STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERV

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION -

Note: This notice relates ONLY to your Social Services.
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

YOUR IHSS OFFICE

CALIFORNIA DEPT. OF SOCIAL SERV
ATTN: APD -- CONLAN UNIT
744 P STREET, MS 19-96
SACRAMENTO CA 95814-6413

IF REQUESTING A STATE HEARING, PLEASE SEND T

STATE HEARINGS DIVISION
CALIFORNIA DEPT OF SOCIAL SERV
744 P STREET, MS 19-97
SACRAMENTO CA 95814-6413

CASE NUMBER

DATE MAILED
SEP 16 2009

The following action(s) is supported by Federal Law (Social Security Act). State Law (Welfare and Institutions Code), Federal Regulation (Code of Federal Regulations), State Regulations (California Administrative Code and California Department of Social Services Manual o Policies and Procedures) and Court Order:

Սա այն փաստաթղթի պատճենն է, որն ուղարկվել է ձեզ անգլերեն լեզվով 2009 թվականի սեպտեմբեր ամսին: Մեզ տեղեկացրել են, որ ձեր մայրենի լեզուն անգլերենը չէ: Այսպիսով, մենք ուղարկում ենք ձեզ այս փաստաթուղթը, որը ձեր մայրենի լեզվով թարգմանված պատճենն է:

2009 թվականի հոկտեմբերի 1-ից, Պետական օրենքի փոփոխության պատճառով (փոփոխություն Սոցիալական Ապահովման և Հաստատությունների Օրենսգրքի (WIC) 12305.1 Բաժնում) կդադարեցվեն պետության կողմից ֆինանսավորվող MRE կանխավճարները, որոնք պետությունը կատարում է ձեր Medi-Cal ծախսաբաժինը հոգալու համար: Դուք պարտավոր կլինեք ամբողջությամբ մուծել Medi-Cal ծախսաբաժինը, որը նշված է ձեր Medi-Cal Գործողության Ծանուցման մեջ: Երբ ձեր IHSS մատուցողը ներկայացնի իր հաշվեցուցակը, ձեր Medi-Cal մնացած ծախսաբաժինը կհանվի իրեն վճարման չեկից, և դուք ու ձեր մատուցողը կստանաք գրություն, որտեղ կնշվի ձեր կողմից մատուցողին վճարվելիք գումարի չափը: Քանի որ նշված դադարեցումը հանդիսանում է պետական օրենքի փոփոխության արդյունք, այն չի կարող բողոքարկվել Պետական Դատաքննության միջոցով:

If you need assistance with translation of this notice, or if you have any questions or think additional facts should be considered, please contact the California Department of Social Services at 1-877-508-1327.

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEND YOUR WRITTEN REQUEST TO THE DEPARTMENT'S ADDRESS ON THE TOP RIGHT CORNER OF THIS FORM.

PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the Department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesperson. If you want a conference, contact the California Department of Social Services.

2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the Director of the California Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. **YOUR REQUEST FOR A HEARING MUST BE MADE WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.**

3. You may request a State Hearing on your own, or you may call 1-877-508-1327 for assistance.

4. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesperson), of your choice. You may obtain free legal advice and the services of a lawyer. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response. You may also contact the nearest social services rights organization for assistance in presenting your claim.

5. State regulations governing State Hearings for social services are available at the office of the county social services department.

6. Information Practices - The information you are requested to provide is mandatory in order to process your request for a State Hearing pursuant to W&IC 10950. A case file will be established by State Hearing. You have the right to examine the materials that constitute the record for decision. Any information you provide may be shared with the county social services department or the United States Department of Health and Human Services.

If you wish to make a written request for a State Hearing, please send this page to:

State Hearings Division
California Department of Social Services
744 P Street, Mail Station 19-97
Sacramento, CA 95814-6413

To make an oral request for a State Hearing or to obtain further information about your State Hearing rights or files you may contact:

Public Inquiry and Response
California Department of Social Services
1-800-952-5253 (toll-free number)
TDD 1-800-952-8349 For Hearing and Speech Impaired Only (toll-free number)

REQUEST FOR A STATE HEARING

NAME (LAST, FIRST, MIDDLE INITIAL) | PHONE NUMBER | SOCIAL SECURITY NUMBER

ADDRESS | CITY | STATE | ZIP CODE

I HEREBY REQUEST A STATE HEARING BEFORE THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ON THE ACTION TAKEN BY THE DEPARTMENT REGARDING MY SOCIAL SERVICES. THE REASONS FOR MY REQUEST ARE AS FOLLOWS:

I HAVE TROUBLE UNDERSTANDING ENGLISH, THEREFORE I REQUEST AN INTERPRETER FOR MY HEARING IN THE FOLLOWING: | LANGUAGE | DIALECT

SIGNATURE | DATE SIGNED

AUTHORIZED REPRESENTATIVE

I HAVE AUTHORIZED THE FOLLOWING PERSON TO ACT ON MY BEHALF. I AUTHORIZE THE DEPARTMENT TO RELEASE ANY OR ALL INFORMATION ABOUT MY CASE TO THAT PERSON.

NAME OF AUTHORIZED REPRESENTATIVE

ADDRESS OF AUTHORIZED REPRESENTATIVE

SIGNATURE OF STATE HEARING APPLICANT