CalWORKs SPECIALIZED SUPPORTIVE SERVICES 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

(For Mental Health: Immediate Need/Urgent within 2 workdays, Less Urgent within 5 workdays and Non-emergent within 10 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 call me immediately.

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

I understand that I am being referred to an appointment to begin specialized supportive services as indicated above. If I fail to attend this appointment, I understand that I may be called 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

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs SPECIALIZED SUPPORTIVE SERVICES RESULTS

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

Attention:_____
GSW Name/Number

[Fax No.: _____] [ ]

A - Completed by GSW//CCM//RCM/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 from the appointment date)

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 CW 61, Authorization to Release Medical Information, CW 61A, Physical Capacities and CW61B, Mental Capacities*
   *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 ☐ 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. Name of Person Completing this form: (Print Name)	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