

August 2, 2024

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 24-53**

The purpose of this All County Letter is to transmit three revised CalFresh Notices of Action: *CalFresh Notice of Approval of Reinstatement* (CF 388), *CalFresh Notice of Denial for Reinstatement* (CF 389), and *Replacement or Disaster Supplement Affidavit* (CF 303).



KIM JOHNSON  
DIRECTOR

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



GAVIN NEWSOM  
GOVERNOR

August 2, 2024

ALL COUNTY LETTER NO. 24-53

TO: ALL COUNTY WELFARE DIRECTORS  
ALL CALFRESH PROGRAM SPECIALISTS  
ALL CALWORKS PROGRAM SPECIALISTS  
ALL CONSORTIA REPRESENTATIVES  
ALL QUALITY CONTROL COORDINATORS

SUBJECT: CALFRESH NOTICES OF ACTION REVISIONS: CALFRESH  
NOTICE OF APPROVAL OF REINSTATEMENT (CF 388),  
CALFRESH NOTICE OF DENIAL FOR REINSTATEMENT (CF  
389), AND REPLACEMENT OR DISASTER SUPPLEMENT  
AFFIDAVIT (CF 303)

REFERENCE: [MANUAL OF POLICIES AND PROCEDURES \(MPP\) 21-115](#); [ALL COUNTY LETTER \(ACL\) NO. 10-32](#); [ACL NO. 15-42](#); [ACL NO. 19-95](#); [ACL NO. 22-51](#); [ACL NO. 23-57](#)

The purpose of this All County Letter (ACL) is to transmit three revised CalFresh Notices of Action (NOAs): *CalFresh Notice of Approval of Reinstatement* (CF 388), *CalFresh Notice of Denial for Reinstatement* (CF 389), and *Replacement or Disaster Supplement Affidavit* (CF 303).

The CF 388 and CF 389 have been revised to include the following:

- Title change;
- CalFresh budget;
- Explanation of the two food benefit programs: CalFresh and the California Food Assistance Program (CFAP); and
- Non-discrimination statement.

The CF 388 was also updated to include the following:

- Lists of eligible and ineligible individuals;

- Denial reason for individual household members;
- Explanation of household benefit allotment; and
- Income Reporting Threshold (IRT).

The CF 303 County Use Only section has been updated to include two separate benefit allotment replacement fields, one for CalFresh and the other for CFAP.

These changes are intended to clarify factors affecting a household's eligibility.

## **BACKGROUND**

The Reinstatement Waiver allows County Welfare Departments (CWDs) to reinstate eligibility for CalFresh households determined ineligible due to failure to provide a required report (e.g., SAR 7), verification, and/or other information, as long as the household has taken the required action within 30 days of the effective date of ineligibility. The California Department of Social Services (CDSS) has been authorized by the United States Department of Agriculture, Food and Nutrition Service (USDA, FNS) to extend the Reinstatement Waiver for a five-year period, effective July 1, 2022, through June 30, 2027.

The CWD is required to send the approval (CF 388) or denial (CF 389) NOAs to households requesting reinstatement of aid, following adequate noticing rules.

Additional revisions include changes necessary for the upcoming CFAP expansion. CFAP information on the CF 388 and CF 389 apply to currently eligible participants and individuals who will be eligible once the expansion is implemented. CFAP information on the CF 303 will apply to all CFAP eligible individuals once the expansion is implemented. More information about the CFAP expansion can be found in [ACL No. 23-57](#) released on June 29, 2023.

## **OVERVIEW OF CHANGES**

### **TITLE CHANGE**

The CF 388 is now titled *CalFresh Notice of Approval of Reinstatement* and the CF 389 is now titled *CalFresh Notice of Denial for Reinstatement*. The titles of these NOAs have changed for clarity in alignment with current language in the federal waiver conditions and previously established ACL guidance.

### **INDIVIDUAL ELIGIBILITY DETERMINATION**

The CF 388 must list the name(s) of the individual(s) who are approved or denied for reinstatement of CalFresh and/or CFAP, and the reason for the denial. This update was made to provide clarity about the eligibility determination for each individual in the household. The language illustrated below in **bold** has been added to the CF 388.

