

FOOD AND NUTRITION SERVICES WORKFARE REFERRAL FORM

Date of DSS Action _____ Date sent to Workfare unit _____ Date received by Workfare unit _____

____ New Referral ____ 12 Month Renewal ____ Information Change

A. VOLUNTEER INFORMATION

____ ABAWD needs _____ hours/week

____ Volunteer requests _____ hours/week OR _____ hours/month

____ 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/Workfare Period _____ Caseworker _____
(From) (To)

B. TERMINATION OF VOLUNTEER STATUS

____ Request of volunteer ____ No longer participating with Workfare

____ 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 Workfare unit according to FNS policy. Place copy in case file.