APPLICATION FOR CALIFORNIA RESTAURANT MEALS ALLOWANCE

(Application for Optional supplemental Variation C – Independent Living Arrangement Without Cooking Facilities)

NAME *(Of Applicant/Recipient)*	**SSN** *(Of Applicant/Recipient)*

I/We am/are applying for the Restaurant Meals Allowance and understand that to be eligible, the following requirements must be met:

1) I/we do not receive meals as a part of my/our living arrangements, AND

2) Beginning ___/___/___ one of the following conditions exits:
(*Enter date)*

(*Check one or more blocks that apply.)*

☐ I/we do not have access to a working refrigerator or icebox.

☐ My/our cooking facilities are inadequate because I/we 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/our cooking or food storage facilities are temporarily not working and are not expected to be working until ___/___/___
(*Enter date)*

I understand the California Restaurant Meals allowance ends with the month I receive meals as part of my living arrangement or I have access to adequate cooking and food storage facilities.

I agree to immediately notify Social Security Administration if there is any change in my living arrangement as described above.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and / or State Law. I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON (S) MAKING STATEMENT	
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** _____ **SIGN HERE** _____	**Date** *(Month, day, year)* ___/___/___ ___/___/___
Mailing Address *(Number and street, Apt. No., P.O. Box, Rural Route)*	**Telephone Numbers** *(include Area Code)* **Home ( ) -** **Work ( ) -**
City and State	**ZIP Code**

SSA Decision: ☐ Approved effective ___/___/___ ☐ Denied ☐ Notice of Planned Action provided ☐ Redetermination only			
By: *(Print Name)*	**Signature:**	**Title:** ☐ CR ☐ SR ☐ TE ☐ _____	**Date:**
Social Security Administration, American River Field Office, 5839 Manzanita Ave. Suite 6, Carmichael, CA. 95608			

Form SSAFO-E77-7527 (3/10/03)