January 22, 2019

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

EXECUTIVE SUMMARY

ALL COUNTY LETTER NO. 19-03

The purpose of this All County Letter (ACL) is to transmit new notices and an updated form related to the Intercounty Transfer (ICT) process due to the implementation of the Supplemental Nutrition Benefit (SNB) Program and Transitional Nutrition Benefit (TNB) Program.

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

PAT LEARY
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

January 22, 2019

ALL COUNTY LETTER (ACL) NO. 19-03

TO: ALL CALWORKS PROGRAM SPECIALISTS
ALL COUNTY CALFRESH SPECIALISTS
ALL COUNTY WELFARE DIRECTORS
ALL CONSORITA PROJECT MANAGERS
ALL QUALITY CONTROL PROGRAM COORDINATORS

SUBJECT: CALFRESH NEW NOTICES AND UPDATED FORM FOR INTERCOUNTY TRANSFER PROCESS

REFERENCE: ASSEMBLY BILL 1811 (CHAPTER 35, STATUTES OF 2018); WELFARE AND INSTITUTIONS CODE 18900.5 TO .7; ALL COUNTY LETTER (ACL) 18-131; ACL 18-108; ACL 18-107; ACL 18-92; ACL 18-91; ACL 18-90

This ACL transmits new notices and an updated form related to the Intercounty Transfer (ICT) process due to the implementation of the Supplemental Nutrition Benefit (SNB) Program and Transitional Nutrition Benefit (TNB) Program. The new ICT notices will be used when either an ongoing CalFresh household participating in the SNB Program or a household participating in the TNB Program moves from one county to another within the State of California. The updated ICT form will be used as it is used currently, when any household, with or without SNB Program or TNB Program benefits, moves from one county to another within the State of California.

The California Department of Social Services (CDSS) is issuing the following new ICT notices:

- SNB 7: CalFresh and Supplemental Nutrition Benefit Informing Notice of Receiving Intercounty Transfer
- SNB 8: CalFresh and Supplemental Nutrition Benefit Informing Notice of Sending Intercounty Transfer

- TNB 7: Transitional Nutrition Benefit Informing Notice of Receiving Intercounty Transfer
- TNB 8: Transitional Nutrition Benefit Informing Notice of Sending Intercounty Transfer

The CDSS is issuing the following updated ICT form:

- CF 215: CalFresh Notification of Intercounty Transfer

Background
As described in ACL 18-90 released on July 31, 2018, AB 1811 reversed the CalFresh eligibility policy known as cash-out, under which recipients of Supplemental Security Income and/or State Supplementary Payment (SSI/SSP) are ineligible for CalFresh. Effective June 1, 2019, individuals receiving SSI/SSP benefits are eligible for CalFresh, provided all other eligibility criteria are met.

The CWDs will implement the policy change for newly eligible households as of June 1, 2019. For existing households, the CWDs will implement the policy change on a rolling basis at the household's next periodic report, recertification, or when voluntarily requested by the household, beginning on the implementation date.

In addition to reversing the cash-out policy, AB 1811 creates two state-funded nutrition benefit programs intended to "hold harmless" existing CalFresh households negatively affected by the policy change. The two state-funded programs, known as the SNB Program and TNB Program, will provide CalFresh households with nutrition benefits to mitigate the reduction of CalFresh benefits or CalFresh ineligibility, respectively.

On July 31, 2018, the CDSS released ACL 18-91 and ACL 18-92 providing policy instructions for implementation and automation of the SNB Program and TNB Program. Additionally, ACL 18-108 and ACL 18-107, released August 30, 2018 issued SNB Program and TNB Program notices and corresponding instructions. The SNB Program will provide supplemental state-funded nutrition benefits to those existing CalFresh households with excluded members that receive SSI/SSP benefits that, at the time of implementation of the reversal of the cash-out policy, experience a reduction of CalFresh benefits. The TNB Program will provide transitional state-funded nutrition benefits to CalFresh households with excluded members that receive SSI/SSP benefits that, at the time of the implementation of the reversal of the cash-out policy, become ineligible for CalFresh.

Implementation Timeline
All notices and forms for the SNB Program and TNB Program must be automated and available for use by the CWDs no later than June 1, 2019.

New Notices and Updated Form: Intercounty Transfer

SNB 7 **CalFresh and Supplemental Nutrition Benefit Informing Notice of Receiving Intercounty Transfer**

The SNB 7 is a new notice. The purpose of the SNB 7 is to provide an ongoing CalFresh household that is also receiving SNB Program Benefits with ICT information from the new county of residence, known as the "receiving county". The notice functions in the same manner as the existing CalFresh Informing Notice of Receiving Intercounty Transfer (NA 1267), but includes information relevant to the SNB Program.

SNB 8 **CalFresh and Supplemental Nutrition Benefit Informing Notice of Sending Intercounty Transfer**

The SNB 8 is a new notice. The purpose of the SNB 8 is to provide an ongoing CalFresh household that is also receiving SNB Program benefits with ICT information from the original county of residence, known as the "sending county". The notice functions in the same manner as the existing CalFresh Informing Notice of Sending Intercounty Transfer (NA 1268), but includes information relevant to the SNB Program.

TNB 7 **Transitional Nutrition Benefit Informing Notice of Receiving Intercounty Transfer**

The TNB 7 is a new notice. The purpose of the TNB 7 is to provide a household receiving TNB Program benefits with ICT information from the "receiving county". The notice functions in the same manner as the NA 1267, but includes information relevant to the TNB Program.

TNB 8 **Transitional Nutrition Benefit Informing Notice of Sending Intercounty Transfer**

The TNB 8 is a new notice. The purpose of the TNB 8 is to provide a household receiving TNB Program benefit with ICT information from the "sending county". The notice functions in the same manner as the NA 1268, but includes information relevant to the TNB Program.

NOTE: All of the new SNB Program and TNB Program notices listed above, must be provided to the household with a NA Back 9 outlining the SNB Program and TNB Program household's hearing rights.

CF 215 (6/19) **CalFresh Notification of Inter-County Transfer**

The purpose of this form has not changed. The CF 215 has been updated to include relevant SNB Program and TNB Program

information, provided the household has been determined eligible due to the reversal of SSI cash-out, that should be included when a household's case transfers from the sending county to the receiving county. Other minor changes, unrelated to the reversal of SSI cash-out, have also been made and are included below.

Changes include:

- Under the "Documentation Sent" section, a "SNB & TNB Notices" box has been added.

- Under the "Household Type" section

    - The "Semi-Annual Reporting" household type box has been removed.

    - An "ESAP" household type box has been added.

    - For an Able Bodied Adult without Dependents (ABAWD) member, a "# of Countable Months used" and "Consecutive Months Began" text line has been added.

    - For SSI/SSP members, a "SSI/SSP Members: # SSI excluded from the household on 6/1/2019" text line has been added to identify the number of SSI/SSP recipient members included in the household prior to the reversal of SSI cash-out.

    - For SSI/SSP members, a subsection has been added to identify if the household has had the reversal of SSI cash-out applied prior to completing the ICT. This subsection also includes checkboxes to identify if the household is SNB Program or TNB Program eligible and, if so, what the SNB Program or TNB Program benefit amount is, along with the new household size including the previously excluded SSI/SSP recipient members.

CAMERA-READY COPIES AND TRANSLATIONS

For a camera-ready copy in English, contact the CDSS Forms Management Unit at fmudss@dss.ca.gov. You may obtain these forms from the CDSS forms/Brochure webpage.

When all translations are completed per MPP Section 21-115.2, they are posted on an on-going basis on the CDSS webpage. Copies of the translated forms can be obtained at the CDSS Translated Forms and Publications webpage.

For questions on translated materials, please contact the CDSS Language Services at (916) 651-8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the GEN 1365 – Notice of Language Services and a local contact number.

The CWDs shall ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services shall be provided free of charge to the applicant/recipient. In the event that CDSS does not provide translations of a form, it is the CWD's responsibility to provide interpreter services if an applicant or recipient requests them. More information regarding translations can be found in MPP Section 21-115.

This ACL and other CDSS Letters and Notices are available on the internet at the CDSS Letters and Notices webpage.

For CalFresh Program questions, or inquiries related to the attached notices and form, please contact the CalFresh Policy Bureau at (916) 651-8047.

Sincerely,

Original Signed By:

KIM JOHNSON
Deputy Director
Family Engagement and Empowerment Division

Attachments

CALFRESH NOTIFICATION OF INTER-COUNTY TRANSFER

Instructions: Workers are to complete each relevant space.

Sending County Name and Address:

Receiving County:

Case Name:	**Case Number:**	**SSN:**

Recipient Home Address: Number/Street		**Recipient Mailing Address: (If Different)** Number/Street	
City:	Zip Code:	City:	Zip Code:

Name of Authorized Representative:

Sending County Discontinuance Date:	**Recert Due** (MO/YR):	**SAR 7 Submit Month:**

Number of Household Members:
Federal: _____ CFAP: _____

Documentation Sent:

☐ SAWS 1 ☐ SAWS 2 ☐ SAR 7 ☐ CF 377.5
☐ OI Documentation ☐ SAWS 2 PLUS ☐ CF 285 ☐ Disability Verification
☐ Income Verification ☐ Citizen/Noncitizen Verification ☐ SAWS 2A SAR
☐ SNB & TNB Notices ☐ Other _____

Case Information:

☐ Current Benefit Amount: _____ ☐ Budgeted Gross Income: _____

Budgeted Expenses:

☐ Rent/Housing Cost: _____ ☐ SUAS Benefit Paid Date: _____
☐ LIHEAP Benefit Paid Date: _____ ☐ WINS Benefit Paid Date: _____
☐ SUA ☐ TUA ☐ LUA ☐ Medical Expenses: _____
☐ Dependent Care: _____ ☐ Child Support Paid: _____

Overissuance Claims Transferred:

Error Type	**Balance**	**OI Period (from/to dates)**	**Lomeli Date**
☐ IPV ☐ IHE ☐ Agency	$		
☐ IPV ☐ IHE ☐ Agency	$		
☐ IPV ☐ IHE ☐ Agency	$		
☐ IPV ☐ IHE ☐ Agency	$		

Household Type:

☐ Homeless ☐ Elderly/Disabled ☐ ESAP ☐ Seasonal Farm Worker

☐ Ineligible HH member(s): _____

Reason(s): _____

☐ ABAWD member(s): _____

# of Countable Months used: _____ Consecutive Months Began: _____ MO/YR

Known ABAWD Exemptions: _____

☐ SSI/SSP Members: # SSI excluded from the household on 6/1/2019: _____

SSI Cash Out Reversal applied: ☐ No ☐ Yes, HH Effective Date: _____

Results of Cash Out Reversal: ☐ Not eligible to TNB or SNB

☐ TNB Eligible: Benefit $ _____ New HH size, including SSI/SSP: _____

☐ SNB Eligible: Benefit $ _____ New HH size, including SSI/SSP: _____

Sending Worker Information:

Name:	
Worker Number:	Telephone Number:
Fax Number:	Date Completed:

Comments:

CALFRESH AND SUPPLEMENTAL NUTRITION BENEFIT (SNB) INFORMING NOTICE OF RECEIVING INTERCOUNTY TRANSFER

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

COUNTY OF

Notice Date : _____

Case Name : _____

Case Number : _____

Worker Name : _____

Worker Number : _____

Telephone Number : _____

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.

_____ County has transferred your CalFresh and Supplemental Nutrition Benefit (SNB) case to our county.

This letter has your new case number, worker's name and telephone number. Please refer to this letter when you contact us.

