NOTIFICACIÓN DE NEGACIÓN PROGRAMA DE ASISTENCIA MONETARIA PARA INMIGRANTES (CAPI)

CONDADO DE

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

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador : _____
Número : _____
Teléfono : _____
Dirección : _____
_____
_____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el Estado: Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En la siguiente página se le explica cómo solicitarla. Es posible que sus beneficios no cambiarán si usted solicita una audiencia antes de que esta acción entre en vigor.

Su solicitud para los beneficios del Programa de Asistencia Monetaria para Inmigrantes (CAPI) con fecha de _____ (mes/día/año), se ha negado debido a que:

- ☐ Su situación migratoria/ciudadanía no cumple con los requisitos de CAPI. (MPP 49-020)
- ☐ Sus ingresos en la cantidad de $_____, que podría incluir ingresos de su patrocinador que se consideran, son más que el límite permitido. (MPP 49-035)
- ☐ Sus recursos, que podrían incluir los recursos de su patrocinador que se consideran son más que el límite permitido de $2,000 dólares para una persona o $3,000 dólares para una pareja. (MPP 49-040)
- ☐ No ha presentado las pruebas de que ha solicitado los beneficios de SSI (Programa de Ingresos Suplementales de Seguridad) ni ha tomado todas las medidas necesarias para obtener los beneficios de SSI. (MPP 49-030)
- ☐ Sus beneficios de SSI han sido aprobados; no puede recibir al mismo tiempo los beneficios de SSI y los pagos de CAPI. (MPP 49-030)
- ☐ No cooperó con el proceso de solicitud del condado (vea los comentarios). (MPP 49-015.1)
- ☐ Usted reside en una institución pública. (MPP 49-010.21)
- ☐ Usted no es un residente de California. (MPP 49-010.14)
- ☐ El Condado tiene información que la persona que solicitó los beneficios ha muerto. (MPP 49-060.33)
- ☐ Usted no tiene 65 años de edad o más, ni es una persona ciega ni incapacitada. (MPP 49-025)
- ☐ Usted voluntariamente ha retirado su solicitud.
- ☐ Usted está fuera de los Estados Unidos por un mes entero. (MPP 49-010.24)
- ☐ Otro: _____.

Reglas: Las siguientes reglas, las cuales puede revisar en la oficina de bienestar público, son pertinentes: Código de Bienestar Público e Instituciones, División 9, Parte 6, Capítulo 10.3, de la Sección 18937 a la Sección 18944; Manual de Prácticas y Procedimientos (MPP), de la Sección 49-001 a la Sección 49-070.

Commentarios:

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