



### Client Referral

To be submitted by Case Manager for Client Participation in the Extra Helpings Food Program

Please circle:                      **New Client**    **Continuing Client**

Client Name: \_\_\_\_\_  
(First)    (Middle Initial)    (Last)

Mother's Maiden Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

ARIES Extended Uniform Record Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Leave Message:  Yes  No

PLEASE CHECK ALL THAT APPLY

- \_\_\_\_\_ Documentation of HIV/AIDS status is on file.
- \_\_\_\_\_ Case manager has completed the ARIES Referral Tab for Food Bank services

Case Manager Name (please print): \_\_\_\_\_

\_\_\_\_\_  
Signature of Contra Costa County Case Manager    Date

*This referral expires at the end of February each program year. An updated referral must be fully completed & submitted by March 1 on a yearly basis, verifying that the client is in care and still qualified to participate in the food program.*

Please fax this form to Kristy, the Extra Helpings Program Coordinator at 925-674-8090

**PLEASE MAKE SURE THAT YOU FAX THIS FORM WITH THE NECESSARY FORMS BELOW:**  
\_\_\_\_ ARIES Identifier Form    \_\_\_\_ Food Bank Client Consent  
\_\_\_\_ ARIES Consent for Food Bank (Share/Non-Share Form)    \_\_\_\_ Home Delivery Referral (if applicable)