Your household's CalFresh benefits have been reinstated effective \_\_\_\_\_  
**for the following individual(s):**

This is the date we got the information needed to reinstate your benefits. Your certification period remains the same and ends on \_\_\_\_\_.

**The following individual(s) are ineligible because:**

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### **EXPLANATION OF BENEFIT ALLOTMENTS**

New language has been added to the CF 388 to inform the household of their benefit allotment for the month of reinstatement, and ongoing benefit allotment for the remainder of their certification period. This update was made to clarify benefit allotments due to the approval of reinstatement. The language illustrated below in **bold** has been added to the CF 388.

**You will get \$\_\_\_\_\_ for the period of \_\_\_\_\_ to \_\_\_\_\_.  
Beginning \_\_\_\_\_, you will receive \$\_\_\_\_\_ monthly. These  
benefits will be available on your Electronic Benefit Transfer (EBT) card.**

### **IRT STATEMENT**

The IRT amount must be provided to households at approval of initial application, recertification, and any time the household's IRT changes during the certification period. If a household does not have an IRT, the field must be populated with "N/A."

A new IRT statement, as illustrated below, has been added to the CF 388 and CF 389 to inform the household of their IRT amount. For more information on the IRT, please refer to [ACL No. 15-42](#) released on April 15, 2015.

**You must report whenever your household income goes above your  
Income Reporting Threshold (IRT). Your IRT is \$\_\_\_\_\_.**

### **CALFRESH BUDGET**

A budget section has been added to CF 388 and CF 389 and must be included when a budget change is authorized. This section informs the household of the income, deductions, and expenses that were used to determine the benefit allotment and separates the federal (CalFresh) and state (CFAP) funded allotments. For auditing purposes, these details will lead to greater accuracy and consistency statewide.

## **CALFRESH BUDGET**

Report Month \_\_\_\_\_  
Household Size \_\_\_\_\_

Total Countable Earned Income	\$ _____
Adjusted Countable Earned Income	\$ _____
Total Countable Unearned Income	\$ _____
Child Support Paid	\$ _____
Net Countable Income	\$ _____
Standard Deduction	\$ _____
Dependent Care	\$ _____
Homeless Shelter Deduction	\$ _____
Excess Medical Expense for Aged/Disabled	\$ _____
Total Deductions	\$ _____
Preliminary Adjusted Income	\$ _____
Housing Expenses	\$ _____
Utility Expenses	\$ _____
Allowable Shelter Deduction	\$ _____
Adjusted Net Income	\$ _____
CalFresh Allotment	\$ _____
CFAP Allotment	\$ _____
Less Overissuance	\$ _____
Total CalFresh Allotment	\$ _____

## **EXPLANATION OF THE TWO FOOD BENEFIT PROGRAMS**

Due to the upcoming CFAP expansion, an explanation of the two food benefit programs has been added to the CF 388 and CF 389. This explanation informs households about the two food benefit programs to help households better understand the itemized budget. When the budget is included, the explanation of the two food benefit programs must also be included on the NOA.

### **California offers two food benefit programs.**

CalFresh is California's name for the federally funded Supplemental Nutrition Assistance Program (SNAP). To receive CalFresh benefits, you must meet federal rules, which require United States citizenship or certain immigration statuses (7 CFR 273.2(f)(ii)(A) and MPP 63-403). CalFresh benefits appear in the budget as "CalFresh Allotment".

The California Food Assistance Program (CFAP) provides state funded food benefits to some immigrants who are not eligible for federal food benefits. If immigration status is the only reason you or someone in your household is not eligible for CalFresh, then you may be eligible for CFAP. CFAP benefits appear in the budget as "CFAP Allotment".

