

NOTICE OF FORM CHANGE NO. 03-179

DATE

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 1 (10/03) Refugee Resettlement Program Services
Application and Assessment Information

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, 6 pages, front to back, one staple,

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

For 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.

REFUGEE RESETTLEMENT PROGRAM SERVICES APPLICATION AND ASSESSMENT INFORMATION

A. WELFARE CASE NUMBER	
B. SERVICE PROVIDER REFERRAL AGENCY	C. DATE OF APPLICATION
D. MANDATORY CASH ASSISTANCE CLIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	

PART A.

I. BASIC CHARACTERISTICS

1. LAST NAME			FIRST NAME			MIDDLE			2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		
3. STREET ADDRESS (RESIDENCE)						CITY/ STATE			ZIP CODE (RESIDENCE) _ _ _ _ - _ _ _ _		
4. AGE	5. BIRTHDATE (M/D/Y)	6. PHONE (RESIDENCE) ()		7. MESSAGE PHONE ()		8. ALIEN NUMBER					

Disclosure of your Social Security Number is voluntary and does not affect your eligibility for services. Your Social Security Number may be used to assist State, County, and Voluntary Agencies in the administration of the Refugee Resettlement Program authorized by the Refugee Act of 1980, P.L. 96-212 and to monitor the effectiveness of agencies in providing refugee services.

9. SOCIAL SECURITY NUMBER			10. PRIOR EDUCATION <input type="checkbox"/> None <input type="checkbox"/> 1-6 Years <input type="checkbox"/> 7-11 Years <input type="checkbox"/> High School Graduate or Equivalent <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate or Higher											
11. STATE OF INITIAL RESETTLEMENT <input type="checkbox"/> California <input type="checkbox"/> Other State			12. DATE OF ENTRY AS A REFUGEE			OR DATE ASYLUM GRANTED			OR DATE OF CERTIFICATION ASA TRAFFICKING VICTIM			13. TIME IN THE U.S. <input type="checkbox"/> 0-12 months <input type="checkbox"/> 13-36 months <input type="checkbox"/> over 36 months		
14. IMMIGRATION STATUS: <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Entrant/Parolee <input type="checkbox"/> Amerasian <input type="checkbox"/> Other _____				15. COUNTRY OF ORIGIN <input type="checkbox"/> Iran / Iraq <input type="checkbox"/> Afghanistan <input type="checkbox"/> Other Middle East <input type="checkbox"/> Vietnam <input type="checkbox"/> Other Southeast Asia <input type="checkbox"/> Caribbean / Latin America <input type="checkbox"/> Ethiopia <input type="checkbox"/> Other African <input type="checkbox"/> Former Soviet Union <input type="checkbox"/> Bosnia <input type="checkbox"/> Other Eastern European <input type="checkbox"/> Other (specify) _____										
16. EMPLOYMENT STATUS <input type="checkbox"/> Not Employed <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time				IF EMPLOYED SPECIFY: Emp. Name: _____ Job Title: _____ Emp. Address: _____ Hrs & Wage _____ Emp. Contact: _____ Emp. Phone: _____										

II. ELIGIBILITY SUMMARY

17. CASH ASSISTANCE STATUS Is client currently receiving cash assistance? a. <input type="checkbox"/> Yes <input type="checkbox"/> No				b. If yes, what type? <input type="checkbox"/> TANF-SF <input type="checkbox"/> GA <input type="checkbox"/> TANF-U <input type="checkbox"/> FOOD STAMPS <input type="checkbox"/> SSI/SSP <input type="checkbox"/> MATCHING GRANT <input type="checkbox"/> RCA/ECA <input type="checkbox"/> OTHER (specify) _____				c. If No, MONTHLY FAMILY INCOME FOR NON CASH ASSISTANCE <input type="checkbox"/> \$560 - or less <input type="checkbox"/> \$561 to \$940 <input type="checkbox"/> \$941 to \$1265 <input type="checkbox"/> \$1266 to \$1490 <input type="checkbox"/> More than \$1490			
18. FAMILY SIZE _____											
19. CURRENT STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not in school						20. TYPE OF SCHOOL <input type="checkbox"/> Primary School <input type="checkbox"/> Secondary School <input type="checkbox"/> College/University <input type="checkbox"/> Other post-secondary (trade or business school, etc)					

ENROLLMENT DATA

21. ENROLLMENT DATE				22. ESTIMATED COMPLETION DATE				23. ENTERING COMPONENT			
24. RE-ENTRY <input type="checkbox"/> Returning <input type="checkbox"/> New											

PART B. ASSESSMENT

25. Previous Work History *(In native country, refugee camp, or USA)*

DATES	POSITION	RESPONSIBILITIES	SALARY
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$

26. A. Is the applicant currently enrolled in a refugee employment services/training program or previously participated in one within the current FFY? Yes No
If yes, where? _____
- B. Services/training components received? _____
- C. When were services/training received? *(Indicate month and year in current FFY)* _____
- D. Any non-RESS/TA funded training? *(Indicate month and year)* _____

