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

WILL LIGHTBOURNE
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

REASON FOR THIS TRANSMITTAL

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

June 25, 2014

ALL COUNTY LETTER 14-37

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CalWORKs PROGRAM SPECIALISTS
ALL CONSORTIUM PROJECT MANAGERS
ALL QUALITY CONTROL PROGRAM COORDINATORS

SUBJECT: UPDATED FORMS FOR THE CALFRESH PROGRAM

REFERENCE: ASSEMBLY BILL 6 (Chapter 501, Statutes of 2011), ALL COUNTY LETTER (ACL) 12-25; ACL13-08; ACL 13-17

The purpose of this letter is to transmit updated CalFresh forms. The California Department of Social Services (CDSS) is in the process of updating forms from their prior 'DFA' and 'FS' designations. The forms have been updated to reflect the new form numbers, new 'CF' designation, referenced the updated numbers for prior forms, and updated any references of 'Food Stamps' to 'CalFresh.' Any additional changes are listed on the attachment.

CAMERA READY COPIES AND TRANSLATIONS

For camera-ready copies in English, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has internet access you may obtain these forms from the CDSS webpage at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

When all translations are completed per Manual of Policies and Procedures (MPP) Section 21-115.2, including Spanish forms, they are posted on an on-going basis on the CDSS webpage. Copies of the translated forms can be obtained at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

For questions on translated materials, please contact 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.

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 county's responsibility to provide the translation if an applicant or recipient requests it. 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: http://www.dss.cahwnet.gov/lettersnotices/default.htm

If you have any questions regarding this letter, please contact your CalFresh county consultant or call the CalFresh Policy Bureau at (916) 651-8047.

Sincerely,

Original Document Signed By:

TODD R. BLAND
Deputy Director
Welfare to Work Division

Enclosure:
CalFresh Updated forms list and referenced forms

Enclosure
CALFRESH UPDATED FORMS

Form #	Form Title, Description, Explanation of Changes, and Directions for Use
CF 18 (ENG/SP) (02/14)	**Important Information** This form replaces the FS 18. The purpose of this form has not changed. This form was updated to replace 'Food Stamps' with 'CalFresh'.
CF 20 (04/13)	**You Do Not Owe Anything for Receiving CalFresh Benefits** This form replaces the FS 20. The purpose of this form has not changed. This form was updated to replace 'Food Stamps' with 'CalFresh' and 'Food and Consumer Service' with 'Food and Nutrition Service'.
CF 21 (04/13)	**Release Form** This form replaces the FS 21. The purpose of this form has not changed. This form was updated to replace 'Food Stamps' with 'CalFresh' and 'Food and Consumer Service' with 'Food and Nutrition Service'.
CF 23 SAR (1/14)	**CalFresh Benefits How to Report Household Changes (Required Form, Substitutes Permitted)** This form replaces the 06/13 version of the CF 23 SAR. The purpose of this form has not changed. This form was updated to remove language for non-mandatory reports for fleeing felons and members over age 60.
CF 23 CR (2/14)	**CalFresh Benefits How to Report Household Changes (Required Form, Substitutes Permitted)** This form replaces the 08/13 version of the CF 23 CR. The purpose of this form has not changed. This form was updated to remove language for non-mandatory reports for fleeing felons and members over age 60.
CF 27 (2/13)	**Non-Assistance CalFresh (NACF) Household Recertification Form (Recommended Form)** This form replaces the FS 27. The purpose and content of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'.
CF 28 (02/14)	**CalFresh Program Restricted Account Coversheet (Required Form, Substitutes Permitted)** This form replaces the FS 28. The purpose and content of this form has not changed. This form was updated to change references from 'Food Stamps' with 'CalFresh' and the cash limit for Elderly/Disabled households from $3000 to $3250.

CF 28A (02/14) **CalFresh Program Restricted Account Agreement Part A (Required Form, Substitutes Permitted)**
This form replaces the FS 28A. The purpose and content of this form has not changed. This form was updated to change references from 'Food Stamps' with 'CalFresh' and the cash limit for Elderly/Disabled households from $3000 to $3250.

CF 28B (02/14) **CalFresh Program Restricted Account Agreement Part B (Required Form, Substitutes Permitted)**
This form replaces the FS 28B. The purpose and content of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'.

CF 303 (02/13) **Replacement Affidavit/Authorization (CF 303) (Required Form, Substitutes Permitted)**
This form replaces the FS 303. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'.

CF 377.4 CR (02/13) **CalFresh Notice of Change for Change Reporting Household (Required Form, Substitute Permitted)**
This form replaces DFA 377.4 QR for Change Reporting households. The use of this form has not changed. This form is used to inform households of a change to household benefits. This form was updated to replace references of 'Food Stamps' with 'CalFresh'.

CF 377.4A (02/13) **CalFresh Notice of Change (Required Form, No Substitutes Permitted)**
This form replaces DFA 377.4A. The use of this form has not changed. This form is used to inform households of a change to household benefits. This form was updated to replace references of 'Food Stamps' with 'CalFresh'.

CF 377.5 SAR (9/13) **CalFresh Mid-Certification Period Status Report (Required Form, No Substitutes Permitted)**
This form replaces the current CF 377.5 SAR. The use of this form has not changed. This form was updated to spell out the acronyms 'Able-Bodied Adults Without Dependents' (ABAWD) and 'Income Reporting Threshold' (IRT).

CF 377.5 CR (11/13) **CalFresh Household Change Report (CF 377.5 CR)**
This form replaces the DFA 377.5. The purpose of this form has not changed. This form was revised to include only required reports and a section for voluntary reports of increased medical or child care expenses. This form was updated to change references from 'Food Stamps' with 'CalFresh' and the cash limit for Elderly/Disabled households from $3000 to $3250.

CF 387 (5/14)

CalFresh Request for Information (Required Form, Substitutes Permitted)

This form replaces the DFA 387. The purpose of this form has not changed.

CF 389 (2/14)

Notice of Denial of Restoration (Required Form, Substitutes Permitted)

This form replaces the DFA 389. The purpose of this form has not changed. This form was updated to replace 'Food Stamps' with 'CalFresh'.

CF 842 (2/14)

Claim Determination Worksheet (Required Form, Substitutes Permitted)

This form replaces the DFA 842. The purpose of this form has not changed. This form was updated to replace 'Food Stamps' with 'CalFresh'.

CF 1239 (4/14)

CalFresh Notice of Approval/Denial/Termination Transitional Benefits (Required Form, Substitutes Permitted)

This form replaces the DFA 1239. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'. The State Hearings box font is now in bold and enlarged to 12 point font.

NA 290 (02/14)

Notice of Action (Required Form, Substitutes Permitted)

This form replaces the current version of the NA 290. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'. The State Hearings box font is now in bold and enlarged to 12 point font.

NA 816 (03/14)

Notice of Action (Required Form, Substitutes Permitted)

This form replaces the current version of the NA 816. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh' and hyphenated references of 'Welfare-to-Work'.

NA 817 (03/14)

Notice of Action (Required Form, Substitutes Permitted)

This form replaces the current version of the NA 817. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh' and hyphenated references of 'Welfare-to-Work'.

NA 818 (03/14)

Notice of Action (Required Form, Substitutes Permitted)

This form replaces the current version of the NA 818. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh' and hyphenated references of 'Welfare-to-Work'.

NA 840 (03/14) **Notice of Action (Required Form, Substitutes Permitted)**
This form replaces the current version of the NA 840. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh' and hyphenated references of 'Welfare-to-Work'.

NA 841 (03/14) **Notice of Action (Required Form, Substitutes Permitted)**
This form replaces the current version of the NA 841. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh' and hyphenated references of 'Welfare-to-Work'.

NA 845 (03/14) **Notice of Action (Required Form, Substitutes Permitted)**
This form replaces the current version of the NA 845. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh' and hyphenated references of 'Welfare-to-Work'.

NA 995 (05/13) **CalFresh Notice of Denial/Disqualification For the California Food Assistance Program (Required Form, Substitutes Permitted)**
This form replaces the current version of the NA 995. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'. The State Hearings box font is now in bold and enlarged to 12 point font.

NA 1240 (04/13) **Notice of Action CalFresh Overissuance and Dormant EBT Account (Required Form, Substitutes Permitted)**
This form replaces the current version of the NA 1240. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'. The State Hearings box font is now in bold and enlarged to 12 point font.

NA 1267 (04/13) **CalFresh Informing Notice of Receiving Intercounty Transfer (Required Form, Substitutes Permitted)**
This form replaces the current version of the NA 1267. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'. The State Hearings box font is now in bold and enlarged to 12 point font.

NA 1268 (04/13) **CalFresh Informing Notice of Sending Intercounty Transfer (Required Form, Substitutes Permitted)**
This form replaces the current version of the NA 1268. The purpose of this form has not changed. This form was updated to change references from 'Food Stamps' to 'CalFresh'. The State Hearings box font is now in bold and enlarged to 12 point font.

IMPORTANT INFORMATION

The County asked for and got a "Quarters of Coverage History" from Social Security for you. The information does not show that there are the 40 eligible quarters of work, which you must have to be eligible for CalFresh.

If you think that the information from Social Security is wrong or incomplete, you may contact Social Security and ask for an appeal. If you do ask for an appeal, Social Security will give you proof that a review is being done.

If you give the County this proof, you can get CalFresh benefits for up to six months from the date of application, or until Social Security finishes the review, whichever is sooner.