## **NON-DISCRIMINATION STATEMENT**

The Non-Discrimination Statement has been added to the CF 388 and CF 389 to comply with federal regulations at [7 CFR 273.2\(b\)\(1\)\(viii\)](#) and [USDA Department Regulation 4300-3 Section 5\(c\)](#):

**Non-Discrimination Statement:** In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language) should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf> from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1.	Mail:	Food and Nutrition Service, USDA 1320 Braddock Place, Room 334 Alexandria, VA 22314; or	CDSS Civil Rights Bureau P.O. BOX 944243, M.S. 9-7-041 Sacramento, CA 94244-2430; or
2.	Fax:	(833) 256-1665 or (202) 690-7442; or	
3.	E-Mail:	<a href="mailto:FNCSIVILRIGHTSCOMPLAINTS@usda.gov">FNCSIVILRIGHTSCOMPLAINTS@usda.gov</a>	

**This institution is an equal opportunity provider.**

### **CF 303 COUNTY USE ONLY**

Households submit the CF 303 to request benefit replacement due to household misfortune and/or disaster supplements. Subsequently, the CWD uses the CF 303 to notify households of the eligibility result of the request.

The REPLACEMENT/DISASTER SUPPLEMENT field of the COUNTY USE ONLY section has been updated with two benefit allotment replacement fields that separate the CalFresh and CFAP benefit amounts.

COUNTY USE ONLY	
Case Name:	_____
Case Number:	_____
Worker:	_____
Date CF 303 Received:	_____
REPLACEMENT/DISASTER SUPPLEMENT	
Approved – EBT Replacement Date	_____
Approved – Benefit Replacement Date	_____
CalFresh Benefit Replacement Amount \$	_____
CFAP Benefit Replacement Amount \$	_____
Approved – Disaster Supplement Date	_____
Disaster Supplement Amount \$	_____
Denied – Reason for Denial (Explain)	_____
	_____
	_____
	_____
Signature (Person Authorized or Denying Request) Date	
Rules: These rules may apply:	_____
You may review at your local county office.	

### **IMPLEMENTATION TIMELINE**

Automation of the CF 388 and CF 389 is anticipated to be completed by the California Statewide Automation Welfare System (CalSAWS) within 12 months from the release of this ACL. Additionally, automation for the CF 303 will be completed once the CFAP expansion is implemented. CWDs must begin using the revised NOAs as soon as automation is complete.

### **QUALITY CONTROL (QC)**

As of the implementation date, all QC reviewers must review the policy changes

outlined in this letter and must apply all pertinent rules pertaining to CalFresh and CFAP.

## **COPIES AND TRANSLATIONS**

Forms referenced in this letter are available on the [CDSS Forms/Brochures](#) webpage.

When CDSS completes all translations of a form, they are posted on the [Translated Forms and Publications](#) webpage. When made available by CDSS, forms translated into an individual's preferred language must be provided to the individual pursuant to [MPP Section 21-115.2](#). For questions on translated materials, please contact Language Services at (916) 651-8876. If translations are not 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.

Per [Government Code Section 7290, et seq.](#), the CWDs must 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 must be provided, free of charge, to the applicant/recipient. If CDSS does not provide translations of a form, it is the county's responsibility to read and interpret the form if an applicant or recipient requests it.

Additionally, the CWDs must provide auxiliary aids and services to persons who are deaf or hearing impaired, or persons with impaired speech, vision, or manual skills, where applicable. More information regarding provisions for services to applicants and recipients who have limited English proficiency or who have disabilities can be found in [MPP Section 21-115](#) and [ACL 19-45](#) issued May 16, 2019.

This ACL and other CDSS letters and notices are available on the internet at: <http://www.cdss.ca.gov/inforesources/Letters-and-Notices>.

If you have any questions or need additional guidance regarding the information in this letter, contact the CalFresh Policy and Employment Bureau at [CalFreshPolicy@dss.ca.gov](mailto:CalFreshPolicy@dss.ca.gov).

If you have any questions or need additional guidance regarding CFAP, contact the CFAP Bureau at [CFAP@dss.ca.gov](mailto:CFAP@dss.ca.gov).

Sincerely,

***Original Document Signed By***

ALEXIS FERNÁNDEZ GARCIA  
Deputy Director  
Family Engagement and Empowerment Division



Attachments

**NOTICE OF APPROVAL  
OF REINSTATEMENT**

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 last page of this form tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.**

Your household's CalFresh benefits have been reinstated effective \_\_\_\_\_ for the following Individual(s):

This is the date we got the information needed to reinstate your benefits. Your certification remains the same and ends on \_\_\_\_\_.

