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.

DSS-8616 (Revised 07/09)
Economic and Family Services