27. Marketable Skills:

28. Results of Basic English Skills Tests (BEST)

DATES	STUDENT PERFORMANCE LEVEL (SPL)

29. Barriers to Employment or Training:

PART B. ASSESSMENT (Continued)

SELF-SUFFICIENCY/EMPLOYABILITY (For All of the AU)

SERVICE*	AGENCY NAME AND ADDRESS	DATE REFERRED	ANTICIPATED DATE OF COMPLETION

SIGNATURE OF INTERVIEWER	SIGNATURE OF SUPERVISOR	DATE
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PROGRESS RECORD

SERVICE*	AGENCY NAME	START DATE	COMPLETION DATE	DROP DATE (IF APPLICABLE) AND REASON**	AUTHORIZED SIGNATURE

* ESL, VESL, Vocational Training, Employment Services, OJT, Work Experience, Education Services
 ** Job Placement, Family Related Issue, Transportation, Failure to Comply, Lost Contact, Other.

PART C. STATE HEARING STATEMENT AND WAIVER OF CONFIDENTIALITY

TO BE READ AND SIGNED BY APPLICANT OR READ TO APPLICANT IN APPLICANT'S NATIVE LANGUAGE

All applicants/recipients of social services in California are entitled to a State Hearing when an action is taken to discontinue, reduce or deny services. Requests for a hearing should be made in writing to State Hearings Division, Department of Social Services, 744 P Street, M.S. 19-37, Sacramento, California 95814; or by telephone to the Public Inquiry and Response Office toll-free (800) 952-5253 (for the deaf only (800) 952-8349).

The information requested in this form is in accordance with the Refugee Act of 1980 (P.L. 96-212); MPP DIV. 69; Welfare and Institutions Code Sec. 10850; AB 3254 (Statutes of 1990); and 45CFR205. We need this information to find out what services you need most, and how best to provide them to you. This information will be kept confidential and will be released only to federal, state, local and other agencies as necessary for the administration of the social services and related assistance programs. You have the right to review any files maintained on you by this agency or by the California Department of Social Services, Refugee Programs Branch.

I hereby request services from your agency and approve the release of any or all data above with the understanding that all information shall be kept strictly confidential and may be transmitted only with utmost caution to: legitimate personnel of appropriate agencies for the express purpose of providing services to me; to the California Department of Social Services for statistical and program management purposes; and to approved agencies for purposes connected with the administration of public assistance programs.

APPLICANT'S SIGNATURE ▶	DATE
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I declare under penalty of perjury that the information which I have provided to complete this application and assessment form is true and correct and that I have not omitted any relevant information.

APPLICANT'S SIGNATURE ▶	DATE
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TO BE COMPLETED AND SIGNED BY THE INTERVIEWER AND/OR INTERPRETER. (Complete Section 1, or 2 below)

SECTION I.

I _____ read the above four paragraphs to _____
(INTERPRETER/INTERVIEWER NAME) (APPLICANT NAME)

on _____ in the _____ language. All information
(DATE) (LANGUAGE)

contained in the above paragraphs was discussed with the applicant and all of the applicant's questions regarding the information were answered to his/her satisfaction.

INTERPRETER/INTERVIEWER SIGNATURE ▶	DATE
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SECTION II.

_____ read the above four paragraphs in English on _____
(APPLICANT NAME) (DATE)

All of the information contained in the paragraphs was discussed with the applicant and all of the applicant's questions regarding the information were answered to his/her satisfaction.

INTERPRETER/INTERVIEWER SIGNATURE ▶	DATE
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REFUGEE RESETTLEMENT PROGRAM SERVICES APPLICATION AND ASSESSMENT – INSTRUCTIONS

A. Welfare Case Number - Mandatory Referred Cash Assistance Clients Only

Enter the full case number from the RS 3, item 3.

B. Service Provider/Referral Agency

Enter the name and address of the Service Provider.

C. Date of Application

Enter the current date.

D. Mandatory Cash Assistance Clients

Check the YES box if the client was mandated to apply for services by the CWD/EDD. If not, check the NO box.

PART A. I. Basic Characteristics

1. Client's Name

Enter the client's last name, first name and middle initial.

2. Sex

Check either male or female.

3. Street Address (Residence)

Enter the client's residence address by number, street, city and zip code. (Enter either the 5 or 9 digit zip code which is applicable for the area.)

4. Age

Enter the client's age.

5. Birthdate

Enter the client's birthdate (month, day, year).

6. Phone Number (Residence)

Enter the client's residence telephone number and area code.

7. Message Phone

Enter the client's message phone number.

8. Alien Number

Enter the client's Alien Number as shown on the Form I-94 or other appropriate documentation.

9. Social Security Number

Enter the client's Social Security Number. If the client does not yet have a Social Security Number, write "none". Disclosure of the Social Security Number is voluntary. Eligibility for services **cannot** be affected if the number is not disclosed.

