APPLICATION FOR CALIFORNIA RESTUARANT MEALS ALLOWANCE

Beneficiary Name SSN

Payee's Name SSN

I am applying for the Restaurant Meals Allowance and understand that to be eligible, the following requirements must be met.

1. I do not receive meals as part of my living arrangement, and

2. Beginning _____ one of the following conditions exists:
mo/day/year

_____ I do not have access to a working refrigerator or icebox.

_____ My cooking facilities are inadequate; I do not have access to a working oven (regular or microwave) plus at least one temperature controlled heating unit, *OR* at least two temperature controlled heating units but no functioning oven.

_____ My cooking or food storage facilities are temporarily not working and are not expected to be working until _____.
mo/day/year

I CERTIFY THE ABOVE TO BE TRUE AND KNOW THAT PROVIDING FALSE STATEMENTS OF REPRESENTATIONS OF THE FACT IS PUNISHABLE UNDER FEDERAL AND/OR STATE LAW.

I understand the California Restaurant Meals allowance ends with the month in which I receive meals as a part of my living arrangement or I have access to adequate cooking and food storage facilities. I agree to immediately notify Social Security if there is any change in my living arrangement as described above.

Beneficiary Signature Date

Payee Signature Date

SSA Decision: □ Approved effective _____ (date)
□ Denied, (Notice of Action Provided if Redetermination)

Decision by: _____
Name Title Date

SSA Office: A85