You will get the CalFresh benefits listed below:

$ _____ effective _____ for _____ person(s).
MM/DD/CCYY

You will get the SNB benefits listed below:

$ _____ effective _____ for _____ person(s).
MM/DD/CCYY

You will receive a new electronic benefits transfer card (EBT) for the benefits listed above. If you don't receive a new EBT card, please contact our office.

If you still have benefits on your EBT card from your old county, you can use that card until those benefits are gone. You will not be able to use your old EBT card for the benefits listed above.

You must report changes that could affect your eligibility on your periodic report and to the worker listed in this notice.

You must complete the forms required for your CalFresh annual recertification when sent to you.

Rules: These rules apply: All County Letter 11-22 and Welfare & Institutions Code § 11053.2. 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, 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

CALFRESH AND SUPPLEMENTAL NUTRITION BENEFIT (SNB) INFORMING NOTICE OF SENDING INTERCOUNTY TRANSFER

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

COUNTY OF

Notice Date : _____

Case Name : _____

Case Number : _____

Worker Name : _____

Worker Number : _____

Telephone Number : _____

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.

You told us you were moving to _____ County. Your CalFresh and Supplemental Nutrition Benefit (SNB) case will be transferred to _____ County.

You do not have to fill out a new application and your CalFresh and SNB benefits will not stop during your transfer to your new county of residence. If you have any questions regarding your CalFresh and SNB benefits during the transfer to the new county or you decide not to move, please call the worker at the telephone number listed in this notice.

You will get another notice from the new county telling you about your new case number and telephone number.

You must continue to report changes that could affect your eligibility on your periodic report and to the worker listed in this notice until you get your notice from the new county.

Rules: These rules apply: All County Letter 11-22 and Welfare & Institutions Code § 11053.2. You may review them at your welfare office.

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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.

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- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
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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

TRANSITIONAL NUTRITION BENEFIT (TNB) INFORMING NOTICE OF RECEIVING INTERCOUNTY TRANSFER

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

COUNTY OF

Notice Date : _____

Case Name : _____

Case Number : _____

Worker Name : _____

Worker Number : _____

Telephone Number : _____

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.

_____ County has transferred your Transitional Nutrition Benefit (TNB) case to our county.

This letter has your new case number, worker's name, and telephone number. Please refer to this letter when you contact us.

You will get the TNB benefits listed below:

$ _____ effective _____ for _____ person(s).
MM/DD/CCYY

You will receive a new electronic benefits transfer card (EBT) for the benefits listed above. If you don't receive a new EBT card, please contact our office.

If you still have benefits on your EBT card from your old county, you can use that card until those benefits are gone. You will not be able to use your old EBT card for the benefits listed above.

You must complete the form required for your TNB recertification when sent to you.

Rules: These rules apply: All County Letter 11-22 and Welfare & Institutions Code § 11053.2. You may review them at your welfare office.

YOUR HEARING RIGHTS

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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>:

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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:

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OR

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, 1-800-952-8349.

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HEARING REQUEST

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☐ 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

TRANSITIONAL NUTRITION BENEFIT (TNB) INFORMING NOTICE OF SENDING INTERCOUNTY TRANSFER

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

COUNTY OF

Notice Date : _____

Case Name : _____

Case Number : _____

Worker Name : _____

Worker Number : _____

Telephone Number : _____

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.

You told us you were moving to _____ County. Your Transitional Nutrition Benefit (TNB) case will be transferred to _____ County.

You do not have to fill out a new application and your TNB benefits will not stop during your transfer to your new county of residence. If you have any questions regarding your TNB benefits during the transfer to the new county or you decide not to move, please call the worker at the telephone number listed in this notice.

You will get another notice from the new county telling you about your new case number and telephone number.

You must complete the form required for your TNB recertification when sent to you.

Rules: These rules apply: All County Letter 11-22 and Welfare & Institutions Code § 11053.2. 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, 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