COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
CALWORKS MENTAL HEALTH SUPPORTIVE SERVICES

DMH CALWORKS BULLETIN NO. 07-01
COMPLETION OF GAIN FORMS

October 1, 2007 (Revised 5-28-08)

TO: All DMH CalWORKs Mental Health Supportive Services Providers

FROM: Elizabeth Gross, Mental Health Clinical Program Head
CalWORKs Program

SUBJECT: Completion of GAIN forms

1. PURPOSE

The purpose of this Bulletin, No. 07-01, is to provide an explanation of the most commonly used GAIN forms and to provide instructions to providers for completing them. These forms (GN 6006A, GN 6006B, GN 6008, PA 1923, *Notification Letter*, PA 1132, GN 6149, GN 6007B, and GN 6011) are required to verify eligibility and to report the attendance of CalWORKs clients to their mental health appointments.

2. BACKGROUND

Forms are used by CalWORKs eligibility staff, GAIN Services Workers (GSWs) and Contract Case Managers (CCMs) when processing participants who have been identified as having a need for specialized supportive services such as Clinical

Assessment, Substance Abuse, Mental Health, Domestic Violence, and Family Preservation. In order for a mental health provider to be reimbursed for CalWORKs mental health services, the client must be eligible for these services and the provider must have documentation to support that eligibility for the period that services are rendered. DPSS has created specific forms to address the eligibility, referral, assessment, and treatment progress of the CalWORKs participant. The client's GSW uses these forms to verify a CalWORKs participant's attendance and participation in the identified specialized supportive service activity. In addition, the service provider uses the form to communicate recommendations for hours of participation in treatment and for the client's participation in additional welfare-to-work activities. The GSW uses these recommendations as a basis for planning with the participant his/her welfare-to-work plan.

3. DPSS PROGRAM REQUIREMENTS

Two of the DPSS Performance Requirements (described in DMH CalWORKs Bulletin No. 05-06, Provider Compliance with DPSS CalWORKs Program Requirements) address the use of required forms and timely communication with GAIN. One performance requirement is that the provider track and report to GAIN the CalWORKs participant's progress towards employment; the other is that staff sends required GAIN documents to the GSW on a timely basis. This communication is necessary for GAIN to credit the participant for his/her compliance with the GAIN contract and to manage the CalWORKs participant's case appropriately.

DPSS Manual Letter Number 4687 (6/15/06) provides guidelines for GSWs and CCMs regarding the completion of the forms routinely used to communicate with specialized supportive service providers at different stages of the referral or treatment process. Providers must accurately and thoroughly complete the Provider section of the required forms to ensure that the participant is properly credited for the identified activity.

4. SPECIFIC FORMS

GN 6006A – Page 1, *CalWORKs Clinical Assessment Provider Referral*; and
Page 2, *CalWORKs Clinical Assessment Results*
These forms are used by the GSW or CASC Service Advocate when referring a participant to Clinical Assessment for substance abuse and/or mental health; Page 2 must be completed and returned by the provider after the assessment.

GN 6006B – Page 1, *CalWORKs Supportive Services Provider Referral*; and
Page 2, *CalWORKs Supportive Services Results*
These forms are used by the mental health service provider after the clinical assessment to communicate the participant's decision regarding continuing in treatment.

GN 6008 – *Mental Health/Substance Abuse/Domestic Violence/Family Preservation Program Service Provider Progress Report*

This form is automatically generated by GEARS—the DPSS computer data system—every 90 days and mailed to the treatment provider. Mental health treatment providers are required to complete this form every 90 days for as long as the client continues to receive services billed to CalWORKs.

PA 1923 – *CalWORKs Treatment/Services Verification*

This form is used by the mental health service provider to identify those CalWORKs participants who are already receiving services at their facility prior to entry into GAIN to verify their eligibility for CalWORKs mental health services.

DPSS' responses to the PA 1923 – There are several different forms used by DPSS to respond to the PA 1923. These include the ***Notification Letter*** to the treatment provider to inform them of the participant's eligibility for CalWORKs; the **PA 1132** (*CalWORKs Eligibility Worker/GAIN Services Worker Notification to Service Providers*) which confirms receipt of the PA 1923 and provides GAIN worker information; and the **GN 6149** (*CalWORKs Welfare-to-Work Notification*), which is used by the GSW to confirm receipt of the PA 1923 for participants receiving supportive services and to notify the treatment services provider whether or not a Welfare-to-Work plan has been signed.

GN 6007B – *CalWORKs Supportive Services Enrollment Termination Notice*

This form is used by the mental health service provider to inform the GSW that the CalWORKs participant will no longer receive CalWORKs mental health services at that agency.

