NOTICE OF FORM CHANGE NO. 03-078

7/10/2003

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☒ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE
SEE BELOW

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MO	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: SEE BELOW	REPLACES: SEE BELOW	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted
REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval
☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ Other:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☐ Use until exhausted
☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☒ Use new form effective 7/03

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached iare Reproducible Copies of the following forms:

LIC 300A (7/03) - Removal Confirmation - Exemption Needed (Replaces 12/02)
LIC 300B (7/03) - Removal Confirmation - Denied (Replaces 12/02)
LIC 300C (7/03) - Removal Confirmation - Rescinded (Replaces 12/02)
LIC 300D (7/03) - Removal Confirmation - Non-Exemptible (Replaces 12/02)

All are to be printed 8 1/2 X 11, 1-sided

Check on the internet to see if forms are available at www.dss.cahwnet.gov.

For camera-ready copy copies of English form, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov.

Date: _____

CONFIRMATION OF REMOVAL FOR: _____

This is to confirm that the Department of Social Services, Caregiver Background Check Bureau, informed you that the person identified above must be removed from your facility/home. The individual must be removed because of the nature of his/her criminal record information received from the Department of Justice.

If you wish to have the individual return to your facility/home, the individual must have a criminal record exemption. To request an exemption on the individual's behalf, you must submit the information outlined in the Immediate Action Required letter sent to you.

To confirm that the individual has been removed from your facility/home, you must sign below and return the entire notice, **within five (5) days** of the date of this notice to the address below. Retain a copy of the signed notice for your records.

Regional Office _____

Address _____

City/State/Zip Code _____

Failure to immediately remove the individual may result in an assessment of civil penalties and/or a disciplinary action including suspension of your license. If you have any questions regarding this letter, you may contact your local regional office at (___) _____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses are true and correct. I confirm that the individual named above has been removed from the facility/home.

DATE INDIVIDUAL WAS REMOVED: _____

NAME OF PERSON COMPLETING THIS FORM: _____

TITLE: _____

SIGNATURE: _____

c: _____

Date: _____

CONFIRMATION OF REMOVAL FOR: _____

This is to confirm that the Department of Social Services, Caregiver Background Check Bureau, informed you that the person identified above must be removed from your facility/home. The individual must be removed because his/her criminal record exemption has been denied.

To confirm that the individual has been removed from your facility/home, you must sign below and return the entire notice, **within five (5) days** of the date of this notice to the address below. Retain a copy of the signed notice for your records.

Regional Office _____

Address _____

City/State/Zip Code _____

Failure to immediately remove the individual may result in an assessment of civil penalties and/or a disciplinary action including suspension of your license. If you have any questions regarding this letter, you may contact your local regional office at (___) _____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses are true and correct. I confirm that the individual named above has been removed from the facility/home.

DATE INDIVIDUAL WAS REMOVED: _____

NAME OF PERSON COMPLETING THIS FORM: _____

TITLE: _____

SIGNATURE: _____

c: _____

Date: _____

CONFIRMATION OF REMOVAL FOR: _____

This is to confirm that the Department of Social Services, Caregiver Background Check Bureau, informed you that the person identified above must be removed from your facility/home. The individual must be removed because his/her criminal record exemption has been rescinded.

To confirm that the individual has been removed from your facility/home, you must sign below and return the entire notice, **within five (5) days** of the date of this notice to the address below. Retain a copy of the signed notice for your records.

Regional Office: _____

Address _____

City/State/Zip Code _____

Failure to immediately remove the individual may result in an assessment of civil penalties and/or a disciplinary action including suspension of your license. If you have any questions regarding this letter, you may contact your local regional office at (___)_____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses are true and correct. I confirm that the individual named above has been removed from the facility/home.

DATE INDIVIDUAL WAS REMOVED: _____

NAME OF PERSON COMPLETING THIS FORM: _____

TITLE: _____

SIGNATURE: _____

c: _____

Date: _____

CONFIRMATION OF REMOVAL FOR: _____

This is to confirm that the Department of Social Services, Caregiver Background Check Bureau, informed you that the person identified above must be removed from your facility/home. The individual must be removed because he/she has been convicted of a crime for which an exemption cannot be granted.

To confirm that the individual has been removed from your facility/home, you must sign below and return the entire notice, **within five (5) days** of the date of this notice to the address below. Retain a copy of the signed notice for your records.

Regional Office _____

Address _____

City/State/Zip Code _____

Failure to immediately remove the individual may result in an assessment of civil penalties and/or a disciplinary action including suspension of your license. If you have any questions regarding this letter, you may contact your local regional office at (___) _____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses are true and correct. I confirm that the individual named above has been removed from the facility/home.

DATE INDIVIDUAL WAS REMOVED: _____

NAME OF PERSON COMPLETING THIS FORM: _____

TITLE: _____

SIGNATURE: _____

c: _____