ASSEMBLY BILL (AB) 74 COUNTY WELFARE DEPARTMENT FAMILY STABILIZATION (FS) PLAN

COUNTY WELFARE DEPARTMENT (CWD):			DATE:
	CMD CONTVC.	T INFORMATION	
NAME/POSITION:	CWD CONTAC	I INI ORMATION	
ADDRESS:			
PHONE NUMBER:	EMAIL ADDRESS:		
nine categories. There is an additional will accept up to 1,000 characters	onal text box to enter other of text. If more space is no lso attach any materials t	r information about eeded you may als hat address each	gram and include responses to the following your FS program if needed. The text boxes so submit attachments to accommodate the of the areas below if the materials can be pies).
Please indicate the date your CWI	O will begin offering an FS	program:	
What types of services will be prov		m?	
Homelessness	, -		
☐ Mental Health			
☐ Substance Abuse			
☐ Domestic Violence			
Other, please list			
How will clients be informed of the	FS program?		
How will clients be able to request	participation in the FS pro	ogram?	
How will the county determine whi	ch clients will be selected	for the FS program	1?

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How will the county notify the clients that are participating in the FS program?
How often will county staff contact FS families?
How will FS Intensive Case Management differ from general Case Management?
What types of partnerships will you develop for your FS Program? (i.e. Community based organizations, non-profits, etc.)
What strategies will you use to link clients with these providers?
What strategies does your CWD have to transition clients to WTW?
How does the FS program compliment or enhance your current services?

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Please include any other components of your FS program not covered above:	
Please fill out this form electronically and submit to FSProgram@dss.ca.gov	

Note: CWDs must submit their plans no later than 30 days after implementation of their FS Programs. CDSS may request subsequent submittals of AB 74 FS Plans from CWDs depending on the needs of the program.

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