GN 6011 – *Service Provider Cancellation/Stop Notice*

This form is used by the GSW to notify the treatment provider to stop services.

5. EXPLANATION OF FORMS

GN 6006A – Page 1, CalWORKs Clinical Assessment Provider Referral

This form is completed manually by the GSW, the CCM or the co-located Service Advocate when the participant is referred for a clinical assessment for substance abuse and/or mental health. The form is given to the participant to take to his/her clinical assessment appointment; the GSW or the CASC Service Advocate may also fax the form to the provider. The mental health provider does not complete any portion of this form. This form ensures that the participant is CalWORKs eligible at the time of referral, and the form serves as back-up documentation in the billing reconciliation process in the event of a rejected billing claim.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs

CLINICAL ASSESSMENT PROVIDER REFERRAL

[(Participant's Name and Address)] [(GAIN Regional Office)]]

[(GSWCCM Name/File Number) _____] [(Participant Case Number)_____]

IMPORTANT CLINICAL ASSESSMENT APPOINTMENT NOTICE

Completed by Referring Individual:

The following appointment has been scheduled for you to attend a clinical assessment for:

☐ Mental Health ☐ Substance Abuse

On:___/___/___ at_____
Date Time

Address: _____

_____

Phone No.: _____

Fax No.: _____

Contact Person: _____

It is important for you to keep this appointment and take this notice with you.

If for any reason you cannot keep this appointment or have a problem, please contact your GAIN Services Worker immediately. You may also contact your CASC Service Advocate, _____ and the telephone number to reach him/her is _____.

Person Referring and Title:	File No.:	Phone No.: ( )	Fax No.: ( )

I understand that I am being referred to Clinical Assessment as indicated above. If I fail to attend this appointment, I understand I may be subject to additional contact by a service provider. If additional contact is unsuccessful, I may be put into non-compliance.

_____ _____

GAIN Participant's Signature Date

GN 6006A (Rev. 12/06)

GN 6006A – Page 2, CalWORKs Clinical Assessment Results

This form should contain the GAIN Region name and address, the GSW/CCM name and fax number, and Section A should have been completed. This form should also bear the signature of the GAIN participant in Section C.

The mental health provider should complete Section B and return the form to the GSW within 5 workdays of the scheduled Clinical Assessment appointment. The provider must check the appropriate boxes to indicate if the participant appeared for the assessment and agrees to continue in treatment. If the participant agrees to participate in treatment, the mental health provider must complete the "Referred to" section to indicate the name, address and contact information of the treatment provider. In most cases, this will be the same provider that completed the clinical assessment. The provider must also indicate the date and time of the appointment for the start of treatment, which must be different than the date of the assessment.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs CLINICAL ASSESSMENT RESULTS

[To: (GAIN Regional Office)] [From: (Name & Address of Facility)]

Attention: _____
GSW/CCM Name/File Number

Fax No.: _____

[ ] [ ]

Section A - Completed by Referring Individual

Participant Name:			CalWORKs Case Number:	
Residence Address: (Do not use for domestic violence if confidential address is requested.)			Mailing Address:	
Primary Language:	Birth Date:	Sex: ☐ M ☐ F	Social Security Number: (Confidential for DV)	Phone No.: (Confidential for DV) ( )

Section B - Completed by Clinical Assessor (Complete and return to the GAIN Services Worker within 5 workdays.)

Results of the assessment appointment: IMMEDIATE NEED ☐

- ☐ Participant did not appear/complete the assessment.
- ☐ Participant completed the assessment, but does not need a referral for treatment.
- ☐ Participant completed assessment & needs a referral, but does not agree to treatment for ☐ MH ☐ SA
- ☐ Participant completed assessment and agrees to recommended treatment for ☐ MH ☐ SA
- ☐ Participant completed assessment and does not agree; requests third party assessment. ☐ MH ☐ SA

REFERRAL MADE FOR: ☐ MH and/or ☐ SA

Referred to:

Name of Provider: _____ On: ___/___/___ at _____
Date Time

Address: _____

_____

Phone No.: _____

Fax No.: _____

Contact Person: _____

Name of Assessor:	Facility Name:	Phone No.: ( )

Section C - Completed by GAIN Participant

I authorize the release of information to DPSS regarding the results of my assessment and possible need for treatment services and recommended service plan.

