STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

WILL LIGHTBOURNE
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

September 28, 2011

ALL COUNTY INFORMATION NOTICE NO. I-66-11

TO: ALL COUNTY WELFARE DIRECTORS
ALL CONSORTIA PROJECT MANAGERS
ALL COUNTY ELECTRONIC BENEFIT TRANSFER (EBT) PROJECT MANAGERS
DISASTER CALFRESH COORDINATORS
CALFRESH PROGRAM COORDINATORS

SUBJECT: RELEASE OF THE NEW NOTICE OF APPROVAL/DENIAL FOR DISASTER CALFRESH (DFA 390) FORM AND REVISED APPLICATION FOR DISASTER CALFRESH (DFA 385) FORM FORMERLY ENTITLED APPLICATION FOR EMERGENCY FOOD STAMP ASSISTANCE

The purpose of this letter is to inform counties of the release of the new Notice of Approval/Denial Disaster CalFresh (DFA 390) form, and the revisions to the Application for Disaster CalFresh (DFA 385) form, formerly entitled Application for Emergency Food Stamp Assistance.

Notice of Approval/Denial For Disaster CalFresh - DFA 390

State regulations in the Manual of Policies and Procedures (MPP) Section 63-900.55(c) do not require County Welfare Departments (CWDs) to use a specific form when notifying Disaster CalFresh households of their approval or denial status for Disaster CalFresh benefits. However, the regulations state that the interviewer shall review the application and advise the household verbally or in writing of their approval or denial status for Disaster CalFresh benefits. The interviewer must also verbally advise the household of the following:

- Their rights and responsibilities;
- The civil and criminal penalties which may apply if a violation of the Food and Nutrition Act of 2008 is committed;
- That the household may be subject to a post-disaster review; and
- The address and telephone number of where the household may apply for the regular CalFresh.

The CWDs currently use the Notice of Approval DFA 377.1 and the Notice of Denial/Pending Status DFA 377.1A forms to notify Disaster CalFresh applicants of their eligibility status for Disaster CalFresh. At the request of counties, the DFA 390 was developed to ensure a uniform response statewide for notifying disaster victims of their eligibility status for Disaster CalFresh benefits.

Application for Disaster CalFresh - Revised DFA 385

The Application for Disaster CalFresh, formerly entitled the Application for Emergency Food Stamp Assistance, has been revised to more accurately reflect the United States Department of Agriculture, Food and Nutrition Service, Example Client Disaster Supplemental Nutrition Assistance Application, and to better assist counties in gathering additional helpful information from Disaster CalFresh applicants. In addition, the form has been revised to reflect the program name change from Food Stamps to CalFresh.

Both the DFA 390 and the revised DFA 385 forms are required forms and substitutes are not permitted. Effective the date of this letter, counties will be required to use the aforementioned forms in the event of a disaster in the State of California that warrants a Disaster CalFresh program.

State regulations in the MPP under Section 63-900 are in the process of being amended to reflect the changes in this letter.

FORMS/CAMERA-READY COPIES AND TRANSLATIONS

For a camera-ready copy of English and Spanish forms, contact the Forms Management Unit at: fmudss@dss.ca.gov.

If your office has internet access, you may obtain these forms from the California Department of Social Services (CDSS) web page at:

www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm

Per MPP Section 21-155.2, all other translations will be posted on the CDSS website on an ongoing basis. Copies of the translated forms and publications in all other required languages can be obtained at:

www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm

For questions on translated materials, please contact Language Services at (916) 651-8876.

If you have any questions regarding this letter, please contact Shanee Clark, Program Analyst, at (916) 653-7973.

Sincerely,

Original Document Signed By:

LINDA PATTERSON, Chief
CalFresh Branch
Welfare to Work Division

(Attachments)

COUNTY OF

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

NOTICE OF APPROVAL/DENIAL FOR DISASTER CALFRESH

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 how. Your benefits may not be changed if you ask for a hearing before this action takes place.

☐ **Your application for Disaster CalFresh benefits has been approved.** Your certification covers the disaster benefit period from _____ through _____.
Your one time Disaster CalFresh benefit allotment for a household of _____ is _____.

☐ **Your application for Disaster CalFresh benefits has been denied because of the following:**

- ☐ You failed to appear for the Disaster CalFresh interview.
- ☐ You did not live or work in the disaster area at the time of the disaster.
- ☐ Your income and resources exceed the income and resource limits for the Disaster CalFresh Program.
- ☐ Other _____.

The table below shows how we calculated the Disaster CalFresh benefit for your household. We used the information you gave us on the Application for Disaster CalFresh (DFA 385) to determine your household's Disaster CalFresh benefit amount.

