



CDSS

WILL LIGHTBOURNE
DIRECTOR

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

744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



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
- Initiated by CDSS

December 2, 2015

ALL COUNTY LETTER NO. 15-96

TO: ALL COUNTY WELFARE DIRECTORS
 ALL CHILD WELFARE SERVICES PROGRAM MANAGERS
 ALL COUNTY ELIGIBILITY SUPERVISORS
 ALL FOSTER CARE MANAGERS
 ALL CHIEF PROBATION OFFICERS
 ALL COUNTY CALWORKS PROGRAM SPECIALISTS
 ALL COUNTY CALFRESH COORDINATORS
 ALL COUNTY CONSORTIUM PROJECT MANAGERS
 CHILD WELFARE SERVICES NEW SYSTEM
 ALL COUNTY EBT PROJECT MANAGERS
 TITLE IV-E AGREEMENT TRIBES
 ALL ADMINISTRATIVE LAW JUDGES
 JUDICIAL COUNCIL STAFF

SUBJECT: APPROVED RELATIVE CAREGIVER FUNDING OPTION PROGRAM
 (ARC PROGRAM): NOTICE-OF-ACTION (NA) FORMS

REFERENCE: [SENATE BILL 855 \(CHAPTER 29, STATUTES OF 2014\)](#); [WELFARE AND INSTITUTIONS CODE \(WI&C\) SECTIONS 11461.3 AND 11466.24](#); [MANUAL OF POLICIES AND PROCEDURES \(MPP\) SECTIONS 45-304, 45-305, AND 45-306](#); [ALL COUNTY INFORMATION NOTICE NO. I-42-14](#); [ALL COUNTY LETTERS \(ACL\) NOS. 14-89, ACL NO. 15-20, ACL NO. 15-20E, ACL NO. 15-54, ACL NO. 15-83.](#)

The purpose of this ACL is to transmit, and to provide counties with information and instructions on, the newly developed Notice-of-Action (NA) forms for the Approved Relative Caregiver Funding Option Program (ARC Program). The ARC NA forms are to be used in conjunction with the California Work Opportunity and Responsibility to Kids (CalWORKs) NA messages M40-171D, M82-832E and M82-832F, which are described in ACL No. 15-54. These CalWORKs NA messages were revised due to the implementation of the ARC Program.

The ARC Program is a county-optional funding program that became effective January 1, 2015. It provides funding to enable participating counties to make the amount paid to an approved relative caregiver for the care and supervision of a child who is under the jurisdiction of the California juvenile court—and who is *ineligible* for the Aid to Families with Dependent Children-Foster Care (AFDC-FC) Program—equal to the basic amount paid on behalf of such a child who is *eligible* for AFDC-FC. The CalWORKs funding is a component of the ARC payment, when applicable.

NEWLY DEVELOPED NA FORMS FOR THE ARC PROGRAM

Four new NA forms are transmitted with this ACL, as follows:

- NA 1277 (11/15), ARC Program, Overpayment;
- NA 1278 (12/15), Approve ARC Payment;
- NA 1279 (12/15), Deny ARC Payment; and
- NA 1280 (12/15), Discontinue ARC Payment.

NA 1277 (11/15). ARC Program. Overpayment

Use the NA 1277 when collecting an overpayment that occurred because a payment was made to an approved relative caregiver participating in the ARC Program when an eligible child was no longer placed with the caregiver. Counties must recoup these overpayments unless certain conditions exist. These conditions are described in [W&IC section 11466.24](#), which applies to the ARC Program pursuant to [W&IC section 11461.3\(d\)](#).

More specifically, W&IC section 11466.24 prohibits collection of overpayments if one of the following conditions applies:

- The cost of collection exceeds the amount of the overpayment that is likely to be recovered by the county. The cost of collecting the overpayment and the likelihood of collection must be documented by the county. Costs that the county must consider when determining the cost-effectiveness to collect are total administrative, personnel, legal filing fees, and investigative costs; and any other applicable costs.
- The child was temporarily removed from the home and payment was owed to the provider to maintain the child's placement, or the child was temporarily absent from the provider's home, or on runaway status and subsequently returned, and payment was made to the provider to meet the child's needs.
- The overpayment was exclusively the result of a county administrative error, or both the county welfare department and the provider were unaware of the information that would establish that the foster child (including an ARC-eligible child) was not eligible for foster care (or ARC) benefits.