_____ _____
GAIN Participant's Signature Date

GN 6006B – **Page 1, CalWORKs Service Provider Referral**

This form is completed by the clinical assessor when referring the participant to treatment services after the clinical assessment. It is the appointment notice for the participant with information about his/her appointment for the start of treatment. Your local GAIN office may or may not require this form to be submitted to the GSW.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs
SUPPORTIVE SERVICE PROVIDER REFERRAL

[(Participant's Name and Address)] [(CalWORKs District or GAIN Regional Office)]

[ ] [ ]

IMPORTANT APPOINTMENT NOTICE

You have been scheduled to attend the following appointment for:

- ☐ Mental Health Services
- ☐ Substance Abuse Services
- ☐ Domestic Violence Case Management
- ☐ Domestic Violence Legal Services
- ☐ Direct Referral for Mental Health services
- ☐ Family Preservation

(Immediate Need/Urgent within 2 workdays and Non-emergent within 5 workdays)

On: ___/___/___ at _____ (Date / Time)

Address: _____

_____

Phone No.: _____

Fax No.: _____

Contact Person: _____

It is important for you to keep this appointment. Bring this notice with you.

If for any reason you cannot keep this appointment or have a problem, please contact me immediately.

Person Making Referral:	File No:	Phone No.: ( )	Fax No.: ( )

I understand that I am being referred to an appointment to begin supportive services as indicated above. If I fail to attend this appointment, I understand that I may be contacted by the clinical assessor and/or service provider. If additional contact is unsuccessful, a compliance process may follow, which may result in the lowering of my cash aid.

_____ _____

GAIN Participant's Signature Date

GN 6006B (Rev. 12/05)

GN 6006B – **Page 2, CalWORKs Supportive Services Results**

The GSW should fax this form to the treatment provider with Section A filled in and Section C signed by the participant. **The provider must complete Section B and return the form to DPSS within 5 workdays from the appointment date.** Upon receipt of this form, the GSW reviews the information and updates the component on GEARS. The GSW also uses the information on the form to authorize other supportive services such as child care, transportation and other ancillary services, as appropriate.

The Mental Health provider should complete subsections I, III, IV, and V of Section B (Subsection II is for DV only). In Subsection I, the provider must indicate the date the participant began services; this date must be different than the date of the clinical assessment appointment by at least one day. It is also helpful for the GSW to know if the number of hours in treatment at your facility is distributed over more than one day, as this will affect transportation and childcare arrangements. Do not include travel time in your hours of participation in mental health services.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs SUPPORTIVE SERVICES RESULTS

[To: (GAIN Regional Office)] [From: Name & Address of Facility]

Attention: _____
GSW Name/Number

[Fax No.: _____] [ ]

A - Completed by GSW//CCM/CalWORKs Eligibility Staff or Co-located staff

Participant Name:			CalWORKs Case No.:	
Residence Address **(Do not use for domestic violence if confidential address is requested):**			Mailing Address: (DV only)	
Primary Language:	Birth Date:	Sex: ☐ M ☐ F	Social Security No.:	Phone No. (Confidential for DV) ( )

B - Completed by Service Provider (Complete and return to the GSW/CCM within 5 workdays)

I. SUBSTANCE ABUSE ☐ AND/OR MENTAL HEALTH ☐ (Complete as applicable)

1. ☐ Participant failed to appear for services.
2. ☐ Participant began services on: ____/____/____. Services are: ☐ Residential ☐ Non-Residential
3. ☐ Expected duration of needed services: _____ months.
4. ☐ Participant is receiving treatment/services 32 or more hrs/week: ☐ Yes ☐ No If no, number of hrs/week: _____. (Participant may be considered full-time or may be eligible to medical exemption and receive services as an exempt volunteer).
5. ☐ Participant is able to participate in other Welfare-to-Work (WtW) activities?: ☐ Yes ☐ No If yes, how many hrs/week: _____. (Participant may be eligible for an exemption and still participate in GAIN as an exempt volunteer).
6. ☐ Participant may be eligible to medical exemption. Please issue a GN 6051, Verification of GAIN Exemption/Deferral, form* *A medical exemption may be granted if a participant, due to a physical or mental disability, is unable to fully participate for 32/35 hours for at least 30 days.

II. DOMESTIC VIOLENCE CASE MANAGEMENT ☐ AND/OR LEGAL SERVICES ☐ (Complete as applicable)

7. ☐ Participant failed to appear for services.
8. ☐ Participant began services on: ____/____/____. Services are: ☐ Residential ☐ Non-Residential
9. ☐ Expected duration of needed services: _____ months.
10. ☐ Participant can participate in DV services:_____ hrs/week and is able to do other WtW activities:_____ hrs/week **within** a WtW plan.
    To allow for successful participation, the following requirements shall be waived:
    - ☐ 32 hrs/week GAIN participation requirement.
    - ☐ Core hours of participation.
    - ☐ Regular GAIN flow.
    - ☐ Mandatory participation in GAIN WtW activities and possibly subject to financial sanction.
    - ☐ Child Support Cooperation or ☐ Other: _____
11. ☐ Participant shall be granted Waiver from the WtW program requirements and receive DV services **outside** of a WtW Plan.
12. ☐ Participant can participate in DV services:_____ hrs/week and/or other WtW activities:_____ hrs/week **outside** of a WtW plan and be granted a waiver. (Participant may be eligible for an exemption and still participate in GAIN as an exempt volunteer).

