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 you how.

Effective _____, your ☐ Welfare to Work ☐ Cal-Learn payment for ☐ transportation ☐ work or training related expenses for _____ will be $ _____. This amount is less than you asked for.

Here's why:

You have to pay us back any money we advance to you that you do not use to pay for ☐ Welfare to Work ☐ Cal-Learn expenses.

☐ The proof of costs show that you did not use all of your advance for _____.

☐ You failed to give us proof of costs by the 10th of this month. You must give us _____

_____.

If you give us this information, you may still get your payment up to your approved maximum payment, but it may be late.

☐ Other:

Your ☐ transportation payment ☐ work or training related expenses payment is figured on this notice.

☐ You still have a balance of $_____ for your unused advance. An amount will be taken out of your payment every month until the balance of the unused advance no longer exists. You will get a notice every month telling you about this.

Rules: These rules apply. You may review them at your welfare office: CalWORKs Implementation Guidelines, Sections VII & XII, Welf. & Inst. Code 11323.2, 11323.4, 11322.9

☐ Your payment of $_____ for _____ will be adjusted effective _____ as follows:

$ _____ your actual advance payment for _____.

– $ _____ your actual costs for that month.

= $ _____ unused advance.

$ _____ amount requested.

– $ _____ unused advance.

= $ _____ adjusted payment.

☐ $ _____ unused advance.

– $ _____ payment adjustment (amount requested-adjusted payment).

= $ _____ balance of unused advance.

Call your Welfare to Work/Cal-Learn worker if this adjusted payment means you will not be able to stay in your

☐ Welfare to Work ☐ Cal-Learn activity, or if you will not be able to accept a job.

You can also call your Welfare to Work/Cal-Learn worker if you think this notice is wrong.

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