- The provider did not have knowledge of and did not contribute to the cause of the overpayment.

For further clarification of what constitutes a temporary absence, please refer to [MPP section 45-302.231](#).

In addition, the following applies to overpayments under the ARC Program pursuant to W&IC section 11461.3(d):

- Recouped ARC overpayments, including any portion that was made with CalWORKs funding, are not subject to remittance to the federal government.
- Any overpaid funds collected by counties participating in the ARC Program must be remitted to the State of California after subtracting both of the following:
 - An amount not to exceed the county share of the CalWORKs portion of the ARC payment, if any; and
 - Any other county funds that were included in the ARC payment.

Instructions regarding the claiming of overpayments will be issued in a forthcoming County Fiscal Letter.

Foster care rules. For the purposes of collecting overpayments under the ARC Program, and as specified in W&IC sections 11461.3(d) and 11466.24, foster care rules apply. The overpayment rules and requirements in [MPP sections 45-304, 45-305 and 45-306](#) should be followed.

Fraud. In addition to the proper collection and documentation of evidence supporting the issuance of the NA 1277, counties should consult with their county counsel on whether that evidence supports a determination that the approved relative caregiver engaged in fraudulent activities; and, if so, whether further actions in addition to overpayment collection, such as criminal prosecution, are warranted.

NA 1278 (12/15). Approve ARC Payment

Use the NA 1278 to approve cash aid under the ARC Program. This form includes related instructions about Electronic Benefit Transfer cards, Medi-Cal benefits and Cal-Fresh benefits.

NA 1279 (12/15). Deny ARC Payment

Use the NA 1279 to deny cash aid under the ARC Program, and to indicate the reason(s) why the cash aid is being denied.

NA 1280 (12/15). Discontinue ARC Payment

Use the NA 1280 to discontinue cash aid under the ARC Program, and to indicate the reason(s) why the cash aid is being discontinued.

CAMERA-READY COPIES AND TRANSLATIONS

For a camera-ready copy of the forms in English, contact the California Department of Social Services (CDSS) 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.cdss.ca.gov/cdssweb/PG167.htm>.

When all translations are completed per [MPP section 21-115.2](#), including Spanish forms, they are posted on an ongoing 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 CDSS Language Services at (916) 651-8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be provided the English version of the form or notice along with the [GEN 1365 \(Notice of Language Services\)](#) and a local contact number.

Counties 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 interpreter services if an applicant or recipient requests it. More information regarding translations can be found in MPP section 21-115.

If you have any questions, or need further information regarding this letter, please contact the Foster Caregiver Policy and Support Unit at (916) 651-7465 or ARCFO@dss.ca.gov.

Sincerely,

Original Document Signed By:

GREGORY E. ROSE
Deputy Director
Children and Family Services Division

Attachments

NOTICE OF ACTION

APPROVED RELATIVE CAREGIVER (ARC) OVERPAYMENT

COUNTY OF _____

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

- (1) Name: _____
(2) Address: _____
(3) City, State, Zip: _____

- (4) Notice Date: _____
(5) Case Name: _____
(6) Case Worker Number: _____
(7) Case Worker Name: _____
(8) Case Number: _____
(9) Telephone: _____
(10) Address: _____

For Approved Relative Caregivers participating in the Approved Relative Caregiver Funding Option Program (ARC Program):

This is to inform you that you were overpaid ARC Program benefits

(11) for _____ (NAME OF CHILD)

(12) for the month(s) of _____ to _____
(MM/DD/YYYY) (MM/DD/YYYY)

(13) Total amount you received: \$ _____

(14) Total amount you should have received: \$ _____

(15) Total amount of Overpayment: \$ _____

(16) Date of Discovery: _____
(MM/DD/YYYY)

(Collection is permitted if demand is made within one year of discovery.)

(17) You are required to repay the overpayment amount of \$ _____.

(18) Reason for the overpayment:

(A) From _____ (date) the child/youth was not residing in your home,
and you failed to report that to your county social worker and you received
payments for him/her that you were not entitled to.

(B) Other: _____

By law, we can collect ARC Program overpayments if the approved relative caregiver caused the overpayment. We cannot require you to repay the overpayment if you meet an **exception**. Exceptions to repayment are:

- The overpayment was caused by county administrative error, OR
- Neither the county nor the approved relative caregiver knew of or contributed to the cause of the overpayment.
- The minor's absence was temporary and the funds were used to maintain the home for his/her return or used to support his/her needs.

