Family Access Membership Application

Primary Member Name (Adult): ____

Mailing Address: _____________________________**City & Zip**__________________

Phone: ______________________ **Email:** __________________________________

Do you or your children receive services or benefits from any of the following agencies? (please check all that apply)

- ☐ Food Stamps/CalFresh Program/SNAP (Supplemental Nutritional Assistance Program)
- ☐ Low Income Energy Assistance/HEAP (Home Energy Assistance Program)
- ☐ TANF (Temporary Assistance for Needy Families)
- ☐ WIC (Women, Infants and Children)
- ☐ Other ____
- ☐ First 5 Santa Cruz
- ☐ Section 8/Public Housing
- ☐ Cal WORKS
- ☐ Free/Reduced School Lunch
- ☐ Early Head Start or Head Start

Member Packet Delivery: ☐ Snail Mail ☐ Member will pick up **(must show ID)**

Family Member Name	**Date of Birth**	**Relation to Member**
1.		
2.		
3.		
4.		
5.		
6.		

Please complete this application and present it at the front desk along with your proof of participation in one of the programs listed above.
If applying by mail, please include a copy of your proof and mail to: SCCMOD, Attn: Sylvia Rubio, 1855 41st Ave, Suite C-10, Capitola, CA 95010

Office Use Only

Date ____________________ Staff ______________________

- ☐ Checked Benefits- approved? **YES** **NO**
- ☐ Entered Patron
- ☐ Sold Membership in POS
- ☐ Printed Membership Card
- ☐ Mailed Cards & Packet

Notes: