Street Address
1235 Mission or 1440 Harrison
San Francisco, CA 94103

Web/Phone
www.mybenefitscalwin.org
(415) 558-4700

Mailing Address
P.O. Box 7988
San Francisco, CA 94120

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)
sdf	asdf	asdf

HOME ADDRESS OR DIRECTIONS TO YOUR HOME	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE
sdfsadfa	sd	asdf	lh	lkj	lkjh
MAILING ADDRESS (IF DIFFERENT FROM ABOVE	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE

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
kjh		l

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)?_____
What language do you prefer to speak (if not English)?_____

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 your household a migrant/seasonal farm worker household with liquid resources not exceeding $100?	☐ Yes ☐ No	Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?	☐ Yes ☐ No
Do you have an eviction notice or a notice to pay rent or leave?	☐ Yes ☐ No	Do you need essential clothing, such as diapers or clothing needed for cold weather?	☐ Yes ☐ No

Is anyone pregnant? ☐ Yes ☐ No If yes, did she get a Presumptive Eligibility card? ☐ 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

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years of age or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? ☐ Yes ☐ No
If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME	AUTHORIZED REPRESENTATIVE PHONE NUMBER

Do you want to name someone to receive and spend CalFresh Benefits for your household? ☐ Yes ☐ No
If **yes**, complete the following section:

NAME	PHONE NUMBER

ADDRESS	CITY,	STATE,	ZIP CODE

2a. HEALTH INSURANCE AUTHORIZED REPRESENTATIVES\

You can give a trusted person permission to talk about your application for health insurance, see your information and act for you on things about this part of your application. Do you want to choose an authorized representative for the health insurance part of your application? ☐ Yes ☐ No If **yes**, fill out the information in Appendix C (on the SAWS 2 PLUS).

3. Are you or any member of your family American Indian or Alaskan Native? ☐ Yes ☐ No
If **yes**, and applying for health care, please go to Appendix B (on the SAWS 2 PLUS) for additional questions.

RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☐ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY	ARE YOU OF HISPANIC, LATINO OR SPANISH ORIGIN? ☐ Yes ☐ No	IF YOU ARE OF HISPANIC OR LATINO ORIGIN, DO YOU CONSIDER YOURSELF: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other_____

RACE/ETHNIC ORIGIN

☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed _____

☐ Asian (If checked, please select one or more of the following):
☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian
☐ Other Asian (specify)_____

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You will need to have an interview with the County to discuss your application and to receive cash aid or CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in-person or would prefer an in-person interview. Cash aid applicants must have an in person interview. If you are applying for CalWORKs and CalFresh, your CalFresh interview will be done at the same time as your CalWORKs interview during normal office hours.

☐ Please check this box if you would prefer an in-person interview for CalFresh.

☐ Please check this box if you need other arrangements due to a disability.

5. OTHER PROGRAMS

Has anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Tribal TANF, Medicaid, Supplemental Nutrition Assistance Program [food stamps], General Assistance/General Relief, etc.)? ☐ Yes ☐ No

IF **YES,** WHO?	WHERE *(COUNTY/STATE)*?
IF **YES**, WHO?	WHERE *(COUNTY/STATE)*?

IF YOU ARE APPLYING FOR CASH AID, PLEASE COMPLETE THE FOLLOWING SECTION		
Marital Status ☐Single ☐Married ☐ Separated	City of residence prior to application _______________	Do you intend to stay in San Francisco? ☐YES ☐NO
Date of arrival in San Francisco: ___/___/___	Are you homeless and in need of shelter placement? ☐YES ☐NO	
Are you participating in AB429, Family Reunification Program? ☐YES ☐NO		

For each person living in the home (including yourself), give us all the below information.
If you are pregnant, list the person as "unborn" and give due date.

NAME (FIRST, MIDDLE, LAST)	SEX (✓) ☐M ☐F	BIRTHDATE OR DUE DATE (Month, Day, Year)	IS PERSON LIVING WITH YOU IN YOUR HOME NOW? ☐YES ☐NO
SOCIAL SECURITY NUMBER	PREGNANT ☐YES ☐ NO	RELATIONSHIP TO THE APPLICANT	
TYPE OF AID REQUESTED ☐Cash Aid ☐ CalFresh ☐ Medi-Cal ☐None	MOTHER'S NAME		FATHER'S NAME
NAME (FIRST, MIDDLE, LAST)	SEX (✓) ☐M ☐F	BIRTHDATE OR DUE DATE (Month, Day, Year)	IS PERSON LIVING WITH YOU IN YOUR HOME NOW? ☐YES ☐NO
SOCIAL SECURITY NUMBER	PREGNANT ☐YES ☐ NO	RELATIONSHIP TO THE APPLICANT	
TYPE OF AID REQUESTED ☐Cash Aid ☐ CalFresh ☐ Medi-Cal ☐None	MOTHER'S NAME		FATHER'S NAME
NAME (FIRST, MIDDLE, LAST)	SEX (✓) ☐M ☐F	BIRTHDATE OR DUE DATE (Month, Day, Year)	IS PERSON LIVING WITH YOU IN YOUR HOME NOW? ☐YES ☐NO
SOCIAL SECURITY NUMBER	PREGNANT ☐YES ☐ NO	RELATIONSHIP TO THE APPLICANT	
TYPE OF AID REQUESTED ☐Cash Aid ☐ CalFresh ☐ Medi-Cal ☐None	MOTHER'S NAME		FATHER'S NAME
NAME (FIRST, MIDDLE, LAST)	SEX (✓) ☐M ☐F	BIRTHDATE OR DUE DATE (Month, Day, Year)	IS PERSON LIVING WITH YOU IN YOUR HOME NOW? ☐YES ☐NO
SOCIAL SECURITY NUMBER	PREGNANT ☐YES ☐ NO	RELATIONSHIP TO THE APPLICANT	
TYPE OF AID REQUESTED ☐Cash Aid ☐ CalFresh ☐ Medi-Cal ☐None	MOTHER'S NAME		FATHER'S NAME
NAME (FIRST, MIDDLE, LAST)	SEX (✓) ☐M ☐F	BIRTHDATE OR DUE DATE (Month, Day, Year)	IS PERSON LIVING WITH YOU IN YOUR HOME NOW? ☐YES ☐NO
SOCIAL SECURITY NUMBER	PREGNANT ☐YES ☐ NO	RELATIONSHIP TO THE APPLICANT	
TYPE OF AID REQUESTED ☐Cash Aid ☐ CalFresh ☐ Medi-Cal ☐None	MOTHER'S NAME		FATHER'S NAME
NAME (FIRST, MIDDLE, LAST)	SEX (✓) ☐M ☐F	BIRTHDATE OR DUE DATE (Month, Day, Year)	IS PERSON LIVING WITH YOU IN YOUR HOME NOW? ☐YES ☐NO
SOCIAL SECURITY NUMBER	PREGNANT ☐YES ☐ NO	RELATIONSHIP TO THE APPLICANT	
TYPE OF AID REQUESTED ☐Cash Aid ☐ CalFresh ☐ Medi-Cal ☐None	MOTHER'S NAME		FATHER'S NAME

OFFICE USE ONLY: Referral to CALM/CalWorks _____ Rescheduled Appt. ___/___/___ Backfill _____