The following individual(s) are ineligible because:

\_\_\_\_\_

You will get \$ \_\_\_\_\_ for the period of \_\_\_\_\_ to \_\_\_\_\_. Beginning \_\_\_\_\_, you will get \$ \_\_\_\_\_ monthly. These benefits will be available on your Electronic Benefit Transfer (EBT) card.

You must report whenever your household income goes above your Income Reporting Threshold (IRT). Your IRT is \$ \_\_\_\_\_.

The amounts used to figure your CalFresh are shown on this notice.

Rules: These rules apply: \_\_\_\_\_

You may review them at your local county office.

**CALFRESH BUDGET**

Report Month \_\_\_\_\_

Household Size \_\_\_\_\_

Total Countable Earned Income	\$ _____
Adjusted Countable Earned Income	\$ _____
Total Unearned Income	\$ _____
Child Support Paid	\$ _____
Net Countable Income	\$ _____
Standard Deduction	\$ _____
Dependent Care	\$ _____
Homeless Shelter Deduction	\$ _____
Excess Medical Expense for Aged/Disabled	\$ _____
Total Deductions	\$ _____
Preliminary Adjusted Income	\$ _____
Housing Expenses	\$ _____
Utility Expenses	\$ _____
Allowable Shelter Deduction	\$ _____
Adjusted Net Income	\$ _____
CalFresh Allotment	\$ _____
CFAP Allotment	\$ _____
Less Overissuance	\$ _____
Total CalFresh Allotment	\$ _____

**California offers two food benefit programs.**

*CalFresh is California's name for the federally funded Supplemental Nutrition Assistance Program (SNAP). To receive CalFresh benefits, you must meet federal rules, which require United States citizenship or certain immigration statuses (7 CFR 273.2(f) (1)(ii)(A) and MPP 63-403). CalFresh benefits appear in the budget as "CalFresh Allotment".*

*The California Food Assistance Program (CFAP) provides state funded food benefits to some immigrants who are not eligible for CalFresh. If immigration status is the only reason you or someone in your household is not eligible for CalFresh, then you may be eligible for CFAP. CFAP benefits appear in the budget as "CFAP Allotment".*

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Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

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<https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

- |                  |   |   |
|------------------|---|---|
| <b>1. Mail:</b>  | Food and Nutrition Service, USDA<br>1320 Braddock Place, Room 334<br>Alexandria, VA 22314; or | CDSS Civil Rights Bureau<br>P.O.BOX 944243, M.S. 9-7-041<br>Sacramento, CA 94244-2430; or |
| <b>2. Fax:</b>   | (833) 256-1665 or (202) 690-7442; or  |   |
| <b>3. Email:</b> | <a href="mailto:FNSCIVILRIGHTSCOMPLAINTS@usda.gov">FNSCIVILRIGHTSCOMPLAINTS@usda.gov</a>      |   |

**This institution is an equal opportunity provider.**

**For this form in large print or another format, please call your county.**

## YOUR HEARING RIGHTS

### YOUR HEARING RIGHTS (See also PUB 412 at [www.cdss.ca.gov/inforesources/state-hearings](http://www.cdss.ca.gov/inforesources/state-hearings))

You can ask for a hearing if you disagree with a county/agency action or failure to act. You have **90 days** to do so, starting the day after the date of the notice. After 90 days, you must prove you had a good reason for asking late. You can also ask for a hearing to review your benefits for the past 90 days. If you ask for a hearing before the date of the change, your benefits will continue unchanged. CalFresh will end if you don't recertify when due.

- **Online** at [acms.dss.ca.gov](http://acms.dss.ca.gov) Click "Create an account" to have an ACMS account and get documents online; or click "Submit Appeal without Account" to file without an account **OR**
- **Call** toll free (800) 743-8525 (or TDD (800) 952-8349) **OR**
- **Fax** fill out this page/fax to (833) 281-0905 **OR**
- Fill out this page, and deliver it by one of the following:
  - o **In-person:** \_\_\_\_\_
  - o **Mail to:** CDSS State Hearings Division,  
PO Box 944243, MS 21-37  
Sacramento CA 94244-2430
  - o **Email to:** [SHDCSU@DSS.ca.gov](mailto:SHDCSU@DSS.ca.gov)

