NOTICE OF FORM CHANGE NO. 03-153

DATE: 10/01/2003

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ Private and Public Adoption Agencies
☐ District Attorney
☐ 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: CW 371 (7/01)
Referral To Local Child Support Agency (LCSA)

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
PAD	☐ Free ☒ Sold	$1.45	☐ Yes ☒ No
☐ New ☐ Revised	DATE OF FORM: 7/01	REPLACES:	☐ 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

Form is now printed: 8 1/2 x 11, one sided, pad in 100s.

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

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

REFERRAL TO LOCAL CHILD SUPPORT AGENCY (LCSA)

(Complete one form for each Noncustodial Parent or Alleged Father)

DATE OF REFERRAL

☐ TO LCSA REPRESENTATIVE

☐ FROM CWD REPRESENTATIVE CW # PHONE

CASE NAME

AID TYPE/CASE NUMBER

APPLICANT/RECIPIENT NAME (LAST, FIRST, MIDDLE)

RELATIONSHIP TO CHILD(REN)

MINOR PARENT'S NAME (IF DIFFERENT FROM APPLICANT/RECIPIENT)

A. This case is referred to you because:

☐ Action is necessary to obtain:
- ☐ financial support ☐ medical support ☐ paternity

☐ Recipient is receiving direct support payments. Action needed to transfer payments to county.

☐ Good Cause has been (see CW 51 attached):
- ☐ claimed ☐ granted ☐ denied

☐ Other (see comments)

B. The following information applies to this case:

☐ CA 2.1(Q) Questionnaire is attached.

☐ Noncustodial parent has health insurance coverage. A copy of the DHS 6155 is attached.

☐ Medi-Cal eligibility has not been determined.

☐ Previously sanctioned/penalized; now agrees to cooperate/assign support rights.

☐ Child no longer resides with recipient.

☐ Medi-Cal Only

☐ CS 909, Declaration of Paternity, is attached.

☐ Other (see comments)

☐ Lamb Case (minor parent not eligible as a dependent child: Family Code 4000)

C. Applicant/recipient has not agreed to:

☐ Assign:
- ☐ financial support rights ☐ medical support rights

☐ Cooperate in:
- ☐ obtaining financial support ☐ obtaining medical support and/or
- ☐ establishing paternity

☐ Forward support payments.

D. Penalty/Sanction

☐ Penalty has been applied due to non-cooperation.

☐ Sanction has been applied for refusal to assign rights.

☐ TO CWD REPRESENTATIVE CW #

☐ FROM LCSA REPRESENTATIVE PHONE

☐ Applicant/recipient has cooperated with the law.

☐ Applicant/recipient has not cooperated with the law:
- ☐ Did not appear and/or provide verbal, written or documentary information
- ☐ Rescheduled appointment on _____ ☐ kept ☐ failed
- ☐ Refuses to appear as a witness at court or other hearing
- ☐ Refuses to transmit child support payment(s) received directly from the noncustodial parent

☐ Other (see comments)

☐ This is a notice of renewed cooperation.

☐ Paternity ☐ has ☐ has not been established.

☐ Support order established.

☐ CS 909, Declaration of Paternity, is attached.

☐ Other (see comments)

E. TYPE OF APPLICATION

☐ NEW ☐ REAPPLICATION ☐ ADD A CHILD ☐ ICT ☐ RENEWAL

NONCUSTODIAL PARENT'S OR ALLEGED FATHER'S NAME

CHILD SUPPORT FILE NUMBER

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

CHILD'S NAME

DATE OF BIRTH ☐ MFG RULE APPLIES

F. ☐ APPLICANT PREVIOUSLY RECEIVED AID

SPECIFY TYPE: ☐ CASH AID ☐ MEDI-CAL ONLY ☐ TMC

PLACE (CITY, COUNTY, STATE)

DATE LAST RECEIVED

G. ☐ INTER-COUNTY TRANSFER/INTERSTATE TRANSFER

FROM (COUNTY/STATE)

PRIOR COUNTY'S CHILD SUPPORT FILE NUMBER (IF KNOWN)

H. ☐ CASH AID

APPROVAL DATE

ONGOING CASH AID AMOUNT

$

DISCONTINUANCE DATE

REASON/CODE FOR DISCONTINUANCE

I. ☐ MEDI-CAL ONLY

DATE MEDI-CAL BEGINS/CONTINUES

DATE DISCONTINUED

REASON FOR DISCONTINUANCE

Comments: