

## CalWORKs INTERCOUNTY TRANSFER CONTINUATION REQUEST FOR ADDITIONAL DOCUMENTS

Instructions: The CalWORKs Intercounty Transfer will not be picked up in the receiving county. A Medi-Cal referral must be completed for this case. Please provide copies of the documents indicated below to the worker in the receiving county within ten calendar days.

| RECEIVING COUNTY INFORMATION    |                      |                |          |
|---------------------------------|----------------------|----------------|----------|
| RECEIVING COUNTY                |                      | DATE REQUESTED |          |
| WORKER NAME                     |                      | WORKER NUMBER  |          |
| COUNTY ADDRESS (NUMBER, STREET) |                      | CITY           | ZIP CODE |
| COUNTY PHONE NUMBER<br>(    )   | FAX NUMBER<br>(    ) | E-MAIL ADDRESS |          |

| CASE NAME/BENEFICIARY INFORMATION |                            |          |
|-----------------------------------|----------------------------|----------|
| CASE NAME                         | SENDING COUNTY CASE NUMBER |          |
| CLIENT ADDRESS (NUMBER, STREET)   | CITY                       | ZIP CODE |
| CLIENT PHONE NUMBER<br>(    )     | DATE MOVED                 |          |

### DOCUMENTS REQUESTED FOR MEDI-CAL REFERRAL PACKET

- |   |  |
|---|--|
| <input type="checkbox"/> Statement of Facts and Applicable Supplements<br><input type="checkbox"/> Social Security Card(s)<br><input type="checkbox"/> Identifications (CDL, etc.)<br><input type="checkbox"/> Income Verifications<br><input type="checkbox"/> Primary Wage Earner: _____<br><input type="checkbox"/> Pregnancy Verification for: _____<br><input type="checkbox"/> Completed MC 350<br><input type="checkbox"/> Other (list): _____ | <input type="checkbox"/> Other Health Coverage Information (DHS 6155)<br><input type="checkbox"/> Proof of Alien Status for:<br>_____<br><input type="checkbox"/> Family Support Information (CW 2.1s)<br><input type="checkbox"/> Property Verifications<br><input type="checkbox"/> Incapacity Verification for<br>_____ |
|---|--|

|                        |                      |           |
|------------------------|----------------------|-----------|
| SENDING COUNTY         | WORKER NAME          |           |
| PHONE NUMBER<br>(    ) | FAX NUMBER<br>(    ) | DATE SENT |