NOTICE OF FORM CHANGE NO. 03-032

DATE: March 4, 2003

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE

CW 89 English and Spanish (2/03) Application Withdrawal Request

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☑ Free ☐ Sold		☐ Yes ☑ No
☑ New ☐ Revised	DATE OF FORM 2/03	REPLACES	☐ Obsolete

REQUIRED FORM-
☐ No Change Permitted
REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval
☑ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ OTHER:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☐ Use until exhausted
☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☑ Use new form effective 2/03

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☑ Other (specify) ACIN I-08-03

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Print form: 8 1/2 x 11, one sided.

Check on the Internet to see if forms are available at www.dss.cahwnet.gov.

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov.

Contact Language Services for other languages at (916) 445-6778. or by electronic mail at LTS@dss.ca.gov.

APPLICATION WITHDRAWAL REQUEST

I wish to withdraw my application dated _____ for:

- ☐ Cash Aid
- ☐ Food Stamps
- ☐ Medi-Cal/State-Run CMSP

Reason: _____

Please answer the following questions:

Did you decide to drop this application? . . . . . ☐ YES ☐ NO

Did anyone from the County tell you to drop this application? . . . . . ☐ YES ☐ NO

I understand that I may reapply at any time. I also understand that by withdrawing my application, I will have no appeal rights.

YOU WILL NOT GET A HEARING IF YOU SIGN THIS FORM. THE COUNTY WILL SEND YOU A LETTER TO CONFIRM YOUR APPLICATION WITHDRAWAL.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF APPLICANT	DATE
COUNTY REPRESENTATIVE	DATE

PETICION PARA RETIRAR UNA SOLICITUD

Deseo retirar mi solicitud con fecha de _____ para:

- ☐ Asistencia monetaria
- ☐ Estampillas para comida
- ☐ Programa de Asistencia Médica de California (Medi-Cal)/Programa de Servicios Médicos del Condado administrado por el estado (*State-Run CMSP*).

La razón es: _____

Por favor conteste las siguientes preguntas:

¿Usted decidió retirar esta solicitud? . . . . . ☐ SI ☐ NO

¿Alguien del Condado le dijo que retirara esta solicitud? . . . . . ☐ SI ☐ NO

Yo entiendo que en cualquier momento puedo volver a presentar otra solicitud. También entiendo que no tendré ningún derecho de apelación al retirar mi solicitud.

NO TENDRA UNA AUDIENCIA SI FIRMA ESTE FORMULARIO. EL CONDADO LE ENVIARA UNA CARTA NOTIFICANDOLE QUE SU PETICION HA SIDO RETIRADA.

FIRMA DEL SOLICITANTE	FECHA
FIRMA DEL SOLICITANTE	FECHA
REPRESENTANTE DEL CONDADO	FECHA