Disaster CalFresh Benefit Calculation:		
a. Anticipated Income	$	
b. Accessible Cash Resources	(+)	
c. Total disaster period income = (a+b)	(=)	
d. Total allowable disaster related expenses	(-)	
e. Accessible disaster period income = (c-d)	(=)	
f. Maximum Disaster Income Limit for Household size (use information from Disaster Table)		Household size:
If (e) is equal to or less than (f), the household is eligible.		
g. Disaster Allotment (from Disaster Table)		
h. Regular allotment already received (if any)	(-)	
i. Net disaster allotment (g-h)	(=)	

Rules: These rules apply. MPP 63-900
You may review them at your welfare office.

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 (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 CalFresh (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, CalFresh (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 ☐ CalFresh (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 ☐ CalFresh (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

APPLICATION FOR DISASTER CALFRESH

COUNTY USE ONLY
CASE NUMBER
WORKER
DATE RECEIVED

Disaster benefit period: _____ to _____

IMPORTANT INFORMATION – READ CAREFULLY

YOUR RIGHTS AS AN APPLICANT OR RECIPIENT:

- To be served without regard to race, color, national origin, religion, political affiliation, sex, handicap, or age, and to file a complaint if you feel you have been discriminated against.
- To get Disaster CalFresh benefits within one to three calendar days of the date the application is filed, if you are eligible.
- To talk about any action regarding your case with the County Welfare Department and to ask for a state hearing within 90 days of approval or denial of application.
- To have an immediate review by a supervisor if your application is denied.
- To file a complaint or ask for a state hearing by writing to your County Welfare Department or by calling toll-free 1-800-952-5253. The toll-free number for the deaf (TDD) is 1-800-952-8349.
- To represent yourself at a state hearing or be represented by a household member, friend, attorney, or any other person.
- To have another member of your household, or another adult who knows you, complete this application. If it is completed by an adult who is not a member of your household, attach written approval signed by the head of household or another adult household member.

YOUR RESPONSIBILITIES AS AN APPLICANT OR RECIPIENT:

- Answer the questions truthfully and completely, the best you can. If you refuse to provide any of the needed information, you will not get Disaster CalFresh benefits.
- At your interview, you must verify the identity of the head of household, the identity of the person completing the application, and if possible, proof of the household's residence and/or work address at the time of the disaster.
- You must cooperate with county, state and federal staff if you are selected for a review after the disaster period.
- You can authorize someone to receive, or use your Disaster CalFresh benefits. If you would like to authorize someone, complete the information below:

NAME OF AUTHORIZED REPRESENTATIVE	TELEPHONE NUMBER

ADDRESS INCLUDING CITY AND ZIP CODE

☐ PICK UP EBT CARD ONLY ☐ PICKUP UP EBT CARD TO PURCHASE FOOD FOR HOUSEHOLD

PENALTY WARNING!!

IF YOUR HOUSEHOLD GETS DISASTER CALFRESH BENEFITS, YOU MUST FOLLOW THE RULES LISTED BELOW. FAILING TO REPORT INFORMATION OR MISREPRESENTATION OF FACTS CAN RESULT IN LEGAL PROSECUTION WITH PENALTIES OF A FINE, IMPRISONMENT OR BOTH. THE PENALTIES CAN RESULT IN DISQUALIFICATION FROM THE PROGRAM, FINES UP TO $250,000 OR IMPRISONMENT FOR UP TO 20 YEARS. THE DISQUALIFICATION PENALTIES ARE 12 MONTHS FOR THE FIRST VIOLATION, 24 MONTHS FOR THE SECOND VIOLATION, AND PERMANENT DISQUALIFICATION FOR THE THIRD VIOLATION.

- Do not give false information or withhold information to get Disaster CalFresh benefits.
- Do not trade or sell your Disaster CalFresh benefits, or any other issuance device.
- Do not alter your EBT card or any other issuance device to get Disaster CalFresh benefits you are not entitled to receive.
- Do not use Disaster CalFresh benefits to buy ineligible items such as alcoholic drinks and tobacco.
- Do not use someone else's EBT card, or any other issuance device for your household.

INSTRUCTIONS: Please complete the questions on this form for your expected circumstances during the disaster benefit period shown above.

