

RECOMENDACION DE WTW*

ANEXO

Completado por el WTWCM**	Welfare to Work Office No:	WTWCM No:
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Participant Name:	Social Security Number:	CalWORKs Case #:
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Address: (Street, City, Zip)	Mailing Address, if different:
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Telephone number:	Sex: M () F ()	Birthdate:	Citizen: Yes () No () IF NO, Legal right to work in U.S.: Yes () No ()
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Additional Comments:

I CERTIFY THAT THE ABOVE DATA HAS BEEN VERIFIED/DOCUMENTED BY AN EMPLOYEE OF THE COUNTY WELFARE DEPARTMENT. THE DEPARTMENT CERTIFIES THAT THIS INDIVIDUAL HAS PROVIDED DOCUMENTATION THAT HE/SHE IS LEGALLY ENTITLED TO WORK IN THE U.S.

Welfare to Work Case Manager Signature: _____

Telephone Number: _____ Date: _____

AUTORIZO EL INTERCAMBIO DE INFORMACION PERTINENTE SOBRE WTW/CALWORKS*** ENTRE _____ Y LAS OFICINAS ESTATALES O FEDERALES O SUS REPRESENTANTES PARA EL PROPOSITO DE REVISION, AUDITORIA, Y/O AUDIENCIAS.

Firma del participante de WTW

Fecha