10. Prior Education

Check the appropriate box indicating the highest level of education the client has completed.

11. State of Initial Resettlement

Check the appropriate box indicating if the client was initially resettled in California or in another state.

12. Date of Entry as a Refugee, Date Asylum Granted, or Date of Certification as a Trafficking Victim

Enter the month, date, and year the client entered the United States, as a refugee, or was granted asylum as shown on the Form I-94 or other appropriate documentation or the date of certification as a trafficking victim as shown on the certification letter.

13. Time in the U.S.

Check the appropriate box to indicate the amount of time the client has been in the United States.

14. Immigration Status

Check the appropriate box indicating the client's immigration status as shown on the Form I-94 or other appropriate documentation.

15. Country of Origin

Check the appropriate box for either the country or the geographic area from which the client had to initially flee. The list below is provided to help assign a specific country shown on the I-94 form to a geographic area.

Other Middle East.

Includes any other middle eastern country other than Iran, Iraq, and Afghanistan.

Laos.

Includes Hmong/Highland Lao.

Other Southeast Asia.

Includes any Asian country other than Vietnam, Cambodia and Laos.

Caribbean/Latin America.

Includes Cuba, Haiti, and any other country in the Caribbean Basin and in Central and South America.

Other Africa.

Includes Somalia and any other country on the African Continent.

Other Eastern European.

Includes Albania, Czechoslovakia and Bulgaria.

16. Employment Status

Check the employment status at the time of application by the client. Full-time is defined as working 32 hours or more per week, except where fewer hours are normal for the occupation. **Enter the name of the employer with whom the client is employed, the job title the client holds, the employer's address, the number of hours per week the client works and the wage the client receives, a contact person at the client's employer, and the employer's phone number. This information describes employment only, not services participation.**

II. Eligibility Summary

17. Cash Assistance Status

- a. Check YES if client is receiving cash assistance
if item a is YES, then go to item b
if item a is NO, then go to item c
- b. Check the box for the appropriate aid type – to determine the correct aid type, refer to the first two digits of the Welfare Case Number on the RS 3.
RCA is aid code 01
CalWORKs is aid code 35
GR/GA is different in each county
- c. Monthly Family Income/Non Cash Assistance Clients Only
Check the appropriate box indicating the approximate total income available for the client's family. A family includes: spouse, children, stepchildren and guardianships under 18, who share a common residence. The 18 year old child is to be included in the family if he/she is attending high school or a vocational/technical training program full-time and will graduate before his/her 19th birthday.

18. Family Size

Enter the number of people in the client's family in the box provided.

19. Current Student Status

Check the student status of the client at the time of application.

20. Type of School

Check the type of school the client attends.

21. Enrollment Date

Enter the date the client is to be enrolled in services.

22. Estimated Completion Date

Enter the estimated date that the client will complete services.

23. Entering Component

Enter the name of the service component that the client will be entering.

24. Re-Entry

Check whether the client is new or re-entering services.

PART B. ASSESSMENT

As the Service Provider/Referral Agency Worker interviews the client, he/she will complete questions 25-29. Based on the responses to the questions, the Worker will assess the client's level of employability. Levels of employability are defined as follows:

1. Level I The eligible refugee/asylee/trafficking victim needs employment services only.
2. Level II The eligible refugee/asylee/trafficking victim needs more than employment services but does not need the full range of services (e.g., employment services and ESL only).
3. Level III The eligible refugee/asylee/trafficking victim needs the full range of services (employment, ESL, VESL, Vocational Training, OJT, Work Experience and Educational Services).

Self-Sufficiency/Employability (For all of the AU)

The Service Provider/Referral Agency (henceforth referred to as "Referral Agency") Worker will complete this Plan based on the results of Part B. Include services to any member of the AU that increase the likelihood that the AU will earn enough to become self-sufficient. The specific services, service providers, referral dates and anticipated dates for completion must be included. The worker will sign and date the application and obtain supervisorial approval. It is the supervisor's responsibility to ensure the client is eligible for services, the assessment has been completed, and the employment plan is accurate and appropriate for the client.

Progress Record

The service provider to which the client has been referred is responsible for completing the Progress Record. This includes the specific service and level provided, the Referral Agency who is providing the service, the actual start and completion dates, the drop date and reason, and an authorized signature. The Referral Agency is responsible for updating the Referral Agency client case files from the progress report completed by the service providers. This should be done every time a client returns to the Referral Agency.

PART C. STATE HEARING STATEMENT AND WAIVER OF CONFIDENTIALITY

Immediately upon completion of Parts A and B, the State Hearing and Waiver of Confidentiality Statements must be signed and dated by the client and the Referral Agency Worker. If the client cannot read the statements and/or cannot understand them, it is the responsibility of the Referral Agency Worker to explain them and to ensure that the client understands them before he/she signs.