III. OTHER SUPPORTIVE SERVICES NEEDS (Complete as applicable) Participant needs the following supportive services:

☐ Child care ☐ Public Transportation or ☐ Mileage: _____per month ☐ Other: _____

☐ Ancillary work/related expenses such as: ☐ Books, ☐ Fees, ☐ Uniforms, and/or ☐ Tools/Supplies

IV. OTHER – The following services are ordered by the court system: ☐ DV Counseling ☐ Substance Abuse ☐ Mental Health

V. Signature/Print Name of Person Completing this form:	Title:	Phone No.: ( )	Date:

C - Completed by GAIN Participant:

I authorize the Department of Public Social Services and the above service provider to verify information regarding the status of my CalWORKs application/case and/or continuing eligibility to receive CalWORKs Specialized Supportive Services.

☐ I am aware that my mental health and/or substance abuse services will be incorporated in my CalWORKs Welfare-to-Work plan.

☐ I am aware that my domestic violence services may be incorporated now, or eventually, in a CalWORKs Welfare-to-Work plan.

The determination will be made by my GAIN Services Worker/Contracted Case Manager in consultation with the service provider.

_____ _____
Participant's Signature Date

GN 6006B (Rev. 12/05) Page 2 of 2

GN 6008 - **Mental Health/Substance Abuse/Domestic Violence/Family Preservation Program Service Provider Progress Report**

This form is completed by the treatment provider to notify the GSW of the participant's progress, completion, termination, and/or any other significant changes. This form is automatically generated by GEARS every 90 days and mailed to the CalWORKs mental health treatment providers to be completed and returned within 14 days of receipt. In some cases this form may be completed manually and mailed by the GSW/CCM every 90 days. The form will typically have the provider name, "Reply To" information, Section A and Section B completed, as well as the GAIN Services Worker information at the bottom of the form. In the event that the provider does not receive this form from the GAIN office, it is the provider's responsibility to complete a blank form and mail or fax it to the GSW. Hours of participation in mental health services should not include travel time to and from the mental health appointment.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

MENTAL HEALTH/SUBSTANCE ABUSE/DOMESTIC VIOLENCE/FAMILY PRESERVATION PROGRAM SERVICE PROVIDER PROGRESS REPORT

[ ]

[ ]

Reply To:

Attention: _____

OUR RECORDS INDICATE THAT THE FOLLOWING PARTICIPANT IS RECEIVING SERVICES IN YOUR PROGRAM. VERIFICATION OF PROGRESS IS NEEDED FOR HIS/HER CONTINUING ELIGIBILITY TO CalWORKs. PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ABOVE ADDRESS WITHIN 14 CALENDAR DAYS FROM THE POST DATE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GAIN SERVICES WORKER AT THE PHONE NUMBER POSTED AT THE BOTTOM OF THIS FORM.

A - Completed by GSW/CCM

Participant:	Case No.:
Social Security No.:	Date of Birth:

B - Completed by Service Provider (Complete and return to the GSW/CCM within 14 calendar days from the post date)

I. TYPE OF SERVICE

☐ Mental Health ☐ Substance Abuse ☐ Family Preservation
☐ Domestic Violence (DV) Case Management ☐ Domestic Violence (DV) Legal Services

II. DUAL DIAGNOSIS/CONCURRENT SERVICES (if applicable)

☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services

III. PROGRESS (Complete as applicable)

The above-referenced CalWORKs participant:

1. ☐ is participating and maintaining progress consistent with the above Supportive Services activity.
2. ☐ is currently attending/receiving treatment/services 32 hrs/week. If no, number of hrs/week_____
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services
3. ☐ is now able to include DV activity within the WTW Plan.
4. ☐ is expected to complete services on _____/ _____/_____ (if less than 90 days).
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services
5. ☐ is no longer receiving services under this contract effective _____/ _____ /_____ for:
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services
6. ☐ has dropped-out of services effective _____/ _____ /_____ .
7. ☐ successfully completed services on _____/ _____ /_____ .
8. ☐ requests an extension of the Supportive Services activity until _____/ _____ /_____ (more than 90 days).

IV. CONCURRENT ACTIVITY (Evaluate concurrent activity within six (6) months from start date of services)

The above referenced CalWORKs participant:

☐ **DV** only, is able to participate in another WtW activity: _____ hours/week_____ days/week _____ outside of a WtW Plan and be granted a waiver. (Participant shall granted an exemption and still participate in GAIN as an exempt volunteer.)

