CALFRESH NOTIFICATION OF INTER-COUNTY TRANSFER

Instructions: Workers are to complete each relevant space.

SENDING COUNTY NAME AND ADDRESS:

RECEIVING COUNTY:

CASE NAME:

CASE NUMBER:

SSN:

RECIPIENT HOME ADDRESS:
NUMBER/STREET

CITY ZIP CODE

RECIPIENT MAILING ADDRESS: (IF DIFFERENT)
NUMBER/STREET

CITY ZIP CODE

NAME OF AUTHORIZED REPRESENTATIVE:

SENDING COUNTY DISCONTINUANCE DATE:	RECERT DUE (MO/YR):	SAR 7 SUBMIT MONTH:	NUMBER OF HOUSEHOLD MEMBERS:
			FEDERAL_____ CFAP_____

DOCUMENTATION SENT:

- ☐ SAWS 1
- ☐ SAWS 2
- ☐ SAR 7
- ☐ CF 377.5
- ☐ OI Documentation
- ☐ SAWS 2 PLUS
- ☐ CF 285
- ☐ Disability Verification
- ☐ Income Verification
- ☐ Citizen/Noncitizen Verification
- ☐ SAWS 2A SAR
- ☐ Other_____
- _____

CASE INFORMATION:
Current Benefit Amount: _____

Budgeted Gross Income:_____
Budgeted Expenses:

- ☐ Rent/Housing Cost _____
- ☐ SUAS Benefit Paid Date:_____
- ☐ LIHEAP Benefit Paid Date:_____
- ☐ WINS Benefit Paid Date:_____
- ☐ SUA ☐ TUA ☐ LUA
- ☐ Medical Expenses _____
- ☐ Dependent Care_____
- ☐ Child Support Paid_____

OVERISSUANCE CLAIMS TRANSFERRED:

Error Type	Balance	OI Period (from/to dates)	Lomeli Date
☐ IPV ☐ IHE ☐ Agency	$		
☐ IPV ☐ IHE ☐ Agency	$		
☐ IPV ☐ IHE ☐ Agency	$		
☐ IPV ☐ IHE ☐ Agency	$		

HOUSEHOLD TYPE:

- ☐ Semi-Annual Reporting
- ☐ Change Reporting
- ☐ Homeless
- ☐ Elderly/Disabled
- ☐ Seasonal Farm worker
- ☐ Ineligible HH member(s): _____
  Reason(s):_____
- ☐ ABAWD member(s):_____
  36 Months Began_____ MO/YR # Months used _____
  Consecutive Months Began _____ MO/YR

SENDING WORKER INFORMATION:

NAME:
WORKER NUMBER:
TELEPHONE NUMBER:
FAX:
DATE COMPLETED:

COMMENTS: