Amador County Specialized Care Increment Plan

June 27, 2018

Amador County’s Specialized Care Increment (SCI)/Specialized Care Rate Program provides a supplemental payment to the resource family home provider, in addition to the Level of Care (LOC) rate, for the cost of care and supervision performed or facilitated by the resource parent(s) to meet the additional daily care needs of a child who has behavioral, emotional, and/or physical (including health) challenges. The SCI is intended to meet any needs that are not met by the established LOC rate. The LOC and SCI can be based on the same condition(s) when the care and supervision needs of the child are not met by the determined LOC rate.

Population Served
Children/youth in foster care, including Non-Minor Dependents, will be eligible for SCI consideration, including children receiving foster care benefits in a Non-Relative Legal Guardianship, Kin-GAP, or AAP. The SCI is not available for a child/youth receiving ISFC, placed in TFC (Therapeutic Foster Care), residing in a SILP (Supervised Independent Living Program), or residing in a Group Home/STRTP (Short Term Residential Therapeutic Program). The SCI is also not available for a child who is receiving a Dual Agency Rate as a regional center client.

Currently, there are no children in Amador County who are receiving an SCI. It is anticipated, based on historical information, that there could be, with the implementation of this plan, 4-5 children at any given time receiving an SCI. Information regarding the SCI will be shared at Child and Family Team meetings.

Establishing the SCI
Amador County will utilize a three tiered matrix to establish the SCI. See below. Each tier can be applied to any LOC rate, except for the ISFC (Intensive Services Foster Care) level. Within the mandated timeframes, including the defined triggering events, the social worker assigned to the child’s case will complete the LOC protocol to determine the foster care rate and the SCI worksheet. (See attached worksheet.) To correctly determine the tier, the social worker will have gathered information from the resource parent, biological parents, providers, the child and family team, etc. The social worker will give the completed worksheet to his/her social worker supervisor for review and approval, who will then forward the worksheet to the Program Manager for second level approval. The effective date of the SCI will be the date the Program Manager, or his/her designee, signs the worksheet. The worksheet will be given to the foster care eligibility worker. A copy of the worksheet will be maintained in the child welfare case file. The social worker will enter the SCI rate amount in the placement section of the child welfare case management system, currently CWS/CMS. The eligibility worker will be responsible for issuing the applicable Notice of Action. (See attached Notices of Action.)

Note that there may be exceptional circumstances in which an SCI is needed prior to an initial
LOC rate determination to immediately stabilize a foster care placement. In these instances, the same procedure as above will be followed, and if approved, the SCI will be applied to the basic rate.

Reassessment
The SCI will be reassessed every six months. In between the reassessment periods, the SCI may be reevaluated should the resource parent request a reassessment, should the social worker become aware that the child’s needs have changed, or should the social worker determine that the LOC is not meeting the child’s needs. (This may likely coincide with a new LOC assessment as well.) Should a change be made, the procedures above will be followed, and the foster care eligibility worker will issue the appropriate Notice of Action. Again, the effective date will be the date that the social worker, supervisor, and program manager sign the SCI worksheet.

Implementation
Amador County’s SCI plan will go into effect once the LOC protocol is fully implemented by CDSS. Currently, there are no children in Amador County receiving an SCI to be transitioned to the new SCI plan.

Children/youth placed out of county
Out of county SCI rates will be determined using the county of residences’ criteria and methodology. If the county of residence has no SCI plan, then Amador County will pay using its own SCI rates.

Specialized Care Increment Rates

<table>
<thead>
<tr>
<th>Tier</th>
<th>Add $100.00 to the Level of Care rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2</td>
<td>Add $150.00 to the Level of Care rate</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Add $200.00 to the Level of Care rate</td>
</tr>
</tbody>
</table>

Amador County will apply the same cost of living increases used for the LOC rates to the SCI rates with the same effective dates.