☐ is able to participate in another WtW activity: _____ hours/week_____, days/week _____ within the WtW plan.

Service Provider/Staff Person's Name:	Title:	Phone No.: ( )	Date:

GAIN Services Worker:	File No.:	Telephone No.:	Fax No.:	Date:

GN 6008 (Rev. 12/05)

PA 1923 – CalWORKs Treatment/Services Verification

The PA 1923 form (CalWORKs Treatment/Services Verification) is completed by the service provider 1) to identify CalWORKs participants who are already receiving treatment services at their facility prior to entry into GAIN, or 2) to verify eligibility for CalWORKs mental health services of clients that are self-referred or referred by sources other than GAIN and the CASC Service Advocates. **The service provider should mail or fax this form to Tina Williams at DPSS Central County GAIN Region IV (information pre-printed on the form) within ten (10) workdays—not to exceed thirty (30) days—of initial contact with the participant (or identification of the client as possibly CalWORKs eligible).**

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs TREATMENT/SERVICES VERIFICATION

[To: **Central County GAIN Region IV**] [From:]
3833 S. Vermont Ave
Los Angeles, CA. 90037

[**FAX Number: (323) 730-5881**] [ ]

A. PROVIDER CERTIFICATION

As an authorized employee of the treatment/service provider agency named above, I certify that the individual named below is receiving: ☐ **DOMESTIC VIOLENCE (DV) CASE MANAGEMENT** ☐ **DOMESTIC VIOLENCE (DV) LEGAL SERVICES** ☐ **SUBSTANCE ABUSE SERVICES** ☐ **MENTAL HEALTH SERVICES** to help him/her overcome a barrier to employment. I understand that payment to contracted service provider is contingent on the CalWORKs participant maintaining eligibility to CalWORKs and complying with all requirements, assuming that the provider has been notified of the non-compliance by DPSS. In instances of substance abuse or mental health problems, this includes signing a Welfare-to-Work (WtW) plan which includes the appropriate treatment or services. For domestic violence victims, certain requirements can be waived, including a WtW plan. This form must be submitted within 10 workdays of client's signature, but not to exceed 30 days. In addition, the service provider must have received the GN 6008, Mental Health/Substance Abuse/Domestic Violence/Family Preservation Program Services Provider Progress Report, 90 days from service start date, to confirm participant's continued eligibility to CalWORKs.

Print Name/Title of Authorized Person	Date Signed	Phone Number	Fax Number

B. PARTICIPANT IDENTIFICATION

1. Name (first/last): _____
2. Social Security No. __ __ __ - __ __ - __ __ __ __ and/or DPSS Case No.: __ __ __ __ __ __ __ __
3. Participant began/will begin services: ____/____/_____. Services are: ☐ Residential ☐ Non-Residential

C. SUBSTANCE ABUSE ☐ AND/OR MENTAL HEALTH ☐ (Complete when applicable)

4. ☐ Expected duration of needed treatment/services: _____ months.
5. ☐ Participant is receiving treatment/services 32 or more hrs/week. ☐ Yes ☐ No If no, number of hrs./week: _____
   (Participant may be considered full-time or may be eligible for a medical exemption and receive services as an exempt volunteer).
6. ☐ Participant is able to participate in other WtW activities? ☐ Yes ☐ No If yes, how many hrs/week: _____.
   (Participant may be eligible for an exemption and still participate in GAIN as an exempt volunteer).
7. ☐ Participant may be eligible to medical exemption. Please issue GN 6051, Verification of GAIN Exemption/Deferral, form*.
   * A medical exemption may be granted if a participant, due to a physical/mental disability, is unable to fully participate at least 30 days.
8. ☐ Participant is eligible for an exemption and will participate in GAIN as an exempt volunteer.

D. DOMESTIC VIOLENCE ☐ CASE MANAGEMENT AND/OR ☐ LEGAL SERVICES (Complete when applicable)

9. ☐ Expected duration of needed services: _____ months.
10. ☐ Participant is participating in DV services:_____ hrs./week and is able to do other WtW activities:_____ hrs/week **within** a WtW plan.
    To allow for successful participation, the following requirements shall be waived:
    - ☐ 32 hour/week GAIN participation requirement.
    - ☐ Core hours of participation.
    - ☐ Regular GAIN flow.
    - ☐ Mandatory participation in GAIN/WtW activities, which are subject to financial sanction.
    - ☐ Other, specify: _____.
11. ☐ Participant shall be granted a DV Waiver from the mandatory WW activities and received DV services outside a WtW Plan.
12. ☐ Participant is participating in DV services: _____ hrs/week and other WtW activities:_____ hrs/week **outside** of a WtW plan.
    (Participant may be eligible for an exemption and still participate in GAIN as an exempt volunteer).

