COUNTY OF

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

NOTICE OF ACTION - CHANGE

For Kinship - Guardians Only

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.

☐ The County has approved your Kin-GAP aid.

As of _____, the county is Approving your Kin-GAP aid of
(Date)

$ _____ per month.

This aid is for: _____
(Name of Child)

As of _____, the county is Changing your Kin-GAP aid
(Date)

from $ _____, $ _____.

This aid is for: _____
(Name of Child)

Here's why: Your rate is based on a level of care determination as defined in AB 403 and WIC section 11461.

☐ Your case had a rate increase.

☐ Your case had a rate decrease.

☐ Your case has been issued an Infant Supplemental Payment.

☐ Your case has been issued a Supplemental Care Increment.

☐ The child has _____ income
(Countable)

☐ _____ for _____
(Income Type) (Name of Child)

of $ _____ is effective _____.
(Date)

This is counted as _____ income in the
(Earned/Unearned)

Kin-GAP budget calculation.

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☐ Other: _____

☐ Your case has been discontinued.

As of _____, the county is Discontinuing your
(Date)

Kin-GAP aid.

Here's why:

☐ You are no longer providing foster care for _____.
(Name of Child)

☐ He/she is no longer living in your home/facility. The County will stop paying for Kin-GAP from the day the child leaves your home/facility.

☐ He/she no longer meets the age rules.

☐ The child has too much income.

☐ The child has too much property. See attached page.

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If the County figured that the child's car or other vehicle was worth more than you think its worth, you can give the County proof that it is worth less. Ask the County how. If you can prove it is worth less the child may get Foster Care aid.

☐ The legal guardianship was terminated.

☐ You moved out of the State of California.

☐ You did not return your completed redetermination paperwork.

☐ Other: _____.

☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.

Rules: These rules apply. You may review WIC section: 11364.

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 have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, 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 CalFresh benefits 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, CalFresh 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 ☐ CalFresh ☐ 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 ☐ CalFresh ☐ 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