NOTICE OF FORM CHANGE NO. 04-125

DATE: 04-15-2004

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: CW 215A (3/04)
CalWORKs Intercounty Transfer Continuation Request For Additional Documents

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 3/04	REPLACES: 7/03	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted ☐ 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 3/04

USE FORM IN ACCORDANCE WITH
☒ All County Letter No. 04-14
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE
Attached is a Reproducible Copy

Print form: 8 1/2 x 11, one sided.

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.

CalWORKs INTERCOUNTY TRANSFER CONTINUATION REQUEST FOR ADDITIONAL DOCUMENTS

Instructions: The CalWORKs Intercounty Transfer will not be picked up in the receiving county. A Medi-Cal referral must be completed for this case. Please provide copies of the documents indicated below to the worker in the receiving county within ten calendar days.

RECEIVING COUNTY INFORMATION

RECEIVING COUNTY	DATE REQUESTED	
WORKER NAME	WORKER NUMBER	
COUNTY ADDRESS (NUMBER, STREET)	CITY	ZIP CODE
COUNTY PHONE NUMBER ( )	FAX NUMBER ( )	E-MAIL ADDRESS

CASE NAME/BENEFICIARY INFORMATION

CASE NAME	SENDING COUNTY CASE NUMBER	
CLIENT ADDRESS (NUMBER, STREET)	CITY	ZIP CODE
CLIENT PHONE NUMBER ( )	DATE MOVED	

DOCUMENTS REQUESTED FOR MEDI-CAL REFERRAL PACKET

- ☐ Statement of Facts and Applicable Supplements
- ☐ Social Security Card(s)
- ☐ Identifications (CDL, etc.)
- ☐ Income Verifications
- ☐ Primary Wage Earner: _____
- ☐ Pregnancy Verification for: _____
- ☐ Completed MC 360
- ☐ Other (list): _____
- ☐ Other Health Coverage Information (DHS 6155)
- ☐ Proof of Alien Status for: _____
- ☐ Family Support Information (CW 2.1s)
- ☐ Property Verifications
- ☐ Incapacity Verification for _____

SENDING COUNTY	WORKER NAME	
PHONE NUMBER ( )	FAX NUMBER ( )	DATE SENT