NAME (HEAD OF HOUSEHOLD)

PERMANENT HOME ADDRESS AT TIME OF DISASTER	TELEPHONE NUMBER
TEMPORARY ADDRESS	TELEPHONE NUMBER
MAILING ADDRESS	TELEPHONE NUMBER
WORK ADDRESS AT THE TIME OF DISASTER	TELEPHONE NUMBER

PART A – HOUSEHOLD SITUATION. ***(You must check Yes or No for each question)***

1. Was anyone in your household living ☐ working ☐ or both ☐ *(check appropriate box)* in the disaster area at the time of the disaster?
2. Are you unable to get to your household's income or cash resources? ☐ YES ☐ NO
3. Have your income or cash resources been lowered, delayed or stopped because of the disaster? ☐ YES ☐ NO
4. Will you be buying food and preparing meals during the disaster benefit period? ☐ YES ☐ NO

COUNTY USE ONLY

☐ Disaster Application

Can the identify of the authorized representative be verified?
☐ YES ☐ NO
Type of verification:

Can the head of household's identity be verified?
☐ YES ☐ NO
Type of verification:

Is permanent residence in disaster area?
☐ YES ☐ NO
Type of verification:

Is work address in the disaster area?
☐ YES ☐ NO
Type of verification:

Can the household's residence be verified?
☐ YES ☐ NO
Type of verification:

PART B – HOUSEHOLD MEMBERS

5. List the names of all persons applying for Disaster CalFresh benefits. Include only persons who **were living with you at the time of the disaster.** If you are temporarily staying with another household because of the disaster, **do not list members of that household. *Telling your Social Security Number (SSN) is voluntary. It will be used for identification purposes only.**

	NAME (HEAD OF HOUSEHOLD) (HH)	RELATION TO HH	SSN*	BIRTHDATE
a.				
b.	NAME	RELATION TO HH	SSN*	BIRTHDATE
c.	NAME	RELATION TO HH	SSN*	BIRTHDATE
d.	NAME	RELATION TO HH	SSN*	BIRTHDATE
e.	NAME	RELATION TO HH	SSN*	BIRTHDATE
f.	NAME	RELATION TO HH	SSN*	BIRTHDATE
g.	NAME	RELATION TO HH	SSN*	BIRTHDATE

PART C – INCOME/RESOURCES/EXPENSES

6. a. What is the total amount of take home pay or other income all persons listed above have received or will get during the disaster benefit period? $_____

   b. List all your income sources:

7. List all cash resources the persons listed above will be able to get to during the disaster benefit period. Do not include any money listed in number 6.

Cash on Hand	Savings Accounts	Checking Accounts	Other
$	$	$	$

8. Enter the amount of expenses for losses or damages related to the disaster which you have paid or expect to pay during the disaster period. Do not list amounts which will be paid by someone who is not listed above or which will be reimbursed during the disaster period. Eligible expenses may include some of the following:

   a. Expenses to repair damage to the household's home or other property essential to employment or self-employment of a household member. $ _____
   b. Temporary shelter expenses if the home is uninhabitable or the household cannot reach it; $ _____
   c. Expenses for moving out of the area which was evacuated due to the disaster; $ _____
   d. Expenses related to protection of a home or business from disaster damage; $ _____
   e. Medical expenses due to personal injury. $ _____
   f. Disaster-related funeral expenses. $ _____
   g. Disaster-related pet boarding fees. $ _____
   h. Expenses related to replacing necessary personal and household items, such as clothing, appliances, tools and education materials. $ _____
   i. Fuel for primary heating source. $ _____
   j. Clean-up items expense. $ _____
   k. Disaster-damaged vehicle expenses. $ _____
   l. Storage expenses. $ _____

9. a. Is anyone listed above currently getting CalFresh benefits? ☐ YES ☐ NO

   If yes, Who?_____County_____State____ Monthly Allotment $_____

   b. Did they ask for or get replacement CalFresh benefits for this month?

   If yes, how much did they receive or will receive? _____ ☐ YES ☐ NO

YOUR CERTIFICATION

I certify that I understand the questions on the application and that my household is in need of Disaster CalFresh benefits. I have read the above Penalty Warning (or had it read to me). I authorize the release of any information necessary to determine the accuracy of my eligibility. If I am selected, I will fully cooperate with county, state and federal staff in a review to be conducted after the disaster benefit period. I also understand that I may be required to repay any benefits which are overpaid because I, another adult household member, or the authorized representative reports incorrect or incomplete information.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained on my application is true, correct, and complete.

SIGNATURE *(ADULT HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE)* DATE

WITNESS, IF YOU SIGNED WITH AN "X" DATE

COUNTY USE ONLY

Household size for the number of persons listed in 5 ____

Computation

A. Anticipated Income (from 6) $_____

B. Accessible Cash Resources (from 7) + $ _____

C. Total disaster period income = (A+B) $ _____

D. Total allowable disaster-related expenses (from 8) – $ _____

E. Accessible disaster period income = (C-D) $ _____

F. Maximum Disaster Income Limit for household size (from Table) $ _____

If E is equal to or less than F, the household is eligible.

Eligible: ☐ YES ☐ NO

Allotment

1. Disaster Allotment (from Table) $ _____
2. Regular Allotment Already Received – $ _____
3. Net Disaster Allotment (1–2) = $ _____

EBT Card Number issued

_____

☐ YES ☐ NO

WORKER'S SIGNATURE DATE

SUPERVISOR'S SIGNATURE DATE