

BERLIN FAMILY FOOD PANTRY  
CLIENT REFERRAL FORM

Please accept this letter as a referral for this person who I believe is in need of assistance from the Berlin Family Food Pantry.

NAME of person or family: \_\_\_\_\_

Their ADDRESS: \_\_\_\_\_

Number of people in the family: \_\_\_\_\_

Thank you,

Your name: \_\_\_\_\_ Date \_\_\_\_\_

Your signature: \_\_\_\_\_

Your Organization or relationship to this person/family: \_\_\_\_\_

\_\_\_\_\_

The agencies listed below may be able to assist you in gaining new references and perhaps some additional financial aid.

Government Agency	Phone Number
Commission for the Blind	1-800-392-6450
Commission for the Deaf	1-800-882-1155
Disability Determination	1-800-882-2040
Elder Affairs	1-800-243-4636
Food Stamps	1-800-221-5689
Mass. Rehab Commission	1-800-223-2559
Mass. Health/Medicaid	1-800-882-1228
Medicare	1-800-663-2273
SSI/SSDI	1-800-772-1213
Dept. of Transitional Assistance	1-800-249-2007
WIC – women’s, infants & children’s Nutritional Program	1-800-942-1007
Worker’s Compensation	1-800-323-3249
Fuel Assistance (SMOC)	1-800-286-6776