RECEIPT FOR DOCUMENTS

_____County received the following information
(COUNTY NAME)

for: _____
CLIENT'S NAME (OR CASE NAME, IF DIFFERENT)

_____
CASE IDENTIFIER: (SSN, DOB OR ADDRESS)

_____

- ☐ CA 7 for_____ (MONTH)
- ☐ Birth Certificate:_____
- ☐ Social Security Card: _____
- ☐ Pay Stub(s)_____
- ☐ Dependent Care Receipt
- ☐ Pregnancy Verification
- ☐ Rent Receipt
- ☐ Utility Bills
- ☐ Medical Bills
- ☐ MC 176 SAQ
- ☐ MC 177 S-M
- ☐ MC 210
- ☐ MC 211
- ☐ MC 220
- ☐ MC 223
- ☐ Other:_____

Received by: _____ Date Received _____

Title: _____

CA 31 (7/99) RECOMMENDED FORM

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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