or untrue information. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits and cash aid.
- I understand that Social Security Numbers or Immigration Status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.
- I am giving the Medi-Cal agency the right to pursue and get any money from other health insurance, legal settlements or other third parties.

SIGNATURE OF APPLICANT, CARETAKER RELATIVE (OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE*/GUARDIAN) ***If you have an Authorized Representative please complete question 2 on next page.**	DATE
SIGNATURE OF SPOUSE, OTHER PARENT, AIDED ADULT, OR REGISTERED DOMESTIC PARTNER	DATE