Amador County SCI point of contact
Anne Watts, Program Manager
awatts@amadorgov.org
(209)223-6550
10877 Conductor Blvd.
Sutter Creek, CA 95685

SCI Matrix
The following table is not intended to include every possible condition or situation, but is rather intended as a basic guidelines. In general, the conditions are suggested to be the minimum for a particular Tier, especially for Tier 3.
<table>
<thead>
<tr>
<th>Tier 1 **If three (3) or more of the Tier 1 conditions listed exist, rate will be increased to the next higher level.</th>
<th>Tier 2 **If three (3) or more Tier 2 conditions exist, or two (2) Tier 2 conditions and three (3) Tier 1 conditions exist, or one (1) Tier 2 conditions and six (6) Tier 1 conditions exist, rate will be increased to the next higher level.</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug exposed history or positive toxicology screen.</td>
<td>4-6 appointments per month not including routine dental or physical examinations.</td>
<td>More than 6 appointments per month not including routine dental or physical examinations.</td>
</tr>
<tr>
<td>Alcohol exposure (FAS, FASD or FAE)</td>
<td>Positive toxicology screen at birth (level should be reduced at 6 month review if baby is not exhibiting any symptoms or difficulties)</td>
<td>FAS/FASD with moderate to severe complications (verifiable medical diagnosis)</td>
</tr>
<tr>
<td>Respiratory Difficulties and Diseases</td>
<td>Confirmed by maternal history, drug and/or alcohol exposure prenatal with symptoms. (level should be reduced at 6 month review if infant is not exhibiting any symptoms or difficulties)</td>
<td>Conditions requiring daily at home Physical Therapy (PT), Occupational Therapy (OT), in addition to weekly or biweekly therapy sessions.</td>
</tr>
<tr>
<td>Failure to Thrive</td>
<td>Apnea or heart monitor required (when discontinued, rate to be reduced to appropriate level)</td>
<td>Severe feeding problems, excessive crying, sleep disruptions, etc. due to alcohol/drug exposure</td>
</tr>
<tr>
<td>Diabetes &amp; Heart Disease</td>
<td>Moderate feeding difficulties requiring therapy or special feeding techniques.</td>
<td>Continuous oxygen.</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>Seizures requiring intermittent monitoring, medications and other interventions to control.</td>
<td>Diabetes with special diet, close monitoring of daily blood sugars levels, insulin injections, etc., Minor is compliant with program.</td>
</tr>
<tr>
<td>Seizures</td>
<td>Severe respiratory difficulties requiring medications, breathing treatments (not including the use of inhalers) and/or CPT (Chest Physical Therapy) on a daily basis.</td>
<td>Hemophiliac requiring close monitoring to prevent injury.</td>
</tr>
<tr>
<td>Physical</td>
<td></td>
<td>Minor requires 4 or more injections per week (i.e. growth hormone, asthma, etc)</td>
</tr>
<tr>
<td>Brain Injury (abuse or accidental)</td>
<td>Diabetes with special diet and oral medications. Stable condition, child compliant with prescribed program.</td>
<td>Child requires continuous care and supervision on a daily basis in accordance with a prescribed treatment plan that would otherwise require placement in an institutional facility.</td>
</tr>
<tr>
<td>Visually impaired (birth, abuse, or accidental)</td>
<td>Medical diagnosis of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Disorder (FASD). Not the same as prenatal alcohol exposure Fetal Alcohol Effect (FAE).</td>
<td>Visual or hearing impaired requiring constant care provider assistance with daily</td>
</tr>
<tr>
<td>Hearing impaired (birth, abuse, or accidental)</td>
<td>Shunt placement-functioning stable</td>
<td></td>
</tr>
<tr>
<td>Immune Disorders</td>
<td>Sickle Cell SB Thal Moderate Symptoms 11. Minor requires 1-3 injections per week (i.e. growth hormones, asthma, etc).</td>
<td></td>
</tr>
<tr>
<td>Surgical intervention</td>
<td>Clef lip requiring surgical intervention and special feeding assistance.</td>
<td></td>
</tr>
<tr>
<td>Orthopedic abnormalities (birth or abuse) (i.e. scoliosis)</td>
