

NOTICE OF FORM CHANGE NO. 03-178DATE
11/5/2003**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 RS 3 (10/03) Service Provider Referral/Notification Form

ORDER UNIT MASTER ONLY	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 10/03	REPLACES 5/03	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input type="checkbox"/> No Change Permitted	REQUIRED FORM- <input checked="" type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788		<input type="checkbox"/> 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.govFor camera-ready copies of English form, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov.

- RCA MANDATORY REFERRAL
 CalWORKs MANDATORY REFERRAL

SERVICE PROVIDER REFERRAL / NOTIFICATION FORM

ADDRESS OF COUNTY WELFARE DEPARTMENT

DISTRIBUTION:

- Original Copy: Client*
 1st Copy : Service Provider
 2nd Copy : Return to County Welfare Department When Notification is Required
 3rd Copy : 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 AS A REFUGEE, OR DATE GRANTED ASYLUM, OR DATE OF CERTIFICATION AS A TRAFFICKING VICTIM	
8. INTRACOUNTY OR INTERCOUNTY TRANSFER FROM: _____ COUNTY/DISTRICT PREVIOUS SERVICE PROVIDER: _____	
9. SPECIFY PRIMARY LANGUAGE DESIGNATED ON SAWS 1	
10. DATE OF REFERRAL	
13. COMMENTS	

- 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.: () -

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
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SERVICE PROVIDER USE ONLY

15. Individual reported to Service Provider as required.

AUTHORIZED SIGNATURE	DATE
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16. SERVICE PROVIDER EMBOSSING STAMP

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.

17. Reason for notification to the county welfare department:
- Client has completed participation in training. (see attached RS 3A) Other (Explain in COMMENTS section)
- Client has been placed in employment on _____ DATE (see attached RS 3A)

18. COMMENTS

19. SERVICE PROVIDER AUTHORIZED SIGNATURE	DATE
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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 registrant'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 as a Refugee, Date Granted Asylum, or Date of Certification as a Trafficking Victim** — 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.