### HEARING REQUEST

1. My hearing issue involves \_\_\_\_\_ (benefit program) and \_\_\_\_\_ County/Agency.
2. I want a hearing because: \_\_\_\_\_
3. Print name of person who needs a hearing: \_\_\_\_\_ Birthdate: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
I want to get hearing notices from the State Hearing Division by email. **Email Address:** \_\_\_\_\_
5. **Name/Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_
6. Interpreter: I want a **free** interpreter for the \_\_\_\_\_ language or dialect.
7. Disability Accommodation for hearing? No Yes (explain): \_\_\_\_\_
8. Your Hearing will be scheduled by phone. If you want your hearing conducted by a different method, tell us how:  
By Telephone By Video (*you see judge on your phone/computer*) In person at the county hearing site  
I have no phone or Internet access. I want to go and use the phone or video at hearing site for my hearing.
9. I need a faster scheduled hearing due to Denial of CalWORKs or CalFresh emergency benefits  
Medical Emergency Eviction/homelessness Other (explain): \_\_\_\_\_
10. If you timely appeal before the action listed in the notice takes place, your aid may stay the same. For CalWORKs (including Child Care) and CalFresh, if the county action was correct, you have to pay back any extra aid.  
Check to have your aid lowered or stopped pending the hearing for: CalWORKs Childcare CalFresh
11. You can have a friend, relative, legal counsel or other person help with your hearing. **If they have agreed:**  
Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_
12. **To Get Help:** These groups below may be able to give you legal advice or represent you at the hearing:

# NOTICE OF DENIAL FOR REINSTATEMENT

COUNTY OF \_\_\_\_\_

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Case Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Worker Number : \_\_\_\_\_  
Telephone Number : \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Addressee)

<div></div>	<div></div>
<div></div>	<div></div>

Questions? Ask your Worker.

**State Hearing: If you think this action is wrong, you can ask for a hearing. The last page of this form tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.**

## DENIAL:

Your household's reinstatement of CalFresh benefits has been **denied** because:

**If you still want CalFresh benefits, you may reapply at any time.**

Rules: These rules apply: \_\_\_\_\_

You may review them at your local county office.

**CALFRESH BUDGET**

Report Month \_\_\_\_\_

Household Size \_\_\_\_\_

Total Countable Earned Income	\$ _____
Adjusted Countable Earned Income	\$ _____
Total Unearned Income	\$ _____
Child Support Paid	\$ _____
Net Countable Income	\$ _____
Standard Deduction	\$ _____
Dependent Care	\$ _____
Homeless Shelter Deduction	\$ _____
Excess Medical Expense for Aged/Disabled	\$ _____
Total Deductions	\$ _____
Preliminary Adjusted Income	\$ _____
Housing Expenses	\$ _____
Utility Expenses	\$ _____
Allowable Shelter Deduction	\$ _____
Adjusted Net Income	\$ _____
CalFresh Allotment	\$ _____
CFAP Allotment	\$ _____
Less Overissuance	\$ _____
Total CalFresh Allotment	\$ _____

**California offers two food benefit programs.**

*CalFresh is California's name for the federally funded Supplemental Nutrition Assistance Program (SNAP). To receive CalFresh benefits, you must meet federal rules, which require United States citizenship or certain immigration statuses (7 CFR 273.2(f) (1)(ii)(A) and MPP 63-403). CalFresh benefits appear in the budget as "CalFresh Allotment".*

*The California Food Assistance Program (CFAP) provides state funded food benefits to some immigrants who are not eligible for CalFresh. If immigration status is the only reason you or someone in your household is not eligible for CalFresh, then you may be eligible for CFAP. CFAP benefits appear in the budget as "CFAP Allotment".*

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Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

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<https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

- |                  |   |   |
|------------------|---|---|
| <b>1. Mail:</b>  | Food and Nutrition Service, USDA<br>1320 Braddock Place, Room 334<br>Alexandria, VA 22314; or | CDSS Civil Rights Bureau<br>P.O.BOX 944243, M.S. 9-7-041<br>Sacramento, CA 94244-2430; or |
| <b>2. Fax:</b>   | (833) 256-1665 or (202) 690-7442; or  |   |
| <b>3. Email:</b> | <a href="mailto:FNSCIVILRIGHTSCOMPLAINTS@usda.gov">FNSCIVILRIGHTSCOMPLAINTS@usda.gov</a>      |   |

