APPLICATION FOR CALIFORNIA RESTAURANT MEALS ALLOWANCE

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

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Applicant/Recipient's Name **SSN**

I (we) am (are) 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: (check one)
   (month, 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 ___________________________.
date

I certify the above to be true and know that providing false statements or misrepresentation of fact is punishable under Federal and/or State law.

I understand that the California Restaurant Meals Allowance ends the month following the month in which I start receiving meals as a part of my living arrangement or 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.

Signed:____ Date_______________

Signed:____ Date_______________
(spouse if applying or eligible)

SSA Decision: ☐ Approved effective____

NOTE: Date cannot be earlier than protected filing date (initial claims) or date applicant/recipient reported a COA

☐ Denied, Notice of Planned Action Provided (Redetermination only)

By: Signed _________________________Title _______________ Date _______________

SSA Office ____