E. OTHER SUPPORTIVE SERVICE NEEDS (Complete when applicable)

Participant needs the following supportive services:

☐ Child care ☐ Public Transportation or ☐ Mileage: _____per month ☐ Other: _____

☐ Ancillary work/related expenses such as: ☐ Books ☐ Fees ☐ Uniforms, and/or ☐ Tools/Supplies

F. OTHER Recommended services ordered by the court system? ☐ DV Counseling ☐ Substance Abuse ☐ Mental Health

G. PARTICIPANT AUTHORIZATION

I authorize the Department of Public Social Services and the above treatment/services provider to verify information regarding the status of my CalWORKs application/case and/or continuing eligibility to receive CalWORKs Specialized Supportive Services. I am aware that my Mental Health and/or Substance Abuses services will be incorporated in my CalWORKs Welfare-to-Work Plan. I am aware that my Domestic Violence services may be incorporated now or eventually in my CalWORKs Welfare-to-Work Plan.

_____ Participant's Signature _____ Date

H. COUNTY ACTION: DATE:_____ ☐ ACCEPTED ☐ REJECTED ☐ PENDING ☐ CONDITIONAL ACCEPTANCE

PA 1923 (Rev. 04/2008)

DPSS' response to the PA 1923:

Notification Letter
Upon receipt of the PA 1923, Ms. Williams reviews the form for completeness, checks the LEADER system to confirm whether or not the individual is CalWORKs eligible, and sends a *Notification Letter* (approved or rejected) to the treatment provider at the address listed on the PA 1923 within 3 workdays of receipt of the form. If the PA 1923 is accepted—that is, the individual is found to be eligible for CalWORKs—it is then forwarded to the appropriate District and Region.

PA 1132
The SSS eligibility worker then reviews the case, updates the information on LEADER, and sends the PA 1132 (*CalWORKs Eligibility Worker/GAIN Services Worker Notification to Service Providers***)** to the appropriate service provider to confirm receipt of the PA 1923 and provide worker information within three (3) workdays of receipt of the PA 1923.

GN 6149
The SSS GSW reviews the PA 1923 and checks their GEARS system to verify whether the participant has an open specialized supportive services component and is in an authorized specialized supportive service. If not, the GSW contacts the participant within two (2) workdays of receipt of the PA 1923 to schedule an appointment to interview the participant and open a file. The participant may agree or decline to have the mental health supportive service as part of his/her welfare-to-work plan.

The GSW sends the GN 6149 (*CalWORKs Welfare-to-Work Notification*) to the service provider within 3 workdays of his/her appointment with the participant to inform them that the participant signed the WtW plan, failed to attend the GAIN appointment, or was granted an exemption or waiver of the WtW program requirement. If the participant agreed to sign the WtW plan that includes services for mental health, the GN 6149 will reflect that, and the provider should retain the completed GN 6149 form in the client's chart as supporting documentation of eligibility for CalWORKs mental health supportive services. In the event the participant fails to sign the WtW plan or elects not to include mental health supportive services, the provider should not open the case under CalWORKs mental health supportive services.

County of Los Angeles
DEPARTMENT OF PUBLIC SOCIAL SERVICES
12860 CROSSROADS PARKWAY SOUTH · CITY OF INDUSTRY, CALIFORNIA 91746
Tel (562) 908-8400 · Fax (562) 908-0459

PHILIP L. BROWNING
Director

SHERYL L. SPILLER
Chief Deputy

Reference: [ ] PA 1923 [ ] PA 1206
RE:
SSN/CASE NO.:

Dear Provider:

This is to inform you that the above referenced form:

A. [ ] is ***accepted***, the participant is receiving CalWORKs.
B. [ ] is ***rejected*** for the following reason(s):
   [ ] **PA 1923 - CalWORKs Treatment/Services Verification** (Use with CalWORKs eligible participants only).
      [ ] The individual is not aided on the CalWORKs case, not related to GAIN sanction/time limit.
      [ ] Information is incomplete / Insufficient information, unable to verify.
      [ ] No active case / No case record found.
      [ ] Terminated (exceeding 90-days) effective: _____.
      [ ] Case denied effective: _____.
      [ ] Other: Client is an SSI recipient_____.

   [ ] **PA 1206 - Screening for Potential CalWORKs Eligibility** (Use with Non-Custodial Parents only).
      [ ] Individual has no CalWORKs-eligible child(ren) in Los Angeles County.
      [ ] The individual named is receiving CalWORKs (a PA 1923 should be sent instead).
      [ ] Information is incomplete.
      [ ] No record found.

