STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SER

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 Regulatio (Code of Federal Regulations), State Regulations (California Administrative Code and California Department of Social Services Manual Policies and Procedures) and Court Order:

這是我們在九月2009年寄給你的文件的英文版副本. 我們獲知你的主要語言不是英語, 135

從 2009 年 10 月 1 日起，由於州法律變更（福利與機構法規 (WIC) 第 12305.1 節修訂），州當局為滿足您的 Medi-Cal 費用分攤需要而一直利用州資金為您預付 MRE 的做法將會終止。您將負責支付自己的 Medi-Cal 行動通知上列明的全額 Medi-Cal 分攤費用。當您的 IHSS 提供者提交其工時表時，將從其薪金支票中扣除您欠付的所有剩餘 Medi-Cal 分攤費用，並且您和您的服務提供者會收到一封信，通知您必須向服務提供者支付的金額。
由於這一終止是州法律變更的結果，因此無法透過州聽證進行上訴。

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