WELFARE-TO-WORK REFERRAL FOR EDUCATION/TRAINING

Education Provider Name: **Coastline Community College** **11460 Warner Avenue** **Fountain Valley, CA 92708**		**Name of Participant:**
		CalWIN Case #:
		Phone:
		Assessment: ☐ Pre-ASMT ☐ Post-ASMT — **Welfare-to-Work Participation:** ☐ Mandatory ☐ Voluntary
Contact:	Phone:	**# of months remaining on CW 48-month time clock:**

1. RELEASE OF INFORMATION AUTHORIZATION: **(Must be signed by participant)**

I authorize the above school/agency and Orange County Social Services Agency to exchange information about my records for my Welfare-To-Work participation.

Participants Signature:	Date:

2. TO BE COMPLETED BY WTW CASEWORKER: **(Check type of referral)**

☐ SIP ☐ Learning Disability ☐ ESL ☐ ABE ☐ GED ☐ H/S Diploma ☐ Vocational Training — Other:

If Learning Disability, training goal is:	If ESL or ABE training, goal (Exit criteria) is:

If Vocational training, goal is:

Has H/S: ☒ Yes ☐ No — Has GED: ☐ Yes ☐ No — # School Years Completed:

Degree/Major: (example BA/Engineering)	Certificate/Major: (example: Cert/Cosmetology)

		Reason

Unable to attend: ☐ Morning ☐ Afternoon ☐ Evening — Reason:

Additional Information:

3. TO BE COMPLETED BY SCHOOL/AGENCY *(Please return this form to the WTW office)*

☐ Check here if participant failed to report/enroll.	Date of Enrollment	
Type of Education/Training:	Training Goal:	
Start Date:	Anticipated Date of Completion:	
Certificate	Degree:	Work Study

School/Agency Location: **Coastline Community College**

Current Schedule: ☐ Attached ☒ See Below (Please indicate hours and time of day a.m./p.m.)

Subject/Activity	Mon	Tues	Wed	Thurs	Fri	Sat	Units/Hours
Work Study	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Hours**

Additional Information:

Agency Representative Signature:	Phone:	Date:
Welfare-To-Work Office Address:	From:	Caseload #:
	Phone: Fax:	Date: