

DEPARTMENT OF BENEFIT PAYMENTS  
744 P Street, Sacramento, CA 95814  
(916) 322-4403



December 28, 1976

ALL-COUNTY LETTER NO. 76-143

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: REVISED FOOD STAMP OUTREACH REFERRAL FORM

REFERENCE: ACL 76-133

- This is to inform you that form DFA 285.2 (FSOP) which was attached to All-County Letter 76-133 has been revised to more fully meet the goals of the Food Stamp Outreach Program. The community agencies under contract to perform Outreach have been advised of this revision and have been instructed to discontinue use of the original version of this form.

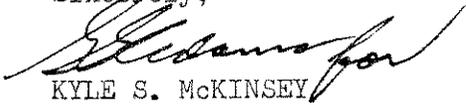
Attached for your information is an advance copy of the revised form, Food Stamp Outreach Referral (FSOP-1). The purpose of the form is the same: to assist the individual applicant and the eligibility worker in the food stamp application process. This will be accomplished by indicating to the pre-screened individual possible food stamp eligibility and by informing the potential client of the intake process.

Please note that the number of copies of the form has been increased to five. As indicated at the bottom of the advance copy, the additional copy is for the county; mainly to have a copy of the authorization to release information.

An interim supply of the form has been sent to the agencies. The interim supply will not be carbonized and will require insertion of carbon paper to complete the county use section information or will require checking the appropriate boxes on each copy. The major shipment, which is forthcoming, will be a carbonized form. Formal use of the form will commence upon signature of individual agency's contracts. For those counties with systems in operation utilizing the prior version of the form, we appreciate your cooperation and regret any inconvenience caused by the revision.

If you have any questions regarding this matter, please contact Dave Watanabe, Food Stamp Outreach Coordinator, at (916) 322-4403.

Sincerely,

  
KYLE S. MCKINSEY  
Deputy Director

Atch. (1 copy to CWD's only)

cc: CWDA  
GEN 654 (2/75)

**FOOD STAMP OUTREACH REFERRAL**

*This form is not an application. This is a prescreening form. It will help us determine if you may be eligible for Food Stamps. If you want to apply for Food Stamps, take this form with you to the County Welfare Department. Eligibility is determined only by County Welfare Department.*

**PLEASE PRINT**

**PLEASE PRINT**

DATE
AGENCY NAME
PRESCREENER

<b>I. BASIC INFORMATION</b>	NAME (LAST, FIRST, MIDDLE)		TELEPHONE NUMBER	ETHNIC CODE
	CURRENT ADDRESS			ZIP CODE
	DATE AND PLACE TO APPLY	RECEIVING AID? AFDC <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI/SSP <input type="checkbox"/> YES <input type="checkbox"/> NO	GA/GR <input type="checkbox"/> YES <input type="checkbox"/> NO
				MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO

<b>OUTREACH SERVICES</b>	LANGUAGE ASSISTANCE (IF YES, ENTER LANGUAGE) <input type="checkbox"/> YES <input type="checkbox"/> NO	TRANSPORTATION ASSISTANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	AUTHORIZED REPRESENTATIVE <input type="checkbox"/> YES <input type="checkbox"/> NO
--------------------------	--	---	---

<b>RESOURCE VALUES</b>	CHECKING ACCOUNT	SAVINGS ACCOUNT	AUTOMOBILE	REAL PROPERTY	OTHER
------------------------	------------------	-----------------	------------	---------------	-------

<b>SOURCE OF INCOME</b>	GROSS MONTHLY SALARY OR WAGES	AFDC GRANT	RETIREMENT INCOME	OTHER
-------------------------	-------------------------------	------------	-------------------	-------

<b>INCOME DEDUCTIONS</b>	RENT	UTILITIES	CHILD CARE	MEDICAL	OTHER
--------------------------	------	-----------	------------	---------	-------

**II. RELEASE OF INFORMATION**

I, \_\_\_\_\_ Social Security Number \_\_\_\_\_ do hereby authorize \_\_\_\_\_ County to release to \_\_\_\_\_ OUTREACH AGENCY all information pertinent to my application for Food Stamps.

\_\_\_\_\_  
SIGNATURE OF CLIENT

\_\_\_\_\_  
DATE

**III. COUNTY USE ONLY**

NAME OF COUNTY	NAME OF EW	EW TELEPHONE	DATE
----------------	------------	--------------	------

Approved     Cancelled     Withdrawn     Already on Food Stamps

Denied (check reason)

Did not meet income test     Did not meet resource test

Other (explain) \_\_\_\_\_

**IV. OUTREACH AGENCY USE ONLY**

WAS APPLICATION REQUESTED FROM CWD? <input type="checkbox"/> YES <input type="checkbox"/> NO    WHEN?	WAS APPLICATION FILED WITH CWD? <input type="checkbox"/> YES <input type="checkbox"/> NO    WHEN?
WAS CLIENT CERTIFIED FOR FOOD STAMPS? <input type="checkbox"/> YES <input type="checkbox"/> NO    WHEN?	WHEN DID ATP CARD ARRIVE?
WHAT OUTREACH SERVICES WERE PROVIDED? <input type="checkbox"/> AUTHORIZED REPRESENTATIVE <input type="checkbox"/> INTERPRETER (GIVE LANGUAGE)	<input type="checkbox"/> TRANSPORTATION (IF SO, GIVE EXPENSE)

**ROUTING**

*First Copy - Food Stamp Outreach Program (response from CWD)*

*Second Copy - Department of Benefit Payments*

*Third Copy - County Welfare Department*

*Fourth Copy - Client*

*Fifth Copy - Food Stamp Outreach Program (trigger)*