NOTICE OF FORM CHANGE NO. 04-066

DATE
03/01/2004

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: FC 18 Notification of AFDC-Foster Care Transfer

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
EACH	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 1/00	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 1/00

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

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Check on the internet for form availability at www.cahwnet.gov

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

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.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

DATE:

NOTIFICATION OF AFDC-FOSTER CARE TRANSFER

SECTION A - SENDING COUNTY COMPLETES *(PLEASE TYPE OR PRINT)*

CASE NAME	CASE NUMBER	CHILD'S PARENTS' NAME(S)
CHILD'S NAME	CHILD'S SOCIAL SECURITY NUMBER	DA CHILD SUPPORT NUMBER(S)

SENDING COUNTY ADDRESS	PAYEE NAME (IF FAMILY PLACEMENT - RELATIONSHIP)
RECEIVING COUNTY ADDRESS	ADDRESS OF FOSTER HOME OR INSTITUTION
	TELEPHONE NUMBER: ( )
DISCONTINUANCE DATE/END OF TRANSFER PERIOD	DATE JURISDICTION TRANSFERRED

CURRENT PAYMENT AMOUNT:	BASIC RATE: $	SPECIALIZED CARE RATE: $	INFANT SUPPLEMENT: $	CURRENT CLOTHING ALLOWANCE: $	☐ INITIAL ☐ ANNUAL:

AID PROGRAMS: ☐ FEDERAL FOSTER CARE ☐ STATE FOSTER CARE ☐ EMERGENCY ASSISTANCE ☐ MEDI-CAL ONLY ☐ COUNTY ONLY "NOT-TO-EXCEED DATE:"____________

DOCUMENTATION:

<u>ENCLOSED</u>	<u>N/A</u>	
☐	☐	EA AUTHORIZATION DOCUMENTS [EA 1/ ACE SCREEN PRINT, OR OTHER DOCUMENTS]
☐		SAWS 1
☐		FC 2/JA 2
☐		SOC 158A OR EQUIVALENT:________________________
☐		BIRTH CERTIFICATE/ALIEN STATUS DOCUMENTATION
☐		SOCIAL SECURITY NUMBER DOCUMENTATION
☐		FC 3/FC 3A - VERIFICATION OF DEPRIVATION
☐	☐	EVIDENCE SUPPORTING FEDERAL ELIGIBILITY [LINKAGE & DEPRIVATION]
☐		COURT ORDER/AUTHORITY FOR PLACEMENT DOCUMENTATION ☐ DETENTION ORDER ☐ DOCUMENTATION OF THREE JUDICIAL FINDINGS ☐ TRANSFER OF JURISDICTION ☐ GUARDIANSHIP/RELINQUISHMENT PAPERS
☐	☐	PROPERTY OF MINOR/TRUST INFORMATION
☐	☐	INCOME OF MINOR:_______________ TYPE:____________________ AMOUNT $______________
☐	☐	INDEPENDENT LIVING PLAN
☐	☐	18 YEARS OLD AND OVER DOCUMENTS [MUTUAL AGREEMENT, SCHOOL VERIFICATION]
☐	☐	DHS6155 HEALTH INSURANCE QUESTIONNAIRE
☐	☐	APPLICATIONS PENDING (SSI/SSP)
☐	☐	FC 4
☐	☐	OTHER:____

SOCIAL WORKER'S NAME	SOCIAL WORKER NUMBER	SOCIAL WORKER'S TELEPHONE NUMBER ( )

COMMENTS:

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ( )

SECTION B: RECEIVING COUNTY COMPLETES: *(PLEASE TYPE OR PRINT)*

☐ TRANSFER ACCEPTED ☐ TRANSFER <u>NOT</u> ACCEPTED - REASON:

☐ CASE ELIGIBLE - WILL BEGIN ON: ☐ CASE INELIGIBLE - REASON:

ELIGIBILITY WORKER'S NAME	ELIGIBILITY WORKER NUMBER	ELIGIBILITY WORKER'S TELEPHONE NUMBER ( )

DISTRICT OFFICE