



Family Solutions Center (FSC)
Two-Way Gram

SECTION A (To be completed by the referring FSC Staff)

To (HCM or BWS-LOD Staff):	Date:
From (FSC Agency Name):	FSC Staff Name:
FSC Staff Telephone Number:	FSC Staff Fax Number:

SECTION B (To be completed by the referring FSC Staff)

Adult Participant Name (Please Print):	SSN (Last four digits only):
Birthdate:	Telephone Number:
Other Adult Name:	SSN (Last four digits only):
Birthdate:	Telephone Number:
Families Immediate Housing Need: <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Move-In Assistance <input type="checkbox"/> Eviction Prevention <input type="checkbox"/> Rental Subsidy Assistance	

SECTION C (To be completed by the HCM or BWS-LOD)

Date Two-Way Gram Received _____ **Date returned to FSC** _____

The participant has the following Homeless Programs and Services potentially available:

- Temporary Homeless Assistance
- Permanent Homeless Assistance
- Moving Assistance
- Emergency Assistance to Prevent Eviction
- 4-Month Rental Assistance
- Housing Relocation
- Emergency Shelter Service
- Homeless CalWORKs Families Project
- No Homeless Programs /Services Available

If **currently** accessing any of the above programs or services, please list below:

SECTION D (To be completed by the HCM or BWS-LOD)

The participant has been scheduled for an appointment with DPSS as follows:

- Apply for CalWORKs
- Apply for Homeless/At-Risk Programs
- Referred to Homeless Services
- Resolve GAIN-related issue/s

DPSS District/GAIN Regional Office: _____ DPSS Case # _____

Date of Appointment _____ Time of Appointment _____

Name of EW/HCM/HSS GSW: _____ Telephone # _____