If Social Security decides that there are not enough quarters for you to be eligible for CalFresh, all the CalFresh benefits you get while they are doing their review will be an overissuance. You will have to pay them back.

INFORMACIÓN IMPORTANTE

El Condado pidió y recibió de la Administración del Seguro Social (SSA), un historial suyo de los trimestres de cobertura conocido en inglés como "*Quarters of Coverage History".* La información que contiene este historial no muestra que usted haya trabajado los 40 trimestres que reunieran los requisitos y que usted necesita para ser elegible para CalFresh.

Si cree que la información que proporcionó la SSA está equivocada o incompleta, puede ponerse en contacto con la SSA y presentar una apelación. Si presenta una apelación, la SSA le dará pruebas de que se está revisando su historial.

Si le presenta estas pruebas al Condado, puede recibir beneficios de CalFresh hasta pr seis meses a partir de la fecha en que el Condado recibió el historial de cobertura, o hasta que la SSA complete la revisión de su caso, lo que ocurra primero.

Si la SSA decide que usted no tiene los suficientes trimestres para ser elegible para CalFresh, la cantidad completa de beneficios de CalFresh que haya recibido mientras que se revisaba su historial de cobertura, sen considerará una emisión excesiva. Usted tendrá que reembolsar esta cantidad.

YOU DO NOT OWE ANYTHING FOR RECEIVING CALFRESH BENEFITS

DATE:	CLIENT NAME:

We received your payment dated _____ and signed by _____in the amount of _____ dollars ($_____) to repay CalFresh benefits received by you in the past. You received CalFresh legally and are under no obligation to make any repayments.

However, if you wish to make a voluntary donation, you can make it payable to the FOOD AND NUTRITION SERVICE (FNS). You can send us the payment for processing, and we will forward it to the appropriate FNS office. **DO NOT SEND CASH.**

If you send a voluntary donation, you must complete the attached release form and return it, along with your voluntary donation, to our office located at:

Information on your donation(s) will not be disclosed to the U.S. Consulate General Office unless you authorize us in writing to do so.

If you have any questions regarding this notice, you may contact:

Name:_____ Phone:_____

RELEASE FORM

NOTICE: This is a legally binding document. Consult your attorney if you do not understand any part of it.

THIS RELEASE is made on the _____day of_____, 20_____, by

_____
(PRINT NAME)

whose residence and/or mailing address is

_____
(PRINT ADDRESS)

I understand that I owe no debt to the Food and Nutrition Service (FNS), and I relinquish all rights to donated funds in the amount of _____ dollars ($_____), tendered to FNS on this date. I understand such funds are a donation to and made payable to FNS, and that the donation to FNS is not returnable. I agree that the funds are donated with no expectation of something in return from any federal, state, or local government entity.

SIGNATURE:	DATE:

CALFRESH BENEFITS
HOW TO REPORT HOUSEHOLD CHANGES

Everyone who receives CalFresh benefits must report when their income or household situation changes. If you're not sure how to report changes, what changes to report, or what proof we need, be sure to ask your worker. You are receiving this notice because:

☐ You have been approved for CalFresh benefits and will be reporting changes on a Change Reporting basis.
☐ Your household was previously assigned Semi-Annual Reporting status and will now be reporting on a Change Reporting basis.

Change Reporting requirements are described below.

CHANGE REPORTING

You **MUST** report the following changes within ten days:

- If your household has a change in the source of monthly earned income, or your household's monthly earned income starts, stops, or changes by more than $100.00.
- If your household has a change in the source of monthly unearned income, or your household's monthly unearned income starts, stops, or changes by more than $50.00.
- Anyone's source of income changes.
- You move in with someone else or anyone moves into or out of your home, including newborns, other children, spouses, other relatives or non-relatives.
- Anyone moves to another address, plans to move or gets a new mailing address.
- Your household's total cash, stocks, bonds or other money is more than $2000 (or $3250 if someone in your household is age 60 or over or disabled).
- If there is a change in the amount of any court ordered child support paid by a member of the household for a child not living in the home.
- If you are meeting the Able Bodied Adult Without Dependents (ABAWD) work rule by working and your work hours drop below 20 hours a week or 80 hours a month. CalFresh rules limit the receipt of CalFresh benefits to 3 months in a 3-year period for ABAWDs who are not working or participating in other allowable activities. You are excused from the ABAWD work rule and do not need to report a drop in your work hours if you are:
  - Living in a county where the ABAWD work rule is waived because of high unemployment rates;
  - Under 18 or 50 years of age or older;
  - Medically certified as physically or mentally unfit for employment'
  - Meeting the CalWORKs Welfare-To-Work rules
  - Caring for an injured or sick person who will need help for more than 30 days;
  - Participating in an alcohol or drug treatment program that keeps you from working 30 hours or more per week;
  - Getting or have applied for Unemployment Insurance benefits;
  - Employed or self-employed at least 30 hours per week or receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours;
  - Going to school at least half-time;
  - Pregnant; or
  - Living in a CalFresh household that contains a minor child even if the minor child is not eligible for CalFresh benefits.

You **MAY** report when:

- Anyone's physical or mental illness begins or ends.
- Anyone's citizenship, immigration status changes or anyone gets a letter, form or new card from the U.S. Citizenship and Immigration Services (USCIS) (formerly INS).
- You have changes in your dependent care costs.
- Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refigured.
- Any member begins to pay court-ordered child support for a child not living in the home.

You may report changes either:

- By mail, telephone, or in person at the County CalFresh Office; or
- By turning in a CF 377.5 CR CalFresh Household Change Report form.

TRANSITIONAL CALFRESH BENEFITS

California's Transitional CalFresh program provides CalFresh benefits for five months to households that leave CalWORKs. If your household begins receiving transitional CalFresh benefits, you do not have to report while receiving these benefits.

If you are receiving transitional CalFresh benefits, you may reapply to see if you can get more benefits. If you reapply and are approved for regular CalFresh benefits, then all normal reporting rules will apply.

CALFRESH BENEFITS
HOW TO REPORT HOUSEHOLD CHANGES

Everyone who receives CalFresh benefits must report when their income or household situation changes. If you're not sure how to report changes, what changes to report, or what proof we need, be sure to ask your local county office. You are receiving this notice because:

☐ You have been approved for CalFresh benefits and will be reporting changes on a Semi-Annual basis.
☐ Your household was previously assigned Change Reporting status and will now be reporting on a Semi-Annual basis.

Semi-Annual Reporting requirements are described below.

SEMI-ANNUAL REPORTING

As a semi-annual reporting household, you will need to turn in a completed Semi-Annual Report form (SAR 7) due by the 5th day of the 6th month after your most recent certification. If you do not turn in your completed SAR 7 by the end of the first working day of the next (7th) month, your benefits will stop.

Your worker will use the income and expense information reported on the SAR 7 to calculate your CalFresh benefits for the remainder of the certification period.

For example:
You completed your annual recertification in May. Your SAR 7 will be due 6 months later, on November 5th and you will report what income you had in October. You will also report any income changes you expect to have in December, January, February, March, April and May. You must turn in your completed SAR 7 by no later than the first working day in December or your benefits will stop. You will lose benefits unless you had a good reason for being late. Your annual recertification will be due in May six months later. Your next SAR 7 will be due for the following certification period six months later.

What you must report on a Semi-Annual Report (SAR 7):

- Earned income from any source;
- Unearned income of any kind;
- Anyone getting free rent or utilities;
- Anyone who has expenses that are paid by someone else;
- Reduced hours of work or training;
- Someone moves in/out of your home;
- If you move;
- Any real or personal property bought, sold or exchanged;
- Any change in legally obligated child support paid by a household member;
- Anyone's citizenship/immigration status changes or receives correspondence from the U.S. Citizenship and Immigration Services (USCIS) (formerly INS);
- Anyone gets a job or payments for training or school expenses;
- Anyone has a job, training or school costs such as for dependent care or supplies;

REPORTING MANDATORY CHANGES DURING THE CERTIFICATION PERIOD

You must report the following changes within ten (10) days even if it is not your report month. You are to report:

- When your household's income is more than 130% of federal poverty level, for your household size (CalFresh IRT).
- If you are meeting the Able Bodied Adult Without Dependents (ABAWD) work rule by working and your work hours drop below 20 hours a week or 80 hours a month. CalFresh rules limit the receipt of CalFresh benefits to 3 months in a 3-year period for ABAWDs who are not working or participating in other allowable activities. You are excused from the ABAWD work rule and do not need to report a drop in your work hours if you are:
  - Living in a county where the ABAWD work rule is waived because of high unemployment rates;
  - Under 18 or 50 years of age or older;
  - Medically certified as physically or mentally unfit for employment;
  - Meeting the CalWORKs Welfare-To-Work rules;
  - Caring for an injured or sick person who will need help for more than 30 days;
  - Participating in an alcohol or drug treatment program that keeps you from working 30 hours or more per week;
  - Getting or have applied for Unemployment Insurance benefits.

REPORTING VOLUNTARY CHANGES

You may also report other information voluntarily, even when it is not your report month. Reporting information voluntarily may cause your household benefits to go up or down. See examples below. The county will take action within ten (10) days after you provide verification. One exception is when the increase results from adding another person to your case. In that situation, the county will take action to increase benefits the first of the month after you provide verification. **Even if you have already reported something to the County, you must also report it on your next SAR 7 or recertification.**

Some examples of voluntary reporting that may cause your benefits to go up include:

- Loss of income;
- Member becomes disabled or 60 years old;
- Member begins to pay court-ordered child support;
- New household member in the home;
- Shelter/housing cost increases;
- If any member who is disabled or age 60 or older has increased or new medical expenses.

(Continued on back)

REPORTING VOLUNTARY CHANGES - Continued

Some examples of voluntary reporting that may cause your benefits to go down include:

- Gain or increase of income that is less than your CalFresh IRT;
- Someone with no income moves out of your home;
- Someone in your home who had no income dies;
- Someone with income moves into your home;
- Shelter cost decrease.

You **MAY** report changes during your households certification period either by:

- Mail, telephone or in person at the county CalFresh office or by turning in a Mid-Certification Period Status Report or SAR 3.

OTHER CHANGES

There are other circumstances that will require the county to decrease or discontinue your benefits during the certification period in which they happen. Here are some examples:

- A household member is sanctioned;
- Someone in your household receives benefits in another household;
- A California Food Assistance Program status changes.

TRANSITIONAL CALFRESH BENEFITS

California's Transitional CalFresh program provides CalFresh benefits for five months to households that leave CalWORKs.

If your household begins receiving transitional CalFresh benefits, you do not have to report while receiving these benefits.

If you are receiving Transitional CalFresh benefits, you may reapply to see if you can get more benefits. If you reapply and are approved for regular CalFresh benefits, then all normal reporting rules will apply.

NON-ASSISTANCE CALFRESH (NACF) HOUSEHOLD RECERTIFICATION FORM

This form can be used at recertification in lieu of the CalFresh only application for Non-Assistance CalFresh households who are subject to Quarterly Reporting/Prospective Budgeting.

Please fill out the following personal information for the person requesting CalFresh benefits.

Fill out as much of this form as you can, sign on page 5, and return it to your local CalFresh office. We need at least your name, address and signature. **If you are without money for food, you may be able to get emergency CalFresh benefits in three (3) days.**

You need to try to answer all questions on this recertification form.

NAME (FIRST, MIDDLE, LAST)	CONTACT PHONE: ( )	**COUNTY USE ONLY**
HOME ADDRESS (NUMBER, STREET)	MAILING ADDRESS (IF DIFFERENT)	
CITY STATE ZIP CODE	CITY STATE ZIP CODE	

Are you homeless? ☐ YES ☐ NO

If "YES", are you temporarily staying in someone else's home? ☐ YES ☐ NO

If "YES", give date you began staying at this home: _____

EXPEDITED BENEFITS

1. Is someone in the household a Migrant/Seasonal Farmworker? ☐ YES ☐ NO
   a. How much is your rent or mortgage this month? $ _____
   b. How much are your utilities this month, if separate from your rent or mortgage? $ _____
   c. How much money do you have? This includes money in bank accounts, in your home, or any other place. $ _____
   d. Do you have or will you receive any income this month? ☐ YES ☐ NO
   List all your household income below:

NAME OF PERSON WHO GETS MONEY	HOW MUCH EACH MONTH?
	$
	$

Complete A, B & C below. If you don't complete this section, the county will do it for you. Check all that apply. THIS WILL NOT AFFECT YOUR ELIGIBILITY.

A. ETHNICITY

Are you Hispanic or Latino? ☐ YES ☐ NO

B. RACE/ETHNIC ORIGIN *(Select one or more of the following:)*

☐ American Indian or Alaskan Native ☐ Black or African American

☐ Asian *(If checked, please select one or more of the following)*
☐ Filipino ☐ Chinese ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Asian Indian
☐ Cambodian ☐ Laotian ☐ Other Asian *(specify)* _____

☐ Native Hawaiian or Other Pacific Islander *(If checked, please select one or more of the following)*
☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)* _____

☐ White

C. PRIMARY LANGUAGE

☐ English ☐ Spanish ☐ Lao ☐ Tagalog ☐ American Sign ☐ Cantonese
☐ Cambodian ☐ Vietnamese ☐ Russian ☐ Other *(specify)* _____

2. **List all persons living with you, including yourself. Attach a separate sheet of paper if needed.**

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:
			HEAD OF HOUSEHOLD

Check all that apply:
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

NAME:	SSN:	DATE OF BIRTH:	RELATIONSHIP:

Check all that apply: Do you want this person to have an EBT card to buy food for you? ☐ YES ☐ NO
☐ U.S. Citizen/National ☐ Noncitizen ☐ Legal Permanent Resident Sponsored: ☐ YES ☐ NO
Do you buy and prepare food with this person? ☐ YES ☐ NO

3. Does anyone live in any of the following type of facilities or take part in any food program including those listed below? *(check all that apply)* ☐ YES ☐ NO

- ☐ Homeless Shelter
- ☐ Correctional Facility
- ☐ Drug/Alcohol Rehabilitation Center
- ☐ Food Distribution Program
- ☐ Reservation for Native American
- ☐ Penal Institution
- ☐ Shelter for Battered Women
- ☐ Psychiatric Hospital/Mental Institution

If YES, complete the following:

NAME:	NAME OF CENTER/SHELTER/ FOOD PROGRAM ETC.	DATE ENTERED	DATE EXPECTED TO LEAVE

4. Do you pay anyone or does anyone pay you for meals and/or a room? ☐ YES ☐ NO
If YES, complete the following:

NAME OF PERSON WHO PAYS FOR MEALS/ROOM	NAME OF PERSON WHO PROVIDES MEALS/ROOM	CHECK ONE: (✔)	HOW MUCH?	HOW OFTEN?	NUMBER OF MEALS PER DAY
		☐ Meals ☐ Room ☐ Both			

5. Is anyone 16 years of age or older enrolled in school, college or a training program? ☐ YES ☐ NO
If YES, complete the following:

NAME OF PERSON	NAME OF SCHOOL	ATTENDANCE	NUMBER OF UNITS PER SEMESTER/ QUARTER	WORKING
		☐ Full time ☐ Half time ☐ Other		☐ YES ☐ NO **Number Of Hours:**
		☐ Full time ☐ Half time ☐ Other		☐ YES ☐ NO **Number Of Hours:**

6. Is anyone in the home unable to buy or fix meals because they are blind, deaf or disabled? ☐ YES ☐ NO
If YES, complete the following:

NAME	EXPLAIN

7. Is anyone in the home pregnant? ☐ YES ☐ NO
If YES, complete the following:

NAME	EXPECTED DUE DATE

8. Do you or anyone living in the home have any housing costs? ☐ YES ☐ NO
If YES, complete the following:

HOUSING COST	TOTAL COST	HOW MUCH DO YOU PAY?	HOW MUCH IS PAID BY RENTAL ASSISTANCE PROGRAMS, SUCH AS HUD, SECTION 8, ETC?	IF SOMEONE ELSE PAYS, HOW MUCH?	HOW OFTEN BILLED?
Rent					
House *(mortgage)* payment					
Property Taxes *(If not in house payment)*					
Insurance *(If not in house payment)*					
Other *(explain):*					

9a. Does anyone have any utility costs? ☐ YES ☐ NO
If YES, please check all boxes below that apply.

Gas		Garbage or trash	
Electricity		Sewer	
Other fuel (*such as propane, butane, wood, coal, etc.)*		Telephone/other means of communication, such as internet, etc.	
Water		Other *(explain)*	

9b. Do you use gas, electricity or other fuel for heating or cooling? ☐ YES ☐ NO
If YES, please check below.

Utility	Used for Heating or Cooling?
Gas	☐ YES ☐ NO
Electricity	☐ YES ☐ NO
Other Fuel	☐ YES ☐ NO

10. Does anyone, including children, have any of the resources listed below? ☐ YES ☐ NO
If YES, explain below:

- Cash or checks
- Mortgages
- Employee deferred compensation
- IRA or Keogh Plans
- Retirement Funds
- Certificate Deposit
- Checking or Saving accounts
- Oil, mining or mineral rights
- Sales contracts
- Trust funds
- Stocks, Bonds
- Money Market accounts
- Credit Union accounts
- Other

TYPE OF RESOURCE	OWNER	CURRENT VALUE	AMOUNT OWED *(IF ANY)*	NAME & ADDRESS OF BANK	ACCOUNT NUMBER

11. Does anyone own or is anyone buying real estate anywhere *(in or outside of the United States)?* ☐ YES ☐ NO
If YES, complete the following:

TYPE	ADDRESS OR LOCATION	USED AS:	OWNER:	ESTIMATED VALUE: / AMOUNT OWED:
		☐ HOME ☐ RENTAL		
		☐ HOME ☐ RENTAL		

12a. Is any member of your household avoiding felony prosecution, custody or confinement after conviction? ☐ YES ☐ NO
If YES, explain below:

NAME	EXPLAIN	NAME	EXPLAIN

12b. Has any member of your household been found to be in violation of probation/parole? ☐ YES ☐ NO
If YES, explain below:

NAME	EXPLAIN	NAME	EXPLAIN

13a. Since August 22, 1996, have you or any member of your household been convicted of a drug-related felony that has not been expunged?

If No, go to question #15.

If Yes: _____ _____
NAME DATE CONVICTED

13b. Was the conviction for any of the following:

- Transporting, importing into this state, selling, furnishing, administering, giving away, possessing for sale, purchasing for the purposes of sale, manufacturing, or processing precursors with the intent to manufacture a controlled substance or cultivating, harvesting, or processing marijuana? ☐ YES ☐ NO
- Encouraging, inducing, soliciting or intimidating a minor to participate in any of the above activities? ☐ YES ☐ NO

14. Have you or any member of your household:

a) Completed a government recognized drug treatment program? ☐ YES ☐ NO
b) Participated in a government recognized treatment program? ☐ YES ☐ NO
c) Enrolled in a government recognized drug treatment program? ☐ YES ☐ NO
d) Been placed on a waiting list for a government recognized drug treatment program? ☐ YES ☐ NO
e) Ceased the use of controlled substances? (Must show proof to your worker) ☐ YES ☐ NO

If YES, please explain:_____

15. You can authorize someone to act on behalf of the head of household in case of illness or other circumstances.
If you would like to authorize someone, complete below:

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE NUMBER

16. Are you interested in information or a referral for medical coverage *(Medi-Cal or Healthy Families)*? ☐ YES ☐ NO

APPLICANT/RECIPIENT CERTIFICATION

I have completed the questions above and read all the information. I understand the new CalFresh rules and penalties apply to my application or reapplication for CalFresh. I understand the new rules and agree to comply with them.

The U.S. Department of Agriculture prohibits discrimination in all its programs and activities on the basis of race, color, sex, religion, national origin, age, disability or political beliefs. You may file a complaint if you think you have been discriminated against. If you disagree with the decision of the county, an appeal process is available to you.

The information on this application may be shared with federal, state and local agencies only for the purposes of certifying eligibility for the CalFresh Program. This process may include confirmation with the U.S. Citizenship and Immigration Services (USCIS, formerly INS) of the immigration status only of those persons seeking CalFresh benefits. Federal law says the USCIS cannot use the information for anything else except cases of fraud.

SIGNATURE

I certify under penalty of perjury under the laws of the United States of America and the State of California that the information I have provided on this application form is true, correct and complete.

Signature (Adult household member or Authorized Representative) **X**	Date
Signature of Witness or Interpreter **X**	Date
Signature of Eligibility Worker **X**	Date

CALFRESH PROGRAM RESTRICTED ACCOUNT AGREEMENT PART A

CASE NAME	CASE NUMBER
COUNTY WORKER NAME	WORKER NUMBER

Read and initial each of the rules below.

Initial	I Understand:
	Funds must be kept in a financial institution, such as a bank, credit union, savings and loan, etc., and all funds in my Restricted Account must be kept separate from any other account.
	I must give proof of account information. Some examples of account information include: ● Bank statement or receipt from a bank, credit union etc. that shows the name and address of the bank ● All account balances and activity since the date you signed the Restricted Account Agreement ● The name(s) on the account(s)
	I understand some examples of proof of how I spent funds withdrawn from the Restricted Account(s), include the following: ● Cancelled check(s) ● Signed statement(s) from the provider(s) of goods or services that shows the type and amount of the expense(s) paid ● Receipt(s)
	This Restricted Account Agreement stops: ● When I don't give the worker proof about the Restricted Account ● When my family is discontinued from CalFresh benefits ● When the Restricted Account is closed ● If the Restricted Account law changes
	There is not a limit on the maximum amount of savings in a restricted account. I can have more than one restricted account, and funds in all restricted accounts do not count against my family's resource limit.
	If my CalFresh benefits stop for any reason, and if I reapply for CalFresh benefits, and there is a break in benefits, my total countable resources, including any money in the Restricted Account(s), cannot be more than the $2,000/$3,250 resource limit. I must enter into a new Restricted Account Agreement at application to start a new Restricted Account. A Restricted Account Agreement is required if there is a break in aid.
	If funds from my Restricted Account(s) are withdrawn and are not spent for an allowable expense, even when I have expenses for a death or life-threatening emergency, the withdrawn amount will count toward the resource limit and the county will re-evaluate all resources.
	The need to have resources close to my $2,000 resource limit ($3,250 if there is at least one household member who is disabled/age 60 or older) for emergencies or other expenses before I start a Restricted Account.
	If I report income and household changes semi-annually and withdraw funds during the semi-annual period, I am required to report the withdrawal on the next income report (SAR 7) or recertification that is due. If I am not a Semi-Annual Reporting household, I must report withdrawals within 10 days of the withdrawal.
	Interest earned on my Restricted Account(s) must be deposited directly into the account(s). If interest is sent to me, I must put it back into the Restricted Account.
	Money saved in a Restricted Account can only be spent for one or more allowable expenses directly related to: ● Purchase of a home that I will live in ● Starting up a new business ● Education or job training for the account holder and his/her dependent(s)

Certification

I have read the coversheet. I understand the rules and my responsibilities as initialed above for starting and keeping a Restricted Account, and the need to have resources close to my $2,000 resource limit or $3,250 (if there is at least one household member who is disabled or who is age 60 or older) for emergencies or other expenses before I start a **Restricted Account.** I will ask my worker if I am not sure what is an allowable expense, what proof I need, or when the proof must be given to the county.

SIGNATURE OR MARK OF HEAD OF HOUSEHOLD OR AUTHORIZED REPRESENTATIVE	DATE
SIGNATURE OR MARK OF WITNESS AND/OR INTERPRETER	DATE

CALFRESH PROGRAM RESTRICTED ACCOUNT AGREEMENT PART B

CASE NAME	CASE NUMBER
COUNTY WORKER NAME	WORKER NUMBER

You must fill in the information below when you start the Restricted Account. Sign, date, and give the original of this Agreement to the county with proof of the account.

ACCOUNT HOLDER(S) NAME(S) ON THE ACCOUNT

NAME AND ADDRESS OF BANK, ETC.	ACCOUNT NUMBER	CURRENT BALANCE
SIGNATURE OR MARK OF HEAD OF HOUSEHOLD OR AUTHORIZED REPRESENTATIVE		DATE

County Use Section

I certify that the household member or authorized representative signing this form has been given a copy of the Restricted Account Coversheet and this Agreement. The individual has stated he/she understands the rules and the responsibilities for starting, keeping, and ending a Restricted Account(s).

SIGNATURE OF COUNTY WORKER	WORKER NUMBER	DATE

CALFRESH PROGRAM RESTRICTED ACCOUNT COVERSHEET

IMPORTANT TO KNOW

A RESTRICTED ACCOUNT IS:

An account in a bank, credit union, etc. where a family who is receiving CalFresh benefits can keep money to be spent for only the following allowable expenses:

- Buying a home to live in;
- Starting a business; or
- Education or job training for the account holder and his/her dependents. (Dependents are those who are or could be claimed as dependents on the account holder's federal income taxes.)

Before opening a restricted account, you may want to have cash and other resources (such as bank accounts, stocks, real estate, etc.) not exceeding your resource limit available for your use. Here's why:

If you use any of the funds in your restricted account(s) to pay for emergencies, even when the emergency is due to a death or life-threatening situation, the withdrawal will count towards the resource limit of $2,000 or $3,250 (if there is at least one person in the household who is disabled or who is age 60 or older).

RULES FOR A RESTRICTED ACCOUNT:

- You must be receiving CalFresh benefits at the time you set up the account.
- More than one restricted account is allowed.
- There is not a limit on the maximum amount of savings in a restricted account.
- Funds in all restricted accounts do not count against your family's resource limit.
- You must sign a Restricted Account Agreement **before** an account can be considered a Restricted Account.
- You can only spend the funds on an allowable expense.
- You must keep the funds, and any interest earned in a restricted account(s) **separate** from any other account.
- Interest earned on the Restricted Account(s) must be deposited directly into the account(s).
- You must complete a Restricted Account Agreement for each Restricted Account.
- If you have a restricted account and go off CalFresh benefits, the funds may be counted against your property and resources if you reapply for benefits.

REPORTING WITHDRAWALS

- **Semi-Annual Reporting Households**
  - Withdrawal of funds during the semi-annual period, do not have to be reported until your next income report (SAR 7) or recertification is due.
  - The county will reassess your resources with receipt of the semi-annual report and decide if the withdrawal was for an allowable expense. If your resources are below the resource limit ($2,000/$3,250), you will remain eligible for benefits if otherwise eligible.
- **Change Reporting Households**
  - A withdrawal made from your Restricted Account must be reported within 10 days of the date the funds were withdrawn.
  - The county will look at the resource limit within 10 days of the report.
  - The reason for your withdrawal will determine continuing eligibility.
  - If your resources are below the resource limit ($2,000/$3,250) you will remain eligible for benefits if otherwise eligible.

EXPENSES

- **Purchase Of A Home To Live In:**

  You can spend Restricted Account funds on:
  - Deposits, fees, down payment, principal payment
  - Closing costs
  - Repairs and fixtures

  You cannot spend Restricted Account funds on:
  - Furniture purchases
  - Household goods
- **Education Or Job Training For The Account Holder(s) And His/Her Dependent(s):**

  You can spend Restricted Account funds on:
  - Fees, tuition, books, school supplies, equipment, special clothing needs
  - Student housing and meals
  - Cost of transportation to and from school/vocational training
  - Child care services needed to attend school

EXPENSES CONTINUED:

- **Starting Up A New Business:**

  You can spend Restricted Account funds on:
  - Purchase, repair, and upkeep of business equipment
  - Tools, uniforms, other protective or required clothing, and shoes
  - Payment on loan principal and interest for business assets or durable goods
  - Rent and utility payments for office or floor space
  - Employee salaries
  - Inventory, shipping, and delivery costs
  - Business fees, taxes, insurance, bookkeeping or other professional services

  You cannot spend Restricted Account funds on:
  - Personal expenses, such as entertainment

PROOF

You must give proof to the county when setting up a Restricted Account and withdrawal of funds from the Restricted Account(s).

- **Some Examples Of Proof Of Establishing And/Or Withdrawing Funds Include The Following:**
  - Passbook, bank statement or receipt from a bank, credit union etc. that shows the name and address of the bank and the names on the account(s), account number(s), and
  - All account balances and activity since the date you signed the Restricted Account Agreement
- **Some Examples Of Proof To Show How You Spent The Funds Include:**
  - Cancelled check
  - Signed statement from the provider of goods or services that shows the type and amount of expense(s) paid
  - A receipt
  - Restricted Account bank balance statement

REPLACEMENT AFFIDAVIT/AUTHORIZATION (CF 303)

Instructions: In Part A check which box(es) apply to you, sign and return this form within 10 days of your reported loss or no replacement can be made.

PART A - HOUSEHOLD AFFIDAVIT

I,_____,
declare that the household:

☐ Electronic Benefits Transfer (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
Home Address (If Different) (Number, Street)		
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

to_____

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

_____

_____

_____

_____

_____

_____

I declare the above 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 (WHO GOT REPLACEMENT) ☛	DATE

COUNTY USE ONLY

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

PART B - REPLACEMENT BENEFITS

☐ APPROVED - EBT Replacement Date _____

☐ EBT: Authorized Replacement Amount $_____

☐ DENIED - Reason for Denial (Explain)

_____

_____

_____

_____

SIGNATURE (PERSON AUTHORIZING OR DENYING REQUEST)	DATE

PART C - ACKNOWLEDGEMENT OF RECEIPT (OVER THE COUNTER)

RECEIVED BY:	DATE

Rules: These rules may apply and you may review at your welfare office MPP 16-515.

CALFRESH MID-CERTIFICATION PERIOD STATUS REPORT

INSTRUCTIONS:

Because you get CalFresh, you must report within 10 days when your household's total monthly income increases to more than the CalFresh Income Reporting Threshold (IRT) as well as when Able-Bodied Adult Without Dependents (ABAWD) work hours drop below 20 hours a week or 80 hours a month.

Use this form to report an income increase to more than the CalFresh IRT which is 130% of the Federal Poverty Level (FPL) per household size and changes in ABAWD work hours that have occurred since your last Semi-Annual Report (SAR 7).

Use this form to report changes you think will increase your CalFresh benefits. Please provide proof, such as, pay stubs, copies of checks, letters from agencies, etc.

If you are reporting changes in expenses, please provide proof such as, receipts, canceled checks, paid invoices, etc.

-
-

Worker: Phone:

MANDATORY REPORT OF INCOME OVER IRT

YOUR HOUSEHOLD IS ONLY REQUIRED TO REPORT CHANGES WHEN YOUR HOUSEHOLD'S TOTAL MONTHLY GROSS INCOME EXCEEDS 130% OF THE FEDERAL POVERTY LEVEL. Your gross income means all of the money your household receives including wages before taxes or other deductions, Social Security, SSI, cash contributions, unemployment compensation, child support, worker's compensation, etc. **This change must be reported within 10 days of when the change occurred. Failure to report this change may result in an overpayment of CalFresh benefits which you will have to repay.**

You were told your IRT when your case was approved. If you are unsure of your household's IRT, contact your local county office. To review a chart of gross income per household at 130% of the federal poverty level, visit: http://www.CalFresh.ca.gov/PG3221.htm

To report a change, you may: Complete this form, **sign it on the other side** and return it to your local county office or contact your local county office. If you need assistance in completing this form you may contact your local county office.

I want to report that:

☐ My household's gross monthly income is over 130% of the federal poverty level.

List the monthly income by each type received:

Source of Money	Who gets it?	How much each month?	Is this new income to your household?	When did it start?

Total gross monthly income is: $ _____.

Do you expect the changes in income you have reported will remain the same? ☐ Yes ☐ No

If you answer no, please explain:_____

_____

_____

_____

_____

_____

MANDATORY ABAWD INFORMATION

☐ I want to report changes in Able-Bodied Adult without Dependents (ABAWD) hours for my household.

The number of hours worked or in training dropped from 20 hours a week or 80 hours a month to _____ hours a week or _____ hours a month.

In the week(s) of _____ _____ _____ _____ _____ _____ _____

In the month(s) of _____ _____ _____

Name of Person(s) _____ Relationship to You _____

Explain What Happened _____

VOLUNTARY INFORMATION *(All households)*

I would like to report the following information: _____

CERTIFICATION

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I understand I may be charged with committing a felony if more than $950 in CalFresh benefits is wrongly paid out.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW:	Head of household, household member or the household's authorized representative.

Signature or Mark	Date Signed	Home Phone	Contact Phone

Signature of Spouse or other Adult Household Member or Authorized Representative	Date Signed	Signature of Witness to Mark, interpreter or other person completing form	Date Signed

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

COUNTY OF

CALFRESH NOTICE OF CHANGE (NON-CITIZEN)

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

(ADDRESSEE)

If you have any questions or want more information about this action, please contact your worker.

State Hearing: If you think this action is wrong, you can ask for a hearing unless you already had a hearing on the amount you owe. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

☐ **CHANGE IN BENEFITS**

Effective_____, your CalFresh benefits are changed from $_____ to $_____each month because:

_____, is an ineligible legal non-citizen.

☐ **TERMINATION**

Effective_____, your CalFresh benefits are terminated because:

There are no eligible legal non-citizens in your household.

If you, or any other legal non-citizens in your household are ineligible because you do not have enough work quarters, you may get CalFresh benefits for up to six months more. To get CalFresh benefits for up to six months, you must contact the Social Security Administration and ask them to review your work quarters (or those of your spouse or parents) and get proof from Social Security that they are reviewing your quarters and give it to the county.

Rules: These rules apply to the above action(s):

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

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

COUNTY OF

CALFRESH NOTICE OF CHANGE FOR CHANGE REPORTING HOUSEHOLDS

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

(ADDRESSEE)

If you have any questions or want more information about this action, please contact your worker.

State Hearing: If you think this action is wrong, you can ask for a hearing unless you already had a hearing on the amount you owe. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

☐ **CHANGE IN BENEFITS**

Effective_____, your CalFresh benefits are changed from $_____ to $_____each month because:

☐ You have already been told about an overissuance of CalFresh benefits and you are getting less CalFresh benefits because the County has been reducing your monthly allotment by 10% or $10 (whichever is more) to pay back the CalFresh benefits that you got and should not have. It has been decided in court or by a state hearing or because you signed a Disqualification Consent Agreement or an Administrative Disqualification Hearing Waiver that this overissuance is an Intentional Program Violation (IPV). Now your monthly allotment is being changed because the County can begin reducing your allotment by 20% or $10 (whichever is more). If there are any other changes to your monthly CalFresh allotment, this form will tell you.

☐ **PROPOSED CHANGE IN BENEFITS**

Effective_____, your CalFresh benefits may be reduced or terminated because information needed to determine your continued eligibility or the correct amount of your benefits was not received with your Change Report (CF 377.5 CR). We must receive the following information by no later than the first day of next month:

If verification of an expense is requested and if you do not provide it, the expense will not be allowed when computing next month's benefits. Also, if you do not provide other requested information, your benefits may be reduced or terminated.

Rules: These rules apply to the above action(s):
You may review them at your welfare office.

☐ **NO CHANGE IN BENEFITS**

Your CalFresh benefits did not change as a result of the document(s)/information we received because:

☐ **TERMINATION**

Effective_____, your CalFresh benefits are terminated because:

☐ Based on the reason your benefits are terminated, your household is also disqualified from participating in the CalFresh Program until_____. You may reapply for benefits at the end of this disqualification period.

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 HOUSEHOLD CHANGE REPORT (CF 377.5 CR)

INSTRUCTIONS:

You must report mandatory changes (Questions 1 - 6) within 10 days of the time you learn of the change.
*You may report changes on this form, in person, **or** by calling the number below.*
If you use this form, only complete the sections that apply to the change(s) you are reporting.
If you have any questions about what changes you must report, ask your worker.

-
-

Worker: Phone:

(1) INCOME CHANGES

A. Did the source of your household's unearned income change or go up or down by more than $50.00, such as: you got $250.00 last month and you got $301.00 this month? If **Yes**, complete 1 (**C**) below.

B. Did the source of earned income for any household member change or go up or down by more than $100.00? If **Yes**, complete 1 (**C**) below.

C. If **Yes** to 1 (**A**) or 1 (**B**) above, enter all income of your household. Attach pay stubs or other proof of earnings. For all other income attach proof when a change is reported. If anyone is self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

Name	Source (If Earnings, List Name of Employer)	Amount (Before Deductions)	How Often Received?	Date of Change

(2) HOUSEHOLD COMPOSITION CHANGES

Change	YES	Date of Change	If **YES**, give name of person, relationship and explain change.
A. Did anyone move into your home, including a newborn?			
B. Did anyone move out of your home or die?			
C. Did you move in with someone else?			
D. Did anyone get married?			
E. Did anyone become disabled or recover from a disability?			
F. Did anyone get a new Social Security Number?* If **YES**, attach proof.			

(3) RESOURCE CHANGES

Did the total of your household's cash on hand, money in checking and/or savings account, stocks, bonds, etc., reach or exceed $2000 or $3250 for a household that has a member who is disabled or age 60 or older? If **YES**, complete section below:

List Each Item	Amount	Date of Change
	$	
	$	
	$	

(4) MANDATORY ABAWD INFORMATION

☐ I want to report changes in Able-Bodied Adult without Dependents (ABAWD) hours for my household.

The number of hours worked or in training dropped from 20 hours a week or 80 hours a month to _____ hours a week or _____ hours a month.

In the week(s) of _____ _____ _____ _____ _____ _____ _____

In the month(s) of_____ _____ _____

Name of Person(s)_____ Relationship to You_____

Explain What Happened_____

_____

_____

_____

* Providing a Social Security Number (SSN) is required by 7 U.S. Code Section 2025E. Anyone who refuses to provide an SSN will be disqualified from receiving CalFresh benefits. The SSNs will be used to check identity, to prevent duplicate participation and to verify eligibility and benefits. The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration, and other agencies. Differences may be checked out with employers, banks or others. Fraudulent participation in the CalFresh Program may result in criminal or civil action or administrative claims.

(5) ADDRESS AND SHELTER COST CHANGES

A. Do you have a new mailing address or phone number or do you plan to move? If **YES**, complete (5) C, (5) D and (5) E.

B. Did you move? If **YES**, complete (5) C, (5) D and (5) E.

C. Does someone else live at this address? If **YES**, give name(s) and relationship: _____

D. Enter you new address and/or phone number below and enter the date of the change here: _____

Home Address (Number and Street)			Mailing Address (If Different)(Number and Street)		
City	Zip code	Home Phone	City	Zip code	Message Phone

E. Did your housing or utility costs change when you moved? If **YES**, complete 1, 2 and 3 below:
You may be asked to provide proof of your new shelter costs.

1. Enter the amount of each housing cost you have. →

2. If you have utility costs, check the box for each utility cost you have. →

Rent or Mortgage: $		Property Taxes or Insurance: $ (If not in mortgage)	
Utility		Utility	
Gas or Fuel	☐	Garbage or Trash	☐
Electricity	☐	Water	☐
Telephone	☐	Sewage	☐
Utility Installation	☐	Other(specify)	☐

3. Did anyone not part of your CalFresh household help you pay any of your housing or utility costs? If **YES**, complete 3a, b and c.
   a. Enter the total housing costs paid by the CalFresh household: $_____
   b. Enter the total utility costs paid by the CalFresh household: $_____
   c. Give the name of each person who paid any of the costs, and if they paid housing and/or utility costs:

(6) CHILD SUPPORT PAID BY HOUSEHOLD

Has any member of the CalFresh household paid legally obligated child support for children not living in the home or with the household? Attach proof of the court order or administrative order showing the requirement to pay the child support and give the amount paid. If there has been a change in the amount of the legally obligated support, attach proof of the change.

WHO PAID CHILD SUPPORT	PAID TO WHOM	AMOUNT PAID	DATE PAID

(7) DEPENDENT CARE EXPENSE CHANGES

Optional - If any household member who works, is looking for work, or is going to school, had an increase in dependent care or child care costs since they last reported, pease complete the section below.

What was the amount paid: **$**_____ **Who paid:**_____

List child/children:_____

(8) MEDICAL EXPENSES (FOR A HOUSEHOLD MEMBER WHO IS DISABLED OR AGE 60 OR OLDER)

Optional - If any household member who is disabled or age 60 or over has new or increased medical expenses, complete the section below as this report may increase your allotment. If the expenses are new or are increased by more than $25, **attach proof.**

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense?	Type of Expense	Amount
		$			$

(9) TEMPORARY CHANGES

Do you think the changes in questions (1) through (6) are temporary?
If **YES**, explain.

CERTIFICATION

- **I understand that failing to report information or intentional misrepresentation of facts can result in legal prosecution with penalties of a fine, imprisonment or both. The penalties can result in disqualification from CalFresh, fine up to $250,000 and imprisonment up to 20 years. The disqualification penalties are 12 months for the first violation, 24 months for the second violation, and permanent disqualification for the third violation.**
- *I understand that I have only 10 days to tell my worker about changes in my household (Questions 1 - 6 only).*
- *I understand that the facts I have reported will be matched and verified by local, state and federal staff.*
- *I understand that the household, any adult member (even if they move out), the sponsor of an alien household member, or the authorized representative of residents in an eligible institution may be required to repay extra benefits the household should not have received, even if it's the County's fault.*
- *I understand that I have the right to ask for a state hearing on any action by the County Welfare Department.*
- *I declare that the facts contained in this report are true, correct and complete.*

SIGNATURE (HOUSEHOLD MEMBER OR AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (WITNESS, IF YOU SIGNED WITH AN X)	DATE

CALFRESH REQUEST FOR INFORMATION

COUNTY OF

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

Questions? Ask your worker.

In order to determine your eligibility for CalFresh benefits, we need the following information from you by _____.
MM/DD/CCYY

Please tell your worker if you need help getting this information. Your worker can help you get it.

Please:
☐ Call us to give us this information
☐ Mail this information to us

If you do not give us this information by _____, you may get a notice of action to stop your CalFresh benefits.
MM/DD/CCYY

RULES: These rules apply: MPP 63-300.5. You may review them at your welfare office.

NOTICE OF DENIAL OF RESTORATION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

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

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

If you still want CalFresh benefits, you may reapply at anytime.

Rules: These rules apply: ACL #10-32.

You may review them at your welfare office.

YOUR HEARING RIGHTS

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

While You Wait for a Hearing Decision for:

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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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CLAIM DETERMINATION WORKSHEET

CASE TRANSFER STATUS: ☐ TO ☐ FROM

CASE NUMBER: | CASE NUMBER:

1. CASE NAME	3. HEAD OF HOUSEHOLD *(IF DIFFERENT)*	4. ANOTHER ADULT	5. ANOTHER ADULT
2. CASE NUMBER	SSN	SSN	SSN
6. DATE OF DISCOVERY / 7. CF CASE STATUS: ☐ ACTIVE ☐ DISCONTINUED	ADDRESS *(PO BOX/STREET)*	ADDRESS	ADDRESS
	(CITY, ZIP)	(CITY, ZIP)	(CITY, ZIP)

8. BASIS FOR CLAIM DETERMINATION:

☐ ADMINISTRATIVE ERROR
☐ INADVERTENT HOUSEHOLD ERROR
☐ POTENTIAL IPV

9. EFF. DATE OF DISQUALIFICATION

10. EXPLANATION OF OVERISSUANCE *(IF APPLICABLE, INCLUDE DATE CHANGE OCCURRED AND DATE REPORTED)*

11. SUMMARY OF CALFRESH OVERISSUANCE

ISSUANCE MONTH/YEAR	ACTUAL BASIS FOR ISSUANCE: HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	CORRECT BASIS FOR ISSUANCE: HOUSEHOLD SIZE	ADJUSTED INCOME	ALLOTMENT	ISSUANCE VERIFICATION: ATP/HIR	DMI	OTHER	REDEMPTION
Continue on reverse	11a Total ▶			11b Total ▶			DOCUMENTATION			

12. Total CalFresh overissuance *(subtotal if continued on reverse)* — 11a Minus 11b ▶

13. Claim offsetting lost benefits not restored.

	DATE:	DATE:
A. Total CalFresh overissuance (from 12 above).		
B. Minus lost benefits not restored.		
C. Minus payment received.		
D. Amount of CalFresh claim to be collected.		

ELIGIBILITY WORKER *(SIGNATURE)*	DATE	SUPERVISOR *(SIGNATURE)*	DATE	REVIEW OFFICER *(APPROVAL SIGNATURE)*	DATE

ACTION *(PLANNED/TAKEN)*

14. Summary of CalFresh overissuance (Continuation) > Include all other overissuance months not listed on the front.

ISSUANCE MONTH/YEAR	ACTUAL BASIS FOR ISSUANCE			CORRECT BASIS FOR ISSUANCE			ISSUANCE VERIFICATION			
	HOUSEHOLD SIZE	ADJUSTED INCOME	BONUS/ALLOTMENT	HOUSEHOLD SIZE	ADJUSTED INCOME	BONUS/ALLOTMENT	ATP / HIR	DMI	OTHER	REDEMPTION
Total this page		14a Subtotal ▶			14b Subtotal ▶					
Total first page		11a Subtotal ▶			11b Subtotal ▶					
15. Total both pages		15a Total (14a + 11a) ▶			15b Total (14b + 11b) ▶					

DOCUMENTATION

16. Total CalFresh overissuance ▶ 11a Minus 11b ▶

17. Claim offsetting lost benefits not restored.	DATE:	DATE:
A. Total CalFresh overissuance (from 16 above).		
B. Minus lost benefits not restored.		
C. Minus payment received.		
D. Amount of CalFresh claim to be collected.		

ELIGIBILITY WORKER *(SIGNATURE)*	DATE	SUPERVISOR *(SIGNATURE)*	DATE

DOCUMENTATION

CALFRESH NOTICE OF APPROVAL/DENIAL/TERMINATION TRANSITIONAL BENEFITS

COUNTY OF

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

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

ADDRESSEE

Questions? Ask your Worker.

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

☐ **Approval**

As of _____ (MM/DD/CCYY), your CalFresh benefits are $ _____ each month.

Because your CalWORKs case has been closed, you will get Transitional CalFresh benefits. You will get Transitional CalFresh benefits starting _____ (MM/CCYY) and ending _____ (MM/CCYY).

This replaces your previous certification period.

Your Transitional CalFresh benefits will end after 5 months unless your household recertifies.

Reporting:

You are encouraged to report if you change your address. Households that get Transitional CalFresh benefits do not have to turn in a reporting form.

Recertification:

You will get a notice when it is time to recertify at the end of the 5-month Transitional CalFresh period.

- You may ask to recertify for regular CalFresh at any time during the Transitional CalFresh period. If you ask to recertify during the first four months of the Transitional CalFresh period and the regular CalFresh benefits are lower than the current Transitional CalFresh amount, you may withdraw your request for recertification.
- If you apply and are approved for CalWORKs and regular CalFresh, you will have a new certification period. Eligibility for Transitional CalFresh will end when the CalWORKs and regular CalFresh benefits are approved, even if your 5 months have not ended.

☐ **Denial/Withdrawal**

As of _____ (MM/DD/CCYY), the CalFresh recertification you asked for during the first 4 months of Transitional CalFresh benefits was not approved. Your current Transitional CalFresh benefit will continue until the end of the Transitional CalFresh benefit period.

Here's Why:

☐ You have withdrawn your request for recertification for regular CalFresh benefits.

☐ You did not give us the information we asked for within 10 days of the date requested.

☐ You did not complete your scheduled interview.

☐ Other (see below):

☐ **Termination**

As of _____ (MM/DD/CCYY), your current Transitional CalFresh benefit period will end.

Here's Why:

☐ Your application for CalWORKs has been approved.
☐ Your application for CalFresh has been approved.
☐ Your CalWORKs and/or CalFresh benefits have been restored.
☐ Other (see below):

Rules: These rules apply: MPP § 63-504.6, MPP § 63-504.13. You may review them at your welfare office.

YOUR HEARING RIGHTS

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While You Wait for a Hearing Decision for:

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☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

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NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

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NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

NOTICE OF ACTION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

Medi-Cal: This notice DOES NOT change or stop Medi-Cal Benefits. **Keep using your plastic Benefits Identification Card(s).** You will get another notice telling you about any changes to your health benefits.

CalFresh: This notice DOES NOT stop or change your CalFresh benefits. You will get a separate notice telling you about any changes to your CalFresh benefits.

Receiving Medi-Cal and/or CalFresh only DOES NOT count against your cash aid time limits.

Rules: These rules apply; you may review them at your welfare office: MPP

YOUR HEARING RIGHTS

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- 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

NOTICE OF ACTION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

_____, as of _____, we are lowering your family's cash aid from $_____ to $_____ as shown on the following page. Cash aid will stop for you.

We are lowering your family's cash aid because you did not have a good reason for not doing what you agreed to do in the compliance plan that you signed. You agreed to: _____

_____

We will not pay for transportation, or work- or training-related expenses while you are off cash aid. We may pay for child care, if you work or attend school.

HOW TO GET YOURSELF BACK ON CASH AID

Your family's cash aid is being lowered because you did not do what we asked you to do and you are being removed from the Assistance Unit. If your family's cash aid is lowered, you can get your portion of the cash aid back if you are eligible for it by contacting the county and telling them you want your cash aid back; then doing what the county asks.

TO CONTACT THE COUNTY ABOUT GETTING BACK ON CASH AID, CALL _____.

The family's other parent, _____, may also get cash aid again if he/she is eligible for it by contacting the county and telling them he/she wants cash aid back; then doing what the county asks.

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

CalFresh: If the failure to meet Welfare-to-Work requirements also causes a CalFresh penalty, you may not be able to get CalFresh. If there is a CalFresh penalty, you will get another notice telling you how long your CalFresh benefits will be stopped.

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). CalFresh MPP § 63-407.521. You may review these rules 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.)**

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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

NOTICE OF ACTION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

_____, as of _____, we are changing your family's cash aid from $_____ to $_____ as shown on the following page.

We are lowering your family's cash aid because you did not have a good reason for not doing what you agreed to do in the compliance plan that you signed. You agreed to:

_____

_____

We will not pay for transportation, or work- or training-related expenses while you are off cash aid. We may pay for child care, if you work or attend school.

HOW TO GET YOURSELF BACK ON CASH AID

Your family's cash aid is being lowered because you did not do what we asked you to do and you are being removed from the Assistance Unit. If your family's cash aid is lowered, you can get your portion of the cash aid back if you are eligible for it by contacting the county and telling them you want your cash aid back; then doing what the county asks.

TO CONTACT THE COUNTY ABOUT GETTING BACK ON CASH AID, CALL _____ .

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

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Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). CalFresh MPP § 63-407.521. You may review these rules 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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<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

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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

NOTICE OF ACTION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

_____, as of _____ , we are taking you out of Welfare-to-Work.

We will not change your cash aid grant amount.

We are taking you out of Welfare-to-Work because you did not have a good reason for not doing what you agreed to do in the compliance plan that you signed. You agreed to:_____
_____

We will not pay transportation, or work- or training-related expenses while you are out of Welfare-to-Work. We may pay for child care, if you work or attend school.

You may be able to get in Welfare-to-Work again at a later date. To find out when you may be able to participate again and what you must do, contact your Welfare-to-Work worker at the telephone number listed below.

Welfare-to-Work Worker's Name: _____

Telephone Number: _____

CalFresh: If the failure to meet Welfare-to-Work requirements also causes a CalFresh penalty, you may not be able to get CalFresh benefits. If there is a CalFresh penalty, you will get another notice telling you how long your CalFresh benefits will be stopped.

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). CalFresh MPP § 63-407.521. You may review these rules at your welfare office.

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

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.

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- 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

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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

NOTICE OF ACTION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

_____, our records show that you did not:

- ☐ Sign the Welfare-to-Work plan on _____.
- ☐ Participate in _____ on _____.
- ☐ Make good progress in your _____ activity because _____ .
- ☐ Accept a job at _____.
- ☐ Keep your job at _____.
- ☐ Keep the same amount of earnings.

WE NEED TO TALK TO YOU

To keep your family's cash aid from being lowered, we must talk with you about this problem. An appointment has been made for you on _____, at _____ o'clock, at _____.
If you need transportation or child care to go to this meeting, call your Welfare-to-Work worker at the telephone number listed below.

Welfare-to-Work Worker's Name: _____
Telephone Number: _____

If you cannot go to this meeting, you must call your worker to set a new time. Unless you have a good reason, you can change this meeting only once. You can also call your worker to talk about the problem instead of going to the meeting. You must call your worker to set a new time to meet, or to talk about your problem on the telephone, by _____ .

When you talk to your worker, you will be asked if you had a good reason ("good cause") for not doing what we asked you to do. If we verify that you had a good reason, your family's cash aid will not be lowered because of this problem. Some examples of good reasons are not having child care or not having transportation. For other good reasons, see the "Request For Good Cause Determination" form sent with this notice.

Your family's cash aid will also not be lowered if you can show us that you should have been exempt at the time you did not do your Welfare-to-Work activity.

If you do not have a good reason for not doing what we asked you to do, you can agree to a compliance plan to meet Welfare-to-Work rules. Your family's cash aid will not be lowered if you agree to a compliance plan and then do what it says. If you agree to a compliance plan and then later do not do what it says, your family's cash aid will be lowered. If this happens, you will get a separate notice.

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). CalFresh MPP § 63.407.521. You may review these rules at your welfare office.

HOW TO STOP YOUR FAMILY'S CASH AID FROM BEING LOWERED

As of _____, your family's cash aid will be lowered from $ _____ to $ _____ as shown on the following page, unless you show us you had a good reason for not doing what we asked you to do. If you do not have a good reason, you can agree to a compliance plan to keep your family's cash aid from being lowered. If you do not agree to a compliance plan, you will not get another notice before your family's cash aid is lowered.

See the next page for more information about how we figured how much your family will get if your family's cash aid is lowered.

We will not pay for transportation, or work- or training-related expenses if you are off cash aid. We may pay for child care, if you work or attend school.

HOW TO GET YOURSELF BACK ON CASH AID

Your family's cash aid is being lowered because you did not do what we asked you to do and you are being removed from the Assistance Unit. If your family's cash aid is lowered, you can get your portion of the cash aid back if you are eligible for it by contacting the county and telling them you want your cash aid back; then doing what the county asks.

TO CONTACT THE COUNTY ABOUT GETTING BACK ON CASH AID, CALL _____ .

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

CalFresh: If the failure to meet Welfare-to-Work requirements also causes a CalFresh penalty, you may not be able to get CalFresh benefits. If there is a CalFresh penalty, you will get another notice telling you how long your CalFresh benefits will be stopped.

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

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>:

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

NOTICE OF ACTION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

_____ , our records show that you did not:

- ☐ Sign the Welfare-to-Work plan on _____ .
- ☐ Participate in _____ on _____.
- ☐ Make good progress in your_____ activity because _____.
- ☐ Accept a job at _____.
- ☐ Keep your job at _____.
- ☐ Keep the same amount of earnings.

We will not change your cash aid grant amount.

WE NEED TO TALK TO YOU

To stay in Welfare-to-Work, we must talk with you about this problem. An appointment has been made for you on _____ , at _____ o'clock, at _____ . If you need transportation or child care to go to this meeting, call your Welfare-to-Work worker at the telephone number listed below.

Welfare-to-Work Worker's Name: _____

Telephone Number: _____

If you cannot go to this meeting, you must call your worker to set a new time. Unless you have a good reason, you can change this meeting only once. You can also call your worker to talk about the problem instead of going to the meeting. You must call your worker to set a new time to meet, or to talk about your problem on the telephone, by _____ .

When you talk to your worker, you will be asked if you had a good reason ("good cause") for not doing what we asked you to do. If we verify that you had a good reason, we will not take you out of Welfare-to-Work because of this problem. Some examples of good reasons are not having child care or not having transportation. For other good reasons, see the "Request For Good Cause Determination" form sent with this notice.

If you do not have a good reason for not doing what we asked you to do, you can agree to a compliance plan to meet Welfare-to-Work rules. We will not take you out of Welfare-to-Work if you agree to a compliance plan and then do what it says. If you agree to a compliance plan and then later do not do what it says, we will take you out of Welfare-to-Work. If this happens, you will get a separate notice.

HOW TO STAY IN WELFARE-TO-WORK

As of _____ , you will be taken out of Welfare-to-Work unless you show us you had a good reason for not doing what we asked you to do. If you do not have a good reason, you can agree to a compliance plan to stay in Welfare-to-Work. If you do not agree to a compliance plan, you will not get another notice before you are taken out of Welfare-to-Work.

We will not pay for transportation, or work- or training-related expenses if you are not in Welfare-to-Work. We may pay for child care, if you work or attend school.

HOW TO GET BACK IN TO WELFARE-TO-WORK

If you are taken out of Welfare-to-Work, you may be able to get in again at a later date. To find out when you may be able to participate again and what you must do, call the county at _____ .

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

CalFresh: If the failure to meet Welfare-to-Work requirements also causes a CalFresh penalty, you may not be able to get CalFresh benefits. If there is a CalFresh penalty, you will get another notice telling you how long your CalFesh benefits will be stopped.

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). CalFresh MPP § 63-407.521. You may review these rules 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.**
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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

NOTICE OF ACTION

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

_____, our records show that you did not:

- ☐ Sign the Welfare-to-Work plan on _____.
- ☐ Participate in _____ on _____.
- ☐ Make good progress in your_____ activity because _____.
- ☐ Accept a job at _____.
- ☐ Keep your job at _____.
- ☐ Keep the same amount of earnings.

WE NEED TO TALK TO YOU

To keep your family's cash aid from being lowered, we must talk with you about this problem. An appointment has been made for you on _____, at _____ o'clock, at _____.
If you need transportation or child care to go to this meeting, call your Welfare-to-Work worker at the telephone number listed below.

Welfare-to-Work Worker's Name: _____
Telephone Number: _____

If you cannot go to this meeting, you must call your worker to set a new time. Unless you have a good reason, you can change this meeting only once. You can also call your worker to talk about the problem instead of going to the meeting. You must call your worker to set a new time to meet, or to talk about your problem on the telephone, by _____.

When you talk to your worker, you will be asked if you had a good reason ("good cause") for not doing what we asked you to do. If we verify that you had a good reason, your family's cash aid will not be lowered because of this problem. Some examples of good reasons are not having child care or not having transportation. For other good reasons, see the "Request For Good Cause Determination" form sent with this notice.

Your family's cash aid will also not be lowered if you can show us that you should have been exempt at the time you did not do your Welfare-to-Work activity.

If you do not have a good reason for not doing what we asked you to do, you can agree to a compliance plan to meet Welfare-to-Work rules. Your family's cash aid will not be lowered if you agree to a compliance plan and then do what it says. If you agree to a compliance plan and then later do not do what it says, your family's cash aid will be lowered. If this happens, you will get a separate notice.

Rules: These rules apply: CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). CalFresh MPP § 63-407.521. You may review these rules at your welfare office.

HOW TO STOP YOUR FAMILY'S CASH AID FROM BEING LOWERED

As of _____, your family's cash aid will be lowered from $ _____ to $ _____ as shown on the following page, unless you show us you had a good reason for not doing what we asked you to do. If you do not have a good reason, you can agree to a compliance plan to keep your family's cash aid from being lowered. If you do not agree to a compliance plan, you will not get another notice before your family's cash aid is lowered.

See the next page for more information about how we figured how much your family will get if your family's cash aid is lowered.

We will not pay for transportation, or work- or training-related expenses if you are off cash aid. We may pay for child care, if you work or attend school.

HOW TO GET YOURSELF BACK ON CASH AID

Your family's cash aid is being lowered because you did not do what we asked you to do and you are being removed from the Assistance Unit. If your family's cash aid is lowered, you can get your portion of the cash aid back if you are eligible for it by contacting the county and telling them you want your cash aid back; then doing what the county asks.

TO CONTACT THE COUNTY ABOUT GETTING BACK ON CASH AID, CALL _____ .

The family's other parent, _____, may also get cash aid again if he/she is eligible for it by contacting the county and telling them he/she wants cash aid back; then doing what the county asks.

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

CalFresh: If the failure to meet Welfare-to-Work requirements also causes a CalFresh penalty, you may not be able to get CalFresh benefits. If there is a CalFresh penalty, you will get another notice telling you how long your CalFresh benefits will be stopped.

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

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 NOTICE OF DENIAL/DISQUALIFICATION FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

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

The County is taking the following action because _____ did not follow the CalFresh work rules for the California Food Assistance Program (CFAP).

As of _____ ,

- ☐ _____ is denied receipt of CalFresh benefits.
- ☐ _____ is disqualified from the CalFresh Program.
- ☐ The amount of your household's CalFresh benefits will be changed from _____ to _____.
- ☐ Other _____

To get CalFresh benefits again, _____ must be eligible. To be eligible, that person must:

- Be exempt from the CFAP work rules, or
- Take action to end the disqualification or denial.

☐ You can take action at any time to end this disqualification.

☐ You can only take action after _____ to end this disqualification.
You can end this disqualification at any time if you become exempt from the work rules.

If your household had other changes you will get another notice.

WHY CALFRESH BENEFITS ARE BEING STOPPED OR DENIED	HOW TO GET CALFRESH BENEFITS
☐ Didn't keep an appointment/ Didn't give us information we asked for.	Call us/ Give us the information.
☐ Didn't go to a job.	Go to a job if it is still available or go to another job when sent.
☐ Turned down a job.	Take the job if it is still there or find another job. the other job must either be at least 30 hours per week, or pay as much per week as: • The job you turned down, or • The Federal minimum wage times 30.
☐ Changed the number of hours worked to less than 30 hours per week.	Increase the hours worked to at least 30 hours per week.
☐ Quit a job.	Get the job back if it is still open, or find another job with at least the same pay or hours as the one quit.
☐ Didn't meet welfare-to-work rules for the California Work Opportunity and Responsibility to Kids (CalWORKs) Program	Start meeting those rules.
☐ Didn't go on a job search work assignment, to school, or to training that we sent you to.	Start doing the assignment we give you. Call or see us. We will tell you what to do.
☐ Other.	

The person listed above may also need to meet the Non-Assistance CFAP work rule. If that person is ineligible for CalFresh because they have not met that rule for enough months to keep getting CalFresh benefits, another notice will be sent telling them what they need to do to get CalFresh benefits again.

RULES: These rules apply. You may review them at your welfare office.
MPP ☐ 63-407 ☐ 63-408 ☐ 63-410 ☐ W&IC 18932(a) ☐ All County Letter 99-78 ☐ Other_____

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.

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- 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.

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TO ASK FOR A HEARING:

- **Fill out this page.**
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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

NOTICE OF ACTION

COUNTY OF

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

CalFresh Overissuance and Dormant EBT Account

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

(ADDRESSEE)

Questions? Ask your Worker.

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

ACCOUNT OVERISSUANCE

Our records show you have an outstanding overissuance of CalFresh benefits in the amount of $ _____ .

Our records also show that you have not used your CalFresh electronic benefit transfer (EBT) account for over 180 days.

BECAUSE YOU HAVE NOT USED YOUR EBT ACCOUNT FOR 180 DAYS, CALFRESH BENEFITS FROM YOUR EBT ACCOUNT WILL BE USED TO REPAY YOUR CALFRESH OVERISSUANCE UNLESS YOU CONTACT US WITHIN 10 DAYS AFTER THE DATE THIS NOTICE WAS MAILED TO YOU.

YOU MUST:

Contact the county within 10 days after the date this notice was mailed to you if you do not want your CalFresh benefits to be applied to your overissuance. Your CalFresh benefits will be used to repay your overissuance if the county does not hear from you.

Rules: These rules apply; you may review them at your welfare office: MPP 16-120.12 and 16-750.12.

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.
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- 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.

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<u>Cal-Learn</u>:

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- 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.

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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**.

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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: _____

_____

_____

_____

_____

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☐ **If you need more space, check here and add a page.**

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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 INFORMING NOTICE OF RECEIVING INTERCOUNTY TRANSFER

COUNTY OF

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

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

(ADDRESSEE)

Questions? Ask your Worker.

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

_____ County has transferred your CalFresh 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 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.

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COUNTY OF

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

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
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(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 case will be transferred to _____ County.

You do not have to fill out a new application and your CalFresh benefits will not stop during your transfer to your new county of residence. If you have any questions regarding your CalFresh benefits during the transfer to the new county or your 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.

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