COUNTY OF

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

NOTICE OF ACTION - APPROVE APPROVED RELATIVE CAREGIVER (ARC) PAYMENT

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____
_____
_____

Questions? Ask your Worker.

(ADDRESSEE)

For Approved Relative Caregivers participating in the Approved Relative Caregiver Funding Option Program (ARC Program):

The County has approved your application, dated _____, MM/DD/YYYY

for cash aid for _____ under NAME OF CHILD

the ARC Program. The cash aid payment for your first month of aid

is $_____. Your first day of cash aid is _____. MM/DD/YYYY

The cash aid payment for your first month of aid may only be for a part of the month. It is for the time from your first day of cash aid, shown above, through the end of the month. If nothing changes, your ongoing monthly cash aid amount will be $_____.

This cash aid will be issued via:

☐ A check mailed to you; or

☐ Direct deposit

EBT: Keep your EBT card if you use EBT, even if your aid is terminated. Please do not throw your card away. If your ARC cash aid will be issued on a new EBT card, you will receive the new EBT card within 10 business days for this case. If your family currently receives CalWORKs or other benefits on an EBT card, and the child's county of court jurisdiction is the same as the child's county of residence, the child's ARC payments will be consolidated onto the family's existing EBT card. If the child is a non-minor dependent, he/she will receive his/her own EBT card.

Medi-Cal: This notice DOES NOT change or stop Medi-Cal benefits. Keep using your plastic Benefits Identification Card(s). You will get another notice telling you about any changes to your health benefits.

CalFresh: This notice DOES NOT stop or change your CalFresh benefits. You will get a separate notice telling you about any changes to your CalFresh benefits.

Rules: These rules apply. You may review them at your county welfare office: Welfare and Institutions Code section 11461.3, Senate Bill 855 (Chapter 29, Statutes of 2014); Section 58 of Chapter 20 of the Statutes of 2015; All County Information Notice I-42-14; All County Letters 14-89, 15-20, 15-20-E,15-83, and 16-92; and County Fiscal Letters 14-15-45, 14-15-52, 14-15-58, 15-16-07, and 15-16-24.

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 before 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:

Welfare to Work:

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.

Cal-Learn:

- 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 can be a friend or relative but cannot interpret for you.)**

NAME	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE