COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC SOCIAL SERVICES

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

VERIFICATION OF BENEFITS

A. VERIFICATION

This will verify that the above participant is receiving:

CalWORKs (cash) in the amount of $ _____ , per month for 1 _____ people.

General Relief (cash) in the amount of $ _____ , per month for 0 _____ people.

Refugee Cash Assistance (cash) in the amount of $ _____ , per month for 0 _____ people.

CalFresh benefits in the amount of $ _____ , per month for 1 _____ people.

Medi-Cal - In Receipt of Medical Benefits , per month for 2 _____ people.

B. ASSISTANCE UNIT (AU) MEMBERS

1.	Name	Applicant	7.	Name	Relation to #1
2	Name	Son	8.	Name	Relation to #1
3.	Name	Relation to #1	9.	Name	Relation to #1
4.	Name	Relation to #1	10.	Name	Relation to #1
5.	Name	Relation to #1	11.	Name	Relation to #1
6.	Name	Relation to #1	12.	Name	Relation to #1

C. CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize DPSS to release the above information to:

_____ _____ _____

_____ _____ _____

_____ Participant Signature _____ Date

_____ Witness Signature, If Participant Not Able to Sign _____ Date

File: Miscellaneous Folder Retention: Three Years

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