C. [ ] is ***pending***, the CalWORKs application was opened on___, and a determination of eligibility is still pending.
D. [ ] is ***conditionally accepted*** (pending resolution of participant's CalWORKs eligibility), the participant is not receiving CalWORKs due to the following reason(s):
      [ ] GAIN sanction, the participant failed to comply with the WtW program requirements.
      [ ] Time Limit, the participant has exhausted the 60-month time limit clock.
      [ ] DA sanction, the participant failed to cooperate with Child Support Enforcement.

Note: Please assist the participant to immediately contact DPSS as follows: 1) GAIN sanction, contact the corresponding GAIN office, Scheduling Clerk, to schedule an appointment to request to remove the sanction and open an SSS component; 2) Time-Limit, contact the corresponding GAIN office, Post Time Limit Services Liaison, to schedule an appointment to request an evaluation for Post Time Limit Services or a time limit extender; and 3) DA sanction, contact his/her CalWORKs Eligibility Worker to request an evaluation of the child support exemption.

Any questions regarding this letter should be directed to Colleen Cunningham at (562) 908-6324.

Very truly yours,

Nadia Mirzayans, HSA III
Specialized Supportive Services Section

Enclosure(s)

"To Enrich Lives Through Effective And Caring Service"

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs Eligibility Worker/GAIN Services Worker
Notification to Service Providers

[Provider's Name and Address] [CalWORKs District or GAIN Regional Office]

[ ] [ ]

Date: _____

This is to confirm receipt of form PA 1923, CalWORKs Treatment/Services Verification, and to provide worker information for the participant listed below for whom you are providing services at your facility.

I. PARTICIPANT INFORMATION

Case Name: _____

Participant Name (if different): _____

LEADER Case Number: __ __ __ __ __ __ __ - __ - __ __ and/or

Social Security Number: __ __ __ - __ __ - __ __ __ __

The above-named participant has been assigned to a specialized supportive services file. The specialized supportive services worker information is as follows:

II. ELIGIBILITY/GAIN SERVICES WORKER INFORMATION

Eligibility/GAIN Services Worker Name: _____

Worker File Number: _____
Eligibility/GAIN Services Worker (circle one)

Phone Number: (_____)_____

Fax Number: (_____)_____

III. APPOINTMENT INFORMATION

The above-named participant has an appointment on _____/_____/_____ to discuss his/her supportive services activity/need at the above location. If he/she is unable to attend, please call me by _____/_____/_____ to reschedule.

Please see above for CalWORKs District or GAIN Region location.

Please note that unless previously notified, you should receive this form from both the Specialized Supportive Services Eligibility Worker and the Specialized Supportive Services GAIN Services Worker.

PA 1132 (Rev. 12/05)

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs WELFARE-TO-WORK NOTIFICATION

[Provider's Name and Address] [GAIN Regional Office]

[ ] [ ]

Participant Name:	CalWORKs Case No.
Residence Address:	Mailing Address:
Birthdate:	Social Security Number:

Dear Provider:

This is to confirm the following information regarding the participant listed above for whom you began providing CalWORKs Supportive Services prior to entry into GAIN and have submitted a PA 1923 for verification.

I. GAIN Activity

1. ☐ Participant signed a Welfare-to-Work (WtW) plan as of _____/_____/_____. The plan includes services for:
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services
2. ☐ Participant signed a WtW plan as of _____/_____/_____. However, the participant elected not to include the below services in his/her plan:
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services
3. ☐ Participant was granted DV Waiver, decided to access DV services outside of a WtW plan as of:____/____/___ .
4. ☐ Participant has not signed a WtW plan as of _____/_____/_____and the following applies:
   ☐ Participant requested and qualifies for an exemption effective: _____/_____/_____.
   ☐ Participant requested to discontinue services and was deregistered.
   ☐ Participant is an exempt volunteer.
   ☐ Participant has been granted a DV Waiver.
5. ☐ Participant was granted Good Cause and a DV Waiver, for not participating in GAIN, decided not to access DV services. (Please discontinue CalWORKs Domestic Violence services.)
6. ☐ Participant's time clock has been adjusted and months of aid have been added back. Participant is now in his/her _____month on aid.
7. ☐ Other: _____.

II. GAIN Activity Has Not Been Opened Because:

☐ The participant did not attend his/her GAIN appointment. I contacted the participant, but was unsuccessful, and therefore, he/she is in non-compliance for failure to sign a WtW plan. The participant must contact me by: _____/_____/_____ to avoid further action (i.e. compliance, sanction, deregistration).