<td>Physical abnormalities requiring medical intervention.</td>
<td></td>
</tr>
<tr>
<td>Severe burns</td>
<td>Moderate Cerebral Palsy or</td>
<td></td>
</tr>
<tr>
<td>Area</td>
<td>Tier 1 **If three (3) or more of the Tier 1 conditions listed exist, rate will be increased to the next higher level.</td>
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<td>------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>□ Sickle Cell – SB + Thal, Mild Symptoms. □ Mild/moderate Cerebral Palsy requiring minimal additional assistance with feeding, dressing, bathing, etc. □ Minimal brain injury requiring minimal additional observations and guidelines. No shunt required or with stable shunt requiring no medical intervention. □ Visual condition is stable and infrequent intervention is needed (e.g., eye drops or eye patch). □ Hearing condition is stable and infrequent intervention is needed or hearing aid is needed. □ Minimal bracing equipment is needed (i.e. AFO's) □ Other:</td>
<td>□ Physical disability requiring assistance with feeding, dressing, etc. □ 2nd degree burns requiring regular, but not daily dressing changes. This generally applies to children 8 or over who can cooperate with the treatment plan. □ Visually impaired requiring minimal assistance with daily living (i.e. Mobility, special education, etc.) 17. Hearing-impaired requiring moderate assistance (i.e. specialized communication techniques, speech therapy, and special school program). □ Scoliosis requiring assisted daily exercise and/or bracing. □ Other:</td>
</tr>
<tr>
<td></td>
<td><strong>Developmental delays or disabilities</strong> Developmental Delay Developmental Disability (e.g., Intellectual Disability, Autism Spectrum etc.) Learning Delays or Disabilities Sensory Integration Disorder</td>
<td><strong>Behavioral Issues</strong> AWOL</td>
</tr>
<tr>
<td></td>
<td>□ Moderate developmental delays or disabilities requiring weekly care provider assistance. □ Other:</td>
<td>□ Behavior modification required but no □ Behavior modification needed in conjunction with prescribed</td>
</tr>
<tr>
<td>Area</td>
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</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Aggressive and Assaultive</td>
<td>medication prescribed.</td>
<td>daily medication.</td>
</tr>
<tr>
<td>Animal Cruelty</td>
<td>□ The child presents some risky behaviors sometimes placing self and/or others at risk.</td>
<td>□ The child is at high risk to self and/or others. Behaviors frequently are disruptive to household, school and in other social interactions.</td>
</tr>
<tr>
<td>CSEC</td>
<td>□ Close supervision is sometimes necessary to minimize risk and/or reduce potential for disruption.</td>
<td>□ Stabilization of disruptive behaviors requires special intervention and discipline strategies.</td>
</tr>
<tr>
<td>Substance Use/Abuse</td>
<td>□ Psychotropic medication may be required with close supervision by care provider and increased follow up by therapeutic provider.</td>
<td>□ Care provider needs special training and participates in counseling with the minor to accomplish this.</td>
</tr>
<tr>
<td>Gang Activity</td>
<td>□ Other:</td>
<td>□ Chronic resistance to behavior modification strategies.</td>
</tr>
<tr>
<td>Fire Setting</td>
<td>□ Other:</td>
<td>□ Personal property of others in the home at high risk.</td>
</tr>
<tr>
<td>Severe mental health issues—including suicidal ideation and/or Self Harm</td>
<td>□ Other:</td>
<td>□ Excessive anti-social behaviors which strictly limits unsupervised social interaction.</td>
</tr>
<tr>
<td>Psychiatric hospitalization(s)</td>
<td>□ Other:</td>
<td>□ Other:</td>
</tr>
<tr>
<td>Adjudicated violent offenses, significant property damage, and/or sex offenders/perpetrators</td>
<td>□ Other:</td>
<td>□ Other:</td>
</tr>
<tr>
<td>Habitual Truancy</td>
<td>□ Other:</td>
<td>□ Other:</td>
</tr>
<tr>
<td>Three or more placements due to the child’s behavior</td>
<td>□ Other:</td>
<td>□ Other:</td>
</tr>
</tbody>
</table>

