

NOTICE OF ACTION

COUNTY OF _____

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

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 how. Your benefits may not be changed if you ask for a hearing before this action takes place.

Fair Market Value \$ _____
Amount Received - _____
(A) Transfer of Property Amount = _____

Family Needs
Basic Need for _____ Persons \$ _____
Special Needs + _____
(B) Family Needs = _____

Optional Person(s) Needs
Basic Need for _____ Persons \$ _____
Special Needs + _____
(C) Optional Person(s) Needs = _____

Differential
Family Needs _____
Optional Person(s) Needs - _____
(D) Differential = _____

Ineligibility for Optional Persons
Your transfer of property amount **(A)**
minus the differential **(D)**
divided by the optional person(s) needs **(C)**
equals the number of ineligible months: . . . _____
(# OF MONTHS)

Rules: These rules apply; you may review them at your Welfare Office: MPP