COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

GENERAL RELIEF
DOMESTIC VIOLENCE SERVICES VERIFICATION

To:
GROW SITE:
ADDRESS:

GCM/EW NAME:

From:

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 ☐ No ☐ **6. If no, enter the number of hours of Domestic Violence participation per week:________**	**5. Is participant receiving Domestic Violence Services?** Yes ☐ No ☐

D. DPSS USE ONLY (CHECK ONLY APPLICABLE BOXES)

GROW Eligibility Determination:	**General Relief (GR) Eligibility Determination:**
7. Participant currently enrolled in GROW: Yes ☐ No ☐ **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 ☐ No ☐ **7. Participant may be eligible to receive GR benefits:** Yes ☐ No ☐ **8. Participant is not eligible to receive GR benefits:** Yes ☐ No ☐
SUPPORTIVE SERVICES LIAISON (NAME AND PHONE NUMBER)	**DESIGNATED DV LIAISON (NAME AND PHONE NUMBER)**

____________________ ______________ ______________
DPSS AUTHORIZED REPRESENTATIVE **DATE** **PHONE NUMBER**

E. PARTICIPANT AUTHORIZATION

I authorize the Department of Public Social Services to release information to the above treatment or services provider regarding the status of my GROW case, as it applies to my participation in Domestic Violence services.

____________________ ______________
Participant's Signature Date