NOTICE OF FORM CHANGE NO. 03-102

DATE: August 6, 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

RS 3 (5/03) Service Provider Referral/Notification Form

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☑ Free ☐ Sold		☐ Yes ☐ No
☐ New ☑ Revised	DATE OF FORM: 5/03	REPLACES: 5/99	☐ 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_____

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

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Print Form: 8 1/2 x 11, two sided, 4-part NCR.

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

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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

☐ **RCA MANDATORY REFERRAL**
☐ **CalWORKs MANDATORY REFERRAL**

SERVICE PROVIDER REFERRAL / NOTIFICATION FORM

DISTRIBUTION:
Original Copy: Client
1st Copy : Service Provider
2nd Copy : Return to County Welfare Department When Notification is Required
3rd Copy : County Welfare Department

ADDRESS OF COUNTY WELFARE DEPARTMENT

TELEPHONE NO.: ( ) —

COUNTY USE ONLY

1. CASE NAME
2. AU SIZE
3. AID CODE/CASE NUMBER
4. REGISTRANT'S NAME
5. SOCIAL SECURITY NUMBER
6. ALIEN NUMBER
   A -
7. DATE OF ENTRY TO U.S. OR DATE GRANTED ASYLUM
8. INTRACOUNTY OR INTERCOUNTY TRANSFER
   FROM: _____ COUNTY/DISTRICT
   PREVIOUS SERVICE PROVIDER: _____
9. SPECIFY PRIMARY LANGUAGE DESIGNATED ON SAWS 1
10. DATE OF REFERRAL

11. YOU ARE REQUIRED TO REPORT TO THE SERVICE PROVIDER BEFORE YOU CAN BE ELIGIBLE FOR CASH ASSISTANCE.

a. ☐ **PLEASE TAKE THIS FORM TO THE FOLLOWING SERVICE PROVIDER AND RETURN TO YOUR WORKER WITH DATED ORIGINAL ON OR BEFORE _____ .**

b. ☐ **YOUR APPOINTMENT AT THE SERVICE PROVIDER IS SCHEDULED FOR:**

DATE:_____ **TIME:**_____

12. SERVICE PROVIDER ADDRESS

TELEPHONE NO.: ( ) —

13. COMMENTS

14. I certify that I have informed the applicant/recipient of his or her rights and responsibilities in regard to the RCA/ECA programs. I have explained that he/she must comply with all eligibility requirements, such as reporting to, and registering with the Service Provider, and participating and cooperating in training and employment activities, and that, if these requirements are not met, he/she may lose their grant.

WORKER'S SIGNATURE	WORKER'S NUMBER	DATE

SERVICE PROVIDER USE ONLY

15. Individual reported to Service Provider as required.

AUTHORIZED SIGNATURE	DATE

When the above named registrant has completed participation in the training program or been placed in employment, please complete the 1st and 2nd copies and return the 2nd copy to the county welfare department addressed above.

16. SERVICE PROVIDER EMBOSSING STAMP

17. Reason for notification to the county welfare department:

☐ Client has completed participation in training. (see attached RS 3A)
☐ Client has been placed in employment on _____ DATE (see attached RS 3A)
☐ Other *(Explain in COMMENTS section)*

18. COMMENTS

19. SERVICE PROVIDER AUTHORIZED SIGNATURE	DATE

SERVICE PROVIDER REFERRAL FORM

Instructions

County Use Only

1. **Case Name** — Enter the refugee's name: last name, first name, and middle initial.

2. **AU Size** — Enter number of persons in the Assistance Unit

3. **Aid Code/Case Number** — Enter the two-digit aid identification code for the appropriate public assistance program/Enter the refugee's case number as assigned by your CWD.

4. **Registrant's Name** — Enter the name of person in the AU who is being referred on a mandatory basis, and required to register with the Service Provider.

5. **Social Security Number** — Enter the registrant's social security number.

6. **Alien Number** — Enter the registrant's alien number.

7. **Date of Entry to U.S. or Date Granted Asylum** — Enter the date shown on the registrant's I-94 form or I-551 form or other appropriate documentation.

8. **Intracounty or Intercounty Transfer** — Enter the county (or district, if Los Angeles), and the Service Provider name and address that the registrant is transferring from.

9. Specify primary language designated on SAWS 1.

10. **Date of Referral** — Enter the date on which the registrant is referred to the Service Provider.

11a. Check this box and enter the date that the registrant is to return the validated original RS 3 form to the Worker.

11b. If you make an appointment for the registrant to report to the Service Provider, check this box and enter the date and time of the appointment.

12. **Service Provider Address** — Enter the address and telephone number of the Service Provider the registrant is being referred to. Enter the Service Provider's full address including, number, street, city and zip code.

13. **Comments** — Self-explanatory.

14. **Worker Name and Worker Number** — Enter the name of worker assigned to the case, and the number that your county uses to identify the worker.

Service Provider Use Only

15. **Authorized Signature** — This is to be signed by the person authorized to certify that the registrant has reported to the Service Provider for registration.

16. **Service Provider Embossing Stamp** — Enter the official certification stamp.

17. Check the appropriate box to indicate why notification is being made.

18. **Comments** — Self-explanatory.

19. **Service Provider Authorized Signature** — This is to be signed and dated by the person authorized to complete this form.