Temporary Sick Meal Program - Request Form

NAME OF PARTICIPANT *(LAST, FIRST, MIDDLE)*

SNP ID NUMBER	HOME SITE

I, _____, residing at _____,
NAME *(PLEASE PRINT)* *ADDRESS*
in _____, _____, certify that the above-named
CITY STATE
participant is unable to attend the home site due to medical reasons. I am aware that the Temporary Sick Meal Program is allowed for five consecutive meal pick-ups only. Beyond five days, it is the responsibility of the participant and/or family member to inquire delivery services via the county's Meals on Wheels or other available food resources.

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge, and was executed on the _____ day of _____, _____,
DAY MONTH YEAR
at _____, California.
CITY

_____
SIGNATURE

FOR SITE STAFF USE ONLY

REVIEWED BY (PRINT/SIGN)	DATE	REQUEST #

DISPOSITION ☐ DENIED ☐ APPROVED

REASON

FOR SNP STAFF USE ONLY

REVIEWED BY (PRINT/SIGN)	DATE

DISPOSITION ☐ DENIED ☐ APPROVED

REASON