

**PROGRAMA DE AYUDA GENERAL
VERIFICACIÓN DE SERVICIOS DE VIOLENCIA DOMÉSTICA**

Para: _____ De: _____
 OFICINA DE GROW: _____
 DIRECCIÓN: _____

GCM/NOMBRE DEL EW: _____

A. PROVIDER CERTIFICATION

As an authorized employee of the agency named above, I certify that the individual named below is receiving **Domestic Violence** services to assist him/her overcome barriers to employment. I understand that payment to contracted service providers is contingent on the participant's eligibility for General Relief assistance, and compliance with all GROW Welfare-to-Work requirements during the period service was provided.

 Signature of Authorized Person/Title Date Signed Phone Number Fax Number

B. PARTICIPANT IDENTIFICATION

1. First Name: _____ 2. Year of Birth: _____
 3. DPSS Case #: _____ 4. Start Date of Services: _____

C. DOMESTIC VIOLENCE (TO BE COMPLETED BY SERVICE PROVIDER)

GR EMPLOYABLE PARTICIPANTS (GR-E)	GR UNEMPLOYABLE PARTICIPANTS (GR-U)
5. Is participant receiving Domestic Violence and participating 20 hours or more per week? Yes <input type="checkbox"/> No <input type="checkbox"/> 6. If no, enter the number of hours of Domestic Violence participation per week: _____	5. Is participant receiving Domestic Violence Services? Yes <input type="checkbox"/> No <input type="checkbox"/>

D. DPSS USE ONLY (CHECK ONLY APPLICABLE BOXES)

GROW Eligibility Determination:	General Relief (GR) Eligibility Determination:
7. Participant currently enrolled in GROW: Yes <input type="checkbox"/> No <input type="checkbox"/> 8. If the participant is no longer enrolled in GROW, provide disenrollment effective date: _____ 9. Contact the Supportive Services Liaison listed below for more information about this participant's current and continuing GROW eligibility:	6. Participant is currently receiving GR benefits: Yes <input type="checkbox"/> No <input type="checkbox"/> 7. Participant may be eligible to receive GR benefits: Yes <input type="checkbox"/> No <input type="checkbox"/> 8. Participant is not eligible to receive GR benefits: Yes <input type="checkbox"/> No <input type="checkbox"/>
SUPPORTIVE SERVICES LIAISON (NAME AND PHONE NUMBER)	DESIGNATED DV LIAISON (NAME AND PHONE NUMBER)

 DPSS AUTHORIZED REPRESENTATIVE DATE PHONE NUMBER

E. AUTORIZACIÓN DEL PARTICIPANTE

Yo autorizo al Departamento de Servicios Sociales Públicos para que proporcione información del tratamiento mencionado arriba o al proveedor de servicios en relación al estado de mi caso de GROW, en lo que se refiere a mi participación en los servicios de Violencia Doméstica.

 Firma del Participante Fecha