

NOTICE OF FORM CHANGE NO. 03-132

DATE

09/08/2003

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

Community Care Licensing District Offices
 Private and Public Adoption Agencies

District Attorney
 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 **QR 377.4 (7/03) English and Spanish
Food Stamp Notice of Change For Quarterly Reporting Household**

ORDER UNIT SET	<input type="checkbox"/> Free <input checked="" type="checkbox"/> Sold	ESTIMATED PRICE \$.40 ENG / \$.84 SP	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised	DATE OF FORM 7/03	REPLACES	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input type="checkbox"/> No Change Permitted	REQUIRED FORM- <input checked="" type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788		<input type="checkbox"/> Other:	

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY <input type="checkbox"/> Use until exhausted	<input type="checkbox"/> Destroy
USE NEW FORM <input type="checkbox"/> When supply available in DSS Warehouse	<input checked="" type="checkbox"/> Use new form effective 9/03
USE FORM IN ACCORDANCE WITH <input checked="" type="checkbox"/> All County Letter No. 03-18	<input type="checkbox"/> Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Form printed: 8 1/2 x 11, 2-part carbon interleaved, NA BACK 9.

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.

COUNTY OF _____

FOOD STAMP NOTICE OF CHANGE FOR QUARTERLY REPORTING HOUSEHOLD

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: You can ask for a hearing if you believe the action is wrong. The back of this page tells how to ask for a hearing. If you already had a hearing on the cause of the overissuance that is being collected, you cannot ask for a new hearing, unless you think the new amount of food stamp benefits you are getting because of the overissuance collection is incorrect.

CHANGE IN BENEFITS

Effective _____, your food stamp benefits are changed from \$ _____ to \$ _____ each month because:

You have already been told about an overissuance of food stamps and you are getting less food stamps because the County has been reducing your monthly allotment by 10% or \$10 (whichever is more) to pay back the food stamps 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 food stamp allotment, this form will tell you.

PROPOSED CHANGE IN BENEFITS

Effective _____, your food stamp 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 Quarterly Eligibility Status Report (QR 7). We must receive the following information by no later than the first day of next month:

If verification of an expense is requested and you do not provide it, the expense will not be allowed when computing next quarter'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 food stamp benefits in this quarter did not change as a result of the document(s) /information we received because:

Any changes you voluntarily reported must be reported again on your next Quarterly Report (QR 7), along with proof of the change.

SUSPENSION

Effective _____, your food stamp benefits are suspended because:

You will not receive any food stamp benefits for _____.

During this period of suspension, you must continue to complete and submit your QR 7 so we can determine if you will be eligible for benefits the month after the month of suspension. If you do not submit a complete QR 7 during your suspension, your food stamp participation will be terminated.

TERMINATION

Effective _____, your food stamp benefits are terminated because:

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

COMMENTS

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

CONDADO DE _____

NOTIFICACION DE CAMBIO PARA UN GRUPO PARA FINES DE ESTAMPILLAS PARA COMIDA QUE TIENE QUE REPORTAR CADA TRIMESTRE

Fecha de la notificación : _____
Nombre del Caso : _____
Número : _____
Nombre del Trabajador : _____
Número : _____
Teléfono : _____
Dirección : _____

(ADDRESSEE)

Si tiene alguna pregunta o quiere más información acerca de esta acción, por favor comuníquese con su trabajador.

Audiencia con el Estado: Si cree que esta acción está equivocada, puede solicitar una audiencia. En la siguiente página se le explica cómo solicitarla. Si ya tuvo una audiencia sobre la razón de la emisión excesiva que se está cobrando, no puede pedir otra audiencia, a menos que usted crea que es incorrecta la cantidad nueva de estampillas para comida que recibirá debido al cobro de la emisión excesiva.

CAMBIO EN LOS BENEFICIOS

A partir de _____, sus beneficios de estampillas para comida cambiarán de \$ _____ a \$ _____ cada mes porque:

Ya se le informó acerca de una emisión excesiva de estampillas para comida y está recibiendo menos estampillas para comida debido a que el Condado redujo su asignación mensual un 10% o \$10 dólares (la cantidad que sea mayor) para reembolsar las estampillas para comida que usted recibió pero no debió haber recibido. Se decidió en una corte o en una audiencia administrativa del Estado o porque usted firmó un "Acuerdo de consentimiento a descalificación" o una "Renuncia a una audiencia administrativa de descalificación" que esta emisión excesiva fue el resultado de una violación intencional del programa (IPV). Ahora cambiará su asignación mensual porque el Condado puede comenzar a reducir su asignación un 20% o \$10 dólares (la cantidad que sea mayor). Este formulario le indicará si hay algún otro cambio en su asignación mensual de estampillas para comida.

CAMBIO PROPUESTO EN LOS BENEFICIOS

A partir de _____, es posible que sus beneficios de estampillas para comida se reduzcan o terminen debido a que no se recibió con su "Reporte trimestral de elegibilidad/situación" (el formulario QR 7) la información necesaria para determinar si sigue teniendo derecho a beneficios o la cantidad correcta de sus beneficios. Tenemos que recibir la siguiente información a más tardar el primer día del próximo mes:

Si se le pide verificación de un gasto y usted no la proporciona, no se permitirá que se incluya este gasto en el cálculo para los beneficios del próximo trimestre. Además, si no proporciona otra información que se le pida, es posible que sus beneficios se reduzcan o terminen.

Reglas: Estas reglas son pertinentes a la acción (o acciones) mencionada anteriormente:
Puede revisarlas en la oficina de bienestar público.

NO HAY CAMBIO EN LOS BENEFICIOS

Sus beneficios de estampillas para comida no han cambiado durante este trimestre debido a los documentos/información que recibimos porque:

Cualquier cambio que usted reportó voluntariamente se tiene que reportar de nuevo en su próximo reporte trimestral (QR 7), y tiