WELFARE-TO-WORK REFERRAL

Date:	From:
To:	ECM Number:
Agency:	Agency:
Address:	Address:
Phone:	Phone:
Email:	Email:

REFERRAL TYPE

Expanded Subsidized Employment (ESE): New or Re-Referral Transition from Expanded Work Experience Worksite:	**Family Stabilization (FS):** FS Assessment Homeless Prevention Services Referral Services Transportation Emergency Assistance
Vocational English as Second Language (VESL)	
Vocational Training	**Behavioral Health Services (BHS):** Mental Health Substance Abuse
Work Study	
Community Services	
Other:	**Domestic Violence Services**

PARTICIPANT INFORMATION

Case Number:	Case Name:
Participant Last Name:	Participant First Name:
Address	Phone:
	Email:
ESE REFERRALS ONLY	Language Needs:
Client Index Number (CIN):	None
CalWORKs eligible (current and future month)	Interpreter Services Needed
Time on Aid eligible (6 months+ available)	Language:

WTW Participation Hours Requirement:	20 hours/week	30 hours/week	35 hours/week

Current WTW Activities:		Schedule:	
1		1	
2		2	
3		3	

Comments:

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release and exchange of information between the Welfare-to-Work program (Health and Human Services Agency, state, or federal agencies, or their representatives) and the Service Provider regarding my attendance, progress, participation, and assessment for monitoring, hearings, and/or auditing purposes.

Participant Signature:	Date:

SERVICE PROVIDER USE ONLY

Referral Received Date:		Referral Type:
Accepted: Yes	No. Reason:	
Start Date:	End Date:	Schedule:
Location:		
Comments:		
Contact Name:		Phone:
Agency:		Email: