COUNTY OF

Date:
Case Name:
Case Number:
Worker Name:
Worker ID:
Worker Phone Number:

VERIFICATION OF BENEFITS

Physical Address:

Home Phone Number:

Monthly Benefits							
Month/Year	CalWORKs	GA/GR	CalFresh	RCA	MC	CMSP	Family Size

Current Household Details										
Name	DOB	Aid Code	In the Home	CalFresh	CW	GA /GR	OHC	Medi-Cal	CMSP	MC/CMSP SOC

Comments