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**For this form in large print or another format, please call your county.**



## YOUR HEARING RIGHTS

### YOUR HEARING RIGHTS (See also PUB 412 at [www.cdss.ca.gov/inforesources/state-hearings](http://www.cdss.ca.gov/inforesources/state-hearings))

You can ask for a hearing if you disagree with a county/agency action or failure to act. You have **90 days** to do so, starting the day after the date of the notice. After 90 days, you must prove you had a good reason for asking late. You can also ask for a hearing to review your benefits for the past 90 days. If you ask for a hearing before the date of the change, your benefits will continue unchanged. CalFresh will end if you don't recertify when due.

- **Online** at [acms.dss.ca.gov](http://acms.dss.ca.gov) Click "Create an account" to have an ACMS account and get documents online; or click "Submit Appeal without Account" to file without an account **OR**
- **Call** toll free (800) 743-8525 (or TDD (800) 952-8349) **OR**
- **Fax** fill out this page/fax to (833) 281-0905 **OR**
- Fill out this page, and deliver it by one of the following:
  - o **In-person:** \_\_\_\_\_
  - o **Mail to:** CDSS State Hearings Division,  
PO Box 944243, MS 21-37  
Sacramento CA 94244-2430
  - o **Email to:** [SHDCSU@DSS.ca.gov](mailto:SHDCSU@DSS.ca.gov)

### HEARING REQUEST

1. My hearing issue involves \_\_\_\_\_ (benefit program) and \_\_\_\_\_ County/Agency.
2. I want a hearing because: \_\_\_\_\_
3. Print name of person who needs a hearing: \_\_\_\_\_ Birthdate: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
I want to get hearing notices from the State Hearing Division by email. **Email Address:** \_\_\_\_\_
5. **Name/Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_
6. Interpreter: I want a **free** interpreter for the \_\_\_\_\_ language or dialect.
7. Disability Accommodation for hearing? No Yes (explain): \_\_\_\_\_
8. Your Hearing will be scheduled by phone. If you want your hearing conducted by a different method, tell us how:  
By Telephone By Video (*you see judge on your phone/computer*) In person at the county hearing site  
I have no phone or Internet access. I want to go and use the phone or video at hearing site for my hearing.
9. I need a faster scheduled hearing due to Denial of CalWORKs or CalFresh emergency benefits  
Medical Emergency Eviction/homelessness Other (explain): \_\_\_\_\_
10. If you timely appeal before the action listed in the notice takes place, your aid may stay the same. For CalWORKs (including Child Care) and CalFresh, if the county action was correct, you have to pay back any extra aid.  
Check to have your aid lowered or stopped pending the hearing for: CalWORKs Childcare CalFresh
11. You can have a friend, relative, legal counsel or other person help with your hearing. **If they have agreed:**  
Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_
12. **To Get Help:** These groups below may be able to give you legal advice or represent you at the hearing:

**REPLACEMENT OR DISASTER SUPPLEMENT AFFIDAVIT (CF 303)**

**Instructions:** Check the box(es) that apply to your household, then sign and return this form.  
**Note:** This form must be submitted within 10 days of your reported food-loss or your household may not be eligible to receive replacement benefits.

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.

**CURRENT HOUSEHOLD INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**DISASTER SUPPLEMENT**

- ☐ My household lived or worked in a federally declared disaster area with Individual Assistance (IA) and I have experienced one or more adverse effects as a result of the disaster.

**HOUSEHOLD AFFIDAVIT**

I, \_\_\_\_\_,  
declare that the household:

**ELECTRONIC BENEFITS TRANSFER (EBT)**

- ☐ EBT card was not received in the mail at the address below and the benefits have been transacted by an unauthorized person:

Mailing Address (Number, Street, P.O. Box)

City State Zip

- ☐ EBT card was reported lost/stolen to the county or to EBT hotline and the county, or the EBT hotline failed to cancel the EBT card and the benefits have been transacted by an unauthorized person.  
Reported on \_\_\_\_\_ at \_\_\_\_\_  
Date Time

**REPLACEMENT**

- ☐ Food destroyed in household misfortune or disaster. What happened and when:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I declare that my statement is true and correct to the best of my knowledge. I also understand that if I give wrong or incomplete facts I may be disqualified from the CalFresh Program, fined, imprisoned, or all three.