III. Subsequent Notification:

1. ☐ The participant did not attend his/her GAIN appointment. I attempted to contact the participant, but was unsuccessful. The participant did not contacted me by the date indicated above. I will begin the non-compliance process effective _____/_____/_____. (Please discontinue CalWORKs DV services.)
2. ☐ We previously reported that the participant did not sign the WtW plan. As of _____/_____/_____, the participant has signed the WtW plan. The plan includes services for:
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services
3. ☐ Participant has been granted a DV Waiver, decided to access DV services outside of the WtW Plan.
4. ☐ Participant's time clock has been adjusted and months of aid have been added back. Participant is now in his/her _____month on aid.
5. ☐ Participant has been granted Good Cause for not participating in GAIN, decided not to access DV services. (Please discontinue CalWORKs DV services.)
6. ☐ Other: _____

GAIN Services Worker	File No.:	Phone No.:	Date:

GN 6149 (Rev. 12/05)

GN 6007B – CalWORKs Supportive Services Enrollment Termination Notice

Providers should use this form to notify the GSW of the termination of a participant from CalWORKs mental health services. The provider may send the completed form to the GSW as soon as the provider has determined that 1) the case will be closed, or 2) the case will be transferred from the CalWORKs plan to another billing plan. Providers may indicate whether the participant successfully completed treatment and write in a final date of service or the participant dropped out of services. In the case of a participant dropping out of treatment, the provider may or may not know if there was "good cause" and may or may not have authorization from the participant to release the reason to the GSW. In either case, the provider may indicate the date that services were discontinued, and the completed form should be faxed or mailed to the GSW.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs SUPPORTIVE SERVICES ENROLLMENT TERMINATION NOTICE

[To: (GAIN Regional Office)] [From: Service Provider Name & Address]

Attention: _____
[GSW Name/Number] [ ]

Provider Certification

Participant Name:	Participant Address:
Social Security No.:	
Case No.:	
GAIN Activity:	

This is to inform you that the above-named participant has:

- ☐ Successfully completed his/her services/treatment activity on: _____
- ☐ Dropped-out of services with good cause on: _____
- ☐ Dropped-out of services without good cause on: _____
  Reason: _____
- ☐ Services not completed; participant entered employment on: _____
- ☐ Services not completed; participant transferred to other WtW activity: _____
- ☐ Terminated his/her services; participant transferred to another provider on: _____
- ☐ Other: _____

_____

_____

Service Provider Representative:	Title:	Phone No.: ( )	Date:

GN 6007B (Rev. 06/06)

GN 6011 – Service Provider Cancellation/Stop Notice

This form is used by the GSW to notify mental health providers to stop providing a particular service to the CalWORKs participant. Mental health providers will routinely receive this form after the completion of the clinical assessment, when the clinical assessment component (coded as 1) is closed on GEARS. The GSW will also send this notice to the provider when the mental health supportive services component (coded as 3) is closed. The effective date requesting that services stop may be several weeks prior to the provider's receipt of the notification. Upon receipt of this form notifying the provider to stop providing mental health services (3), the provider has until the end of that calendar month (up to 30 days) to terminate CalWORKs services with the participant, so discussion of the impending termination should begin immediately. If the provider is unsure what the form means, and the participant indicates that there has been no change is his/her status, the provider is encouraged to contact the GSW for verification of status.

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

SERVICE PROVIDER CANCELLATION/STOP NOTICE

PROVIDER'S ADDRESS

ADDRESS REPLY TO:
GAIN REGIONAL OFFICE

PARTICIPANT NAME: CASE NUMBER:

SOCIAL SECURITY NUMBER: DATE:

CHILD NAME:

DEAR SERVICE PROVIDER:

EFFECTIVE _____, THE ABOVE NAMED GAIN PARTICIPANT IS NO LONGER ELIGIBLE TO RECEIVE THE FOLLOWING GAIN ACTIVITY/SUPPORTIVE SERVICE WHICH YOU HAVE BEEN PROVIDING TO HIM/HER. PLEASE STOP YOUR PROVISION OF

THE REASON FOR THE REQUEST FOR CANCELLATION OF SERVICES TO THE PARTICIPANT IS DUE TO HIS/HER: DROP OUT OTHER

IF YOU ARE CONTINUING TO RECEIVE CHILD CARE PAYMENTS FOR THE CHILD(REN) OF THIS PARTICIPANT, PLEASE DISREGARD THIS NOTICE.

IF YOU HAVE ANY QUESTIONS REGADING THIS NOTICE OR YOUR CHILD CARE PAYMENT, PLEASE CONTACT:

_____ AT _____
GAIN CASE MANAGER TELEPHONE NUMBER

GN 6011