COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs TREATMENT/SERVICES VERIFICATION

[To: **PA 1923 (SSS RR) Centralized Unit**
West Valley GAIN Region II
21415 Plummer Street, Suite B
Chatsworth, CA 91311
FAX Number: (818) 775-6969
] [From:]

[ ] [ ]

A. PROVIDER CERTIFICATION

As an authorized employee of the treatment service provider agency named above, I certify that the individual named below is receiving CalWORKs Specialized Supportive Services (**DOMESTIC VIOLENCE, SUBSTANCE ABUSE, OR MENTAL HEALTH**) to help him/her overcome a barrier to employment. I understand that payment to contracted service provider is contingent on the CalWORKs participant maintaining eligibility to CalWORKs and complying with all requirements, assuming that the provider has been notified of the non-compliance by DPSS. In instances of substance abuse/mental health problems, includes the appropriate treatment services and signing a Welfare-to-Work (WtW) plan. For victims of domestic violence, certain requirements can be waived, including a WtW plan. In addition, the service provider must have received the GN 6008, Mental Health/Substance Abuse/Domestic Violence/Family Preservation Program Services Provider Progress Report, 90-days from service start date/assignment date, to confirm participant's continued eligibility to CalWORKs. This form must be submitted within 10 workdays of client's signature (not to exceed 30 days).

Print Name/Title of Authorized Person:	Date Signed:	Telephone No:	Fax No:

B. PARTICIPANT IDENTIFICATION

Name (First/Last):			CalWORKs Case No.:
Social Security No. : - -	Date of Birth:	Primary Language:	Telephone No.: (Confidential for DV) ( )

C. TYPE OF TREATMENT SERVICES (Complete as applicable) ☐ Residential ☐ Non-Residential

I. ☐ **MENTAL HEALTH** ☐ **SUBSTANCE ABUSE**

Participant began treatment services on _____/_____/_____ for _____ hours per week.*

Expected duration of needed treatment services: _____ months.

☐ Participant is able to participate in another WtW activity in addition to treatment services for _____ hours per week.

☐ Participant is Exempt from GAIN and will participate in GAIN as an Exempt Volunteer.

Note: *MH/SA participants may participate less than 32/35 hours-per-week with Good Cause for a 90-day period.

II. **DOMESTIC VIOLENCE CASE MANAGEMENT** ☐ **DV FAMILY LAW** ☐ **DV IMMIGRATION LAW** ☐ VAWA ☐ Uvisa

Participant began treatment services on _____/_____/_____ for _____ hours per week.

Expected duration of needed treatment services: _____ months.

☐ Participant is able to participate in another WtW activity in addition to treatment services for _____ hours per week.

☐ Participant is Exempt from GAIN and will participate in GAIN as an Exempt Volunteer.

Note: Participant shall be granted a DV waiver from the mandatory WtW Program rules with a clock stopper/extender.

D. OTHER SUPPORTIVE SERVICE NEEDS (Complete as applicable)

Participant needs the following supportive services: ☐ Child care ☐ Public Transportation ☐ Mileage: _____ per month

Work Related/Ancillary Expenses such as: ☐ Books ☐ Fees ☐ Uniforms or ☐ Other: _____

E. OTHER Court-ordered treatment services : ☐ DV Counseling ☐ Substance Abuse ☐ Mental Health

F. PARTICIPANT AUTHORIZATION (Complete as applicable)

I authorize the Department of Public Social Services and the above services provider to verify information regarding the status of my CalWORKs /GAIN case status and/or continuing eligibility to receive CalWORKs Specialized Supportive Services.

☐ I am aware that my Mental Health or Substance Abuse treatment/services will be incorporated in my Welfare-to-Work plan.

☐ I am aware that my Domestic Violence services may be incorporated now or eventually in my Welfare-to-Work plan.

The determination will be made by my GAIN Services Worker/Contracted/REP Case Manager in consultation with the service provider.

Participant's Signature:	Date:

G. COUNTY ACTION: ☐ **ACCEPTED** ☐ **REJECTED** **DATE:**