Signature Of Responsible Household Member Or Representative Date

**COUNTY USE ONLY**

Case Name: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Worker: \_\_\_\_\_  
Date CF 303 Received: \_\_\_\_\_

**REPLACEMENT/DISASTER SUPPLEMENT**

- ☐ APPROVED - EBT Replacement Date \_\_\_\_\_  
☐ APPROVED - Benefit Replacement Date \_\_\_\_\_  
CalFresh Benefit Replacement Amount \$ \_\_\_\_\_  
CFAP Benefit Replacement Amount \$ \_\_\_\_\_  
☐ APPROVED - Disaster Supplement Date \_\_\_\_\_  
Disaster Supplement Amount \$ \_\_\_\_\_  
☐ DENIED - Reason for Denial (Explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature (Person Authorizing Or Denying Request) Date

**Rules:** These rules may apply: \_\_\_\_\_  
You may review them at your local county office.

## YOUR HEARING RIGHTS

### YOUR HEARING RIGHTS (See also PUB 412 at [www.cdss.ca.gov/inforesources/state-hearings](http://www.cdss.ca.gov/inforesources/state-hearings))

You can ask for a hearing if you disagree with a county/agency action or failure to act. You have **90 days** to do so, starting the day after the date of the notice. After 90 days, you must prove you had a good reason for asking late. You can also ask for a hearing to review your benefits for the past 90 days. If you ask for a hearing before the date of the change, your benefits will continue unchanged. CalFresh will end if you don't recertify when due.

- **Online** at [acms.dss.ca.gov](http://acms.dss.ca.gov) Click "Create an account" to have an ACMS account and get documents online; or click "Submit Appeal without Account" to file without an account **OR**
- **Call** toll free (800) 743-8525 (or TDD (800) 952-8349) **OR**
- **Fax** fill out this page/fax to (833) 281-0905 **OR**
- Fill out this page, and deliver it by one of the following:
  - o **In-person:** \_\_\_\_\_
  - o **Mail to:** CDSS State Hearings Division,  
PO Box 944243, MS 21-37  
Sacramento CA 94244-2430
  - o **Email to:** [SHDCSU@DSS.ca.gov](mailto:SHDCSU@DSS.ca.gov)

### HEARING REQUEST

1. My hearing issue involves \_\_\_\_\_ (benefit program) and \_\_\_\_\_ County/Agency.
2. I want a hearing because: \_\_\_\_\_
3. Print name of person who needs a hearing: \_\_\_\_\_ Birthdate: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
I want to get hearing notices from the State Hearing Division by email. **Email Address:** \_\_\_\_\_
5. **Name/Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_
6. Interpreter: I want a **free** interpreter for the \_\_\_\_\_ language or dialect.
7. Disability Accommodation for hearing? No Yes (explain): \_\_\_\_\_
8. Your Hearing will be scheduled by phone. If you want your hearing conducted by a different method, tell us how:  
By Telephone By Video (*you see judge on your phone/computer*) In person at the county hearing site  
I have no phone or Internet access. I want to go and use the phone or video at hearing site for my hearing.
9. I need a faster scheduled hearing due to Denial of CalWORKs or CalFresh emergency benefits  
Medical Emergency Eviction/homelessness Other (explain): \_\_\_\_\_
10. If you timely appeal before the action listed in the notice takes place, your aid may stay the same. For CalWORKs (including Child Care) and CalFresh, if the county action was correct, you have to pay back any extra aid.  
Check to have your aid lowered or stopped pending the hearing for: CalWORKs Childcare CalFresh
11. You can have a friend, relative, legal counsel or other person help with your hearing. **If they have agreed:**  
Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_
12. **To Get Help:** These groups below may be able to give you legal advice or represent you at the hearing: