COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION - DISCONTINUE RESTRICTED ACCOUNT

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use to discontinue Kin-GAP cash aid and apply penalty period when there has been misuse of a restricted account. Fill in the effective date of the discontinuance. Fill in the Kin-GAP child's name. Fill in the date of the end of the period of ineligibility. Check the applicable box(es). Print the computation on the right hand side of the NA 290 and fill in the computation section.

As of _____, the County is stopping your Kin-GAP aid for _____ until _____.

Here's why:

☐ The child got money from the child's restricted account. Then, within 30 days of the time the child got the money, the child didn't:

- ☐ Spend the money on an allowable expense.
- ☐ Put back into the account the part of the money that wasn't needed for the child's allowable expense.
- ☐ Give the County proof of the amount the child took out of the account.
- ☐ Give the County proof of the balance in the account before the child took out the money.
- ☐ Give the County proof of what the child did with the money.

If any boxes above are checked, it is because you were late and missed a deadline. To stop this county action (and restart the child's Kin-GAP cash aid before the end of the time period), you must prove to the County that you had a good reason for being late. Let your worker know right away.

☐ The child got money from his/her restricted account and spent some or all of it on expenses that are not allowed.

☐ Interest was paid out on the child's restricted account.

1. Restricted Account(s) Total..... $ _____
2. Spending Allowed..... - _____
3. Subtotal ..... = _____
4. Basic Need, ____ Persons ..... $ _____
5. Special Needs ..... + _____
6. Basic Need Subtotal..... = _____
7. Period of Months..... = _____

The child may still continue to get Medi-Cal if the child's Kin-GAP aid stops.

Please complete and send in the enclosed Transitional Medi-Cal (TMC) form.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE