

# 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.