1. Contact Information

Date

First Name

Last Name

Email Address

Phone Number

ZIP Code

2. Household Information

Age

Marital Status

Gender

- [ ] Male
- [ ] Female
- [ ] Other

If other, please specify

Current Housing Situation

- [ ] Housed
- [ ] Homeless

Household Size

Approximate Monthly Household Income

Do you have a disability?

- [ ] Yes
- [ ] No

3. What Do You Need Help With?

Please select all that apply. (Continued on page 2)

- [ ] Food assistance
- [ ] Health insurance or healthcare coverage
- [ ] Medical bills or healthcare costs

3. What Do You Need Help With? (continued)

- [ ] Prescription medication costs
- [ ] Financial assistance
- [ ] Nutrition, health, or financial education
- [ ] Benefits application or enrollment assistance
- [ ] Other assistance

If other, please specify

4. Additional Information

Please briefly describe the assistance you are looking for or any concerns you would like our team to know about.

5. Preferred Contact Method

How would you prefer CBS staff to contact you?

- [ ] Phone
- [ ] Email

6. Consent to Contact

- [ ] I agree to be contacted by California Benefits Support Center regarding my request for assistance.

Once complete, email this form to: admin@cabenefitssupport.com

Submitting this form does not guarantee eligibility for any benefits or services. CBS provides information, screening, referrals, and application navigation assistance. Official eligibility decisions are made by the appropriate program agencies.