References
All County Information Notice I-05-10
All County Letter 17-11
All County Letter 18-48
SPECIALIZED CARE INCREMENT WORKSHEET

Child’s Name: ________________________    DOB: ______________

Child’s assessed LOC: __________    Date of LOC determination: __________

This child’s needs for a Specialized Care Increment are based on the following:

( ) MEDICAL CONDITIONS
   ( ) Tier 1
   ( ) Tier 2
   ( ) Tier 3

( ) DEVELOPMENTAL DELAYS OR DISABILITIES
   ( ) Tier 1
   ( ) Tier 2
   ( ) Tier 3

( ) BEHAVIORAL ISSUES
   ( ) Tier 1
   ( ) Tier 2
   ( ) Tier 3

Recommended Tier: ______________

Attach completed Specialized Care Increment Matrix.

Comments:

Social Worker Signature ___________________________    Date ___________________________

Supervisor Signature ___________________________    Date ___________________________

Program Manager ___________________________    Date ___________________________

If approved, effective date: ______________

)approved ( ) denied

*Provide this form to the foster care eligibility worker. Place copy in CPS case file. If approved, enter SCI in CWS/CMS.*

Reassessment Due Date (every six months): ___________________________
NOTICE OF ACTION
For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians

(ADDRESSEE)

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

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

☐ The County has approved your Foster Care aid.

As of ____________, the county is Approving your Foster Care aid
(Date)
of $ ____________, per month.

This aid is for: _______________________________________
(Name of Child)

As of ____________, the county is Changing your Foster Care aid
(Date)
from $ ____________ to $ ____________.

This aid is for: _______________________________________
(Name of Child)

Here's why: Your rate is based on a level of care determination as defined in AB 403 and WIC section 11461.

☐ Your case had a rate increase.

☐ Your case had a rate decrease.

☐ Your case has been issued an Infant Supplemental Payment.

☐ Your case has been issued a Supplemental Care Increment.
NOTICE OF ACTION
For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians

(APPLECSEE)

Notice Date: ________________________________
Case Name: ______________________________________
Number: ______________________________________
Worker Name: ______________________________________
Number: ______________________________________
Telephone: ______________________________________
Address: ______________________________________

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

☐ The child has __________________________ income.
(Countable)

☐ __________________________ for __________________________
(Income Type) (Name of Child)
of $ ______________________ effective ______________________
(Date)
This is counted as ___________________________ income in the
(earned/Unearned)
Foster Care budget calculation.

☐ Other: ______________________________________

☐ Your case has been discontinued.

As of _______________________ the county is Discontinuing your
(Date)
Foster Care aid.

Here's why:

☐ You are no longer providing foster care
for: __________________________
(Name of Child)

☐ He/she is no longer living in your home/facility. The County will
stop paying for Foster Care from the day the child leaves your
home/facility.

☐ He/she no longer meets the age rules.

☐ The child has too much income.

☐ The child has too much property. See attached page.
NOTICE OF ACTION
For Resource Families, including homes certified by a Foster Family Agency, County Approved Relative Homes, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians

(ADDRESSEE)

Notice Date:________________________
Case Name:__________________________
Number:____________________________
Worker Name:________________________
Number:____________________________
Telephone:___________________________
Address:____________________________

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

☐ The legal guardianship was terminated.
☐ You moved out of the State of California.
☐ You did not return your completed redetermination paperwork.
☐ Other: ______________________________

☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.

Rules: These rules apply. You may review WIC sections: 11460, 11461, 11463, 11463.23, and 16519.
YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop:  □ Cash Aid  □ CalFresh  □ Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:
You do not have to take part in the activities.
You may receive child care payments for employment and for activities approved by the county before this notice.
If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.
If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.
- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:
- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county’s written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. (W&I Code Sections 10890 and 10896.)

TO ASK FOR A HEARING:

- Fill out this page.
- Make a copy of the front and back of this page for your records.
- If you ask, your worker will get you a copy of this page.
- Send or take this page to:

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

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of __________________________ County about my:

□ Cash Aid  □ CalFresh  □ Medi-Cal  □ Other (list)

Here’s Why:

□ If you need more space, check here and add a page.
□ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is:

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE:

PHONE NUMBER:

STREET ADDRESS:

CITY  STATE  ZIP CODE:

SIGNATURE:

DATE:

NAME OF PERSON COMPLETING THIS FORM:

PHONE NUMBER:

□ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

NAME:

PHONE NUMBER:

STREET ADDRESS:

CITY  STATE  ZIP CODE:

NA BACK 9 (REV. 4/01/15) - REQUIRED FORM - NO SUBSTITUTE PERMITTED
NOTICE OF ACTION - APPROVAL, CHANGE OR DISCONTINUED
For Kinship - Guardians Only

Notice Date: ____________________________
Case Name: ____________________________
Number: ________________________________
Worker Name: ____________________________
Number: ________________________________
Telephone: ______________________________
Address: ____________________________________________

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

APPROVAL

☐ The County has approved your Kin-GAP aid.
As of ________________, the county is Approving Kin-GAP aid
of $ ______________ per month.
This aid is for: ________________________________________.

CHANGE

As of ________________, the county is Changing your Kin-GAP aid
from $ ______________ to $ ______________.
This aid is for: ________________________________________.

Here’s why: Your rate is based on a level of care determination as
defined in AB 403 and WIC section 11461.
☐ Your case had a rate increase.
☐ Your case had a rate decrease.
☐ Your case has been issued an Infant Supplemental Payment.
☐ Your case has been issued a Supplemental Care Increment.
☐ The child has countable income.

_______________________ for _______________________
(Income Type) (Child’s Name)
of $ ______________ is effective ____________.
This is counted as ______________________ income in the
Kin-GAP budget calculation.
☐ Other: __________________________________________

☐ Due to funding requirements, you may receive multiple checks
for this benefit month. The sum of these checks will be equal to
the amount listed above.

NA 403A (4/17) REQUIRED FORM - SUBSTITUTES PERMITTED

Page ____ of ____
NOTICE OF ACTION - APPROVAL, CHANGE OR DISCONTINUED
For Kinship - Guardians Only

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

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

DISCONTINUED

☐ Your case has been discontinued.
As of __________, the county is Discontinuing your
Kin-GAP aid of $ ___________ per month.

Here's why:
☐ You are no longer providing support for: ______________________________________
He/she no longer meets the age rules.
☐ The youth is at least 18 years of age and does not qualify for extended Kin-GAP.
☐ The youth is at least 21 years of age.
☐ The child has too much income.
☐ The child has too much property. See attached page. If the County figured that the child's vehicle or other property was worth more than you think it's worth, you can give the County proof that it is worth less. Ask the County how. If you can prove it is worth less the child may get Kin-GAP aid.
☐ The legal guardianship was terminated.
☐ You did not return your completed redetermination paperwork.
☐ Other: ______________________________________

Page ____ of ___
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If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh ☐ Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:
You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

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

NAME: ________________________________ PHONE NUMBER: ________________________________

STREET ADDRESS:

CITY: ________________________________ STATE: __________ ZIP CODE: __________

NA BACK 5 (REPLACES NA BACK 8 AND 8P 5) (REVISED 4/2013) - REQUIRED FORM - NO SUBSTITUTE PERMITTED