

FOOD AND NUTRITION SERVICES REFERRAL FORM

Date of DSS Action _____ Date sent to ESC _____ Date received by ESC _____

_____ New Referral _____ 12 Month Renewal _____ Information Change

A. VOLUNTEER INFORMATION

_____ Non ABAWD _____ ABAWD needs _____ hours/week

_____ INTERPRETER needed for reading/writing/speaking (circle and specify language) _____

Name _____ SSN _____

Address _____ (M) _____ (F)

_____ DOB _____

_____ Telephone # _____

FNS Case # _____ County # _____ Date Certified _____

12 month E&T Period _____ Caseworker _____
(From) (To)

B. TERMINATION OF VOLUNTEER STATUS

_____ Request of volunteer _____ No longer participating with ESC

_____ No longer FNS recipient _____ Other* (give reason below)

Reason:

*If termination due to employment, provide name of company and date started working.

Send original to ESC according to FNS policy. Place copy in case file.