If you disagree with the reason for the overpayment or the amount of the overpayment, you may request a hearing. Please see the following page for hearing instructions.

If you agree with the reason for the overpayment and the amount of the overpayment, you must do **one of the following** within 90 calendar days from the day the county gave or mailed you this notice:

- 1) Make a one-time payment of the total amount.

Please pay by check or money order, made payable to:

Send to:

- 2) Sign a written repayment agreement. You must contact the worker at the top of this form to discuss the terms of a written payment agreement.

If you have any questions regarding the overpayment computation or repayment arrangements, please contact the case worker at the top of this form.

Relevant Law: Welfare and Institutions Code sections 11461.3 and 11466.24; MPP sections 22-009, 45-304, 45-305, and 45-306.

(19) Insert overpayment calculations and substantiation of time periods by month as required in regulation. See Manual of Policies and Procedures (MPP) section 45-305. Attach a page if additional space is needed.

NA 1277 FORM AND INSTRUCTIONS

Welfare and Institutions Code (WIC) sections 11461.3 requires county welfare agencies to recoup Approved Relative Caregiver Funding Option Program (ARC Program) overpayments in accordance with WIC section 11466.24. WIC section 11466.24 and MPP sections 45-304 and 45-305 require county welfare agencies to recoup overpayments with certain exceptions. **Do not use this form if overpayment was to an approved relative caregiver who meets one of these exceptions.**

In an effort to clarify instances when an overpayment is legally collectible from an approved relative caregiver participating in the ARC Program on behalf of an eligible child, the California Department of Social Services has developed the NA 1277 form and instructions. This newly developed form has specific language for an approved relative caregiver who is assessed an ARC overpayment and does NOT qualify for one of the exceptions identified in WIC section 11466.24 because the approved relative caregiver knowingly contributed to or caused the overpayment.

1. **Name:** Use this line to report the name of the approved relative caregiver.
2. **Address:** Use this line to report the address of the approved relative caregiver.
3. **City, State, Zip:** Use this line to report the city, state and zip code of the approved relative caregiver.
4. **Notice Date:** Use this line to report the date the notice is drafted.
5. **Case Name:** Use this line to report the name of the child/youth.
6. **Case Worker Number:** Use this line to report the case worker's identification number.
7. **Case Worker Name:** Use this line to report the case worker's name.
8. **Case Number:** Use this line to report the case number associated with the child/youth.
9. **Telephone Number:** Use this line to report the case worker's telephone number.
10. **Address:** Use this line to report the case worker's address.
11. Name of child/youth for whom ARC Program payments were provided.
12. Beginning date and ending date that ARC Program payments were provided for each identified overpayment period. If more than one period is in contention, then a separate NA 1277 form needs to be completed.
13. Total amount of ARC Program funds the provider received.
14. Total amount of ARC Program funds the provider should have received.
15. Total amount of ARC Program funds overpaid.
16. Date overpayment was discovered.
17. Total amount of ARC Program overpayment funds to be repaid.
18. Reason for the overpayment. Check the appropriate box(es).
 - A. You knowingly failed to report the child/youth left your home on _____ and you received payments for him/her that you were not entitled to after this date; or
 - B. Other: Use additional page for detailed explanation that fully describes the reason why an overpayment exists for a period when the child/youth was not in the home that is excluded under WIC section 11466.24. The reason **must** be one of the listed reasons for collecting an overpayment.
19. This section of the NA 1277 is left blank and should be used by counties to identify time periods for overpayments. This section can also be used to provide documentation and substantiation of time periods and mathematical calculations for verification of the overpayment.

The purpose for any attachments submitted by the county pursuant to the instructions in #18 or #19 is for counties to provide clear and complete details of the reasons identified on the front page so that providers understand the basis for the establishment of the overpayment and the demand for repayment.

NOTICE OF ACTION - APPROVE APPROVED RELATIVE CAREGIVER (ARC) PAYMENT

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

(ADDRESSEE)

┌ _____ ┐
└ _____ ┘

┌ _____ ┐
└ _____ ┘

Questions? Ask your Worker.

For Approved Relative Caregivers participating in the Approved Relative Caregiver Funding Option Program (ARC Program):

The County has approved your application, dated _____, for cash
aid for _____ under the ARC Program.
MM/DD/YYYY
NAME OF CHILD

The cash aid payment for your first month of aid is \$ _____.

Your first day of cash aid is _____.
MM/DD/YYYY

The cash aid payment for your first month of aid may only be for a part of the month. It is for the time from your first day of cash aid, shown above, through the end of the month. If nothing changes, your ongoing monthly cash aid amount will be \$ _____.

This cash aid will be issued via:

The Electronic Benefit Transfer (EBT) card; or

A check mailed to you; or

Direct deposit

EBT: Keep your EBT card if you use EBT, even if your aid is terminated. Please do not throw your card away. If your ARC cash aid will be issued on a new EBT card, you will receive the new EBT card within 10 business days for this case. If your family currently receives CalWORKs or other benefits on an EBT card, and the child's county of court jurisdiction is the same as the child's county of residence, the child's ARC payments will be consolidated onto the family's existing EBT card. If the child is a non-minor dependent, he/she will receive his/her own EBT card.

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.

Rules: These rules apply. You may review them at your county welfare office: Welfare and Institutions Code section 11461.3, Senate Bill 855 (Chapter 29, Statutes of 2014); Section 58 of Chapter 20 of the Statutes of 2015; All County Information Notice I-42-14; All County Letters 14-89, 15-20, 15-20-E, and 15-83; and County Fiscal Letters 14-15-45, 14-15-52, 14-15-58, 15-16-07, and 15-16-24.

**NOTICE OF ACTION - DENY
APPROVED RELATIVE CAREGIVER
(ARC) PAYMENT**

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.

**For Approved Relative Caregivers participating in the
Approved Relative Caregiver Funding Option Program
(ARC Program):**

The County has denied your application, dated _____, for cash aid
for _____ under the ARC Program.
MM/DD/YYYY
NAME OF CHILD

Here's why:

You are not eligible for cash aid under the ARC Program for one or more of the following reasons:

Your home was not approved, and you received a Notice of Action—Denial of Home Assessment/Approval (NA 1271) from the County explaining why.

The child is not under the jurisdiction of the California juvenile court.

You do not live in California.

The child does not live in California.

The child is federally eligible under Title IV-E of the Social Security Act and qualifies for foster care funds (rather than ARC funds).

The child is not eligible because of age.

Other _____.

Rules: These rules apply. You may review them at your county welfare office: Welfare and Institutions Code section 11461.3, Senate Bill 855 (Chapter 29, Statutes of 2014); Section 58 of Chapter 20 of the Statutes of 2015; All County Information Notice I-42-14; All County Letters 14-89, 15-20, 15-20-E, and 15-83; and County Fiscal Letters 14-15-45, 14-15-52, 14-15-58, 15-16-07, and 15-16-24.

YOUR HEARING RIGHTS

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

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

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

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

Yes, lower or stop: Cash Aid CalFresh
 Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.

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

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

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:

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

OTHER INFORMATION

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

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

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

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing.

The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 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 can be a friend or relative but cannot interpret for you.)

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

NOTICE OF ACTION - DISCONTINUE APPROVED RELATIVE CAREGIVER (ARC) PAYMENT

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.

For Approved Relative Caregivers participating in the Approved Relative Caregiver Funding Option Program (ARC Program):

As of _____, the County is stopping your cash aid
MM/DD/YYYY
for _____ under the ARC Program.
NAME OF CHILD

Here's why:

You are no longer eligible for cash aid under the ARC Program for one or more of the following reasons:

The child is no longer placed with you.

Your home is no longer approved, and you received a Notice of Action—Denial of Home Assessment/Approval (NA 1271) from the County explaining why.

The child is no longer under the jurisdiction of the California juvenile court.

You no longer live in California.

The child no longer lives in California.

The child is not eligible because of age.

Other _____.

Rules: These rules apply. You may review them at your county welfare office: Welfare and Institutions Code section 11461.3, Senate Bill 855 (Chapter 29, Statutes of 2014); Section 58 of Chapter 20 of the Statutes of 2015; All County Information Notice I-42-14; All County Letters 14-89, 15-20, 15-20E, and 15-83; and County Fiscal Letters 14-15-45, 14-15-52, 14-15-58, 15-16-07, and 15-16-24.

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

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

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

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

Yes, lower or stop: Cash Aid CalFresh
 Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.
 You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.
 If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:

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

OTHER INFORMATION

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

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

NAME	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE