

**NOTICE OF FORM CHANGE NO.**

DATE

**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

ORDER UNIT	<input type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> New <input type="checkbox"/> Revised	DATE OF FORM	REPLACES	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: <b>Department of Social Services Warehouse</b> <b>P.O. Box 980788</b> <b>West Sacramento, CA 95798-0788</b>		<input type="checkbox"/> 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 \_\_\_\_\_

## USE FORM IN ACCORDANCE WITH

 All County Letter No. Other (specify)

## ADDITIONAL INFORMATION REGARDING FORM CHANGE

# NOTICE OF ACTION

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

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

## DENY - FINANCIAL ELIGIBILITY

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

(ADDRESSEE)

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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.

As of \_\_\_\_\_, the county has denied your request for back cash aid.

Here's Why:

- Between October 2002 and July 2003, you were denied cash aid because you had too much income. State law changed raising the amount of income applicants can make and be eligible for cash aid. After reviewing your application using the higher amounts allowed, your income is still more than the need standard set by the State for a family of your size.
- You did not apply for cash aid between October 2002 and July 2003.
- You were denied because you had property that was worth more than the allowed limits.
- You were denied because you failed to provide information or proof needed to determine your eligibility.
- You were denied because there was no eligible child(ren) living in the home.
- Other:

### Family's Total Earned Income

(Assistance Unit + Non-Assistance Unit Members) . \$ \_\_\_\_\_  
 \$90 Disregard for each employed person . . . . . - \_\_\_\_\_  
 Other Nonexempt Income (Assistance Unit + Non-Assistance Unit Members) . . . . . + \_\_\_\_\_  
**(A) Net Countable Income** . . . . . = \_\_\_\_\_

### Family Needs

Basic Need for \_\_\_\_\_ Persons  
 (Assistance Unit + Non-Assistance Unit Members) . \$ \_\_\_\_\_  
 Special Needs (Assistance Unit + Non-Assistance Unit Members) . . . . . + \_\_\_\_\_  
**(B) Family Needs** . . . . . = \_\_\_\_\_

**Medi-Cal:** This notice DOES NOT change or stop Medi-Cal Benefits. **Keep using your plastic Benefits Identification Card(s).**

**Rules:** These rules apply; you may review them at your welfare office: MPP 44-207.1.

## 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 ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, 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 Food Stamps 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, Food Stamps 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  Food Stamps  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  Food Stamps  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

NEGACION - ELEGIBILIDAD FINANCIERA

Fecha de la notificación :
Nombre del caso :
Número Nombre del trabajador :
Número :
Teléfono :
Dirección :

(ADDRESSEE)

Empty box for addressee information.

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el Estado: Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En la siguiente página se le explica cómo solicitarla. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

A partir de \_\_\_\_\_, el Condado negó su solicitud para asistencia monetaria retroactiva.

LA RAZON ES LA SIGUIENTE:

- Entre octubre de 2002 y julio de 2003, se le negó la asistencia monetaria debido a que usted tenía demasiados ingresos.
Usted no solicitó asistencia monetaria entre octubre de 2002 y julio de 2003.
Se le negó la asistencia monetaria debido a que tenía bienes con un valor por encima de los límites permitidos.
Se le negó la asistencia monetaria debido a que usted no proporcionó la información o pruebas que se necesitaban para determinar su elegibilidad.
Se le negó la asistencia monetaria debido a que no había un niño (o niños) elegible viviendo en el hogar.
Otra:

Total de ingresos ganados de la familia

(Unidad de asistencia + miembros que no son parte de la unidad de asistencia) \$
Deducción de \$90 por cada persona que trabaja -
Otros ingresos no exentos (unidad de asistencia + miembros que no son parte de la unidad de asistencia) +
(A) Ingresos netos contables =

Necesidades de la familia

Necesidades básicas para \_\_\_\_\_ personas
(Unidad de asistencia + miembros que no son parte de la unidad de asistencia) \$
Necesidades especiales (unidad de asistencia + miembros que no son parte de la unidad de asistencia) +
(B) Necesidades de la familia =

Medi-Cal: Esta notificación NO cambia ni suspende sus beneficios de Medi-Cal (Programa de Asistencia Médica de California). Continúe usando sus tarjetas de plástico de identificación de beneficios.

Reglas: Las siguientes reglas, las cuales puede revisar en la oficina de bienestar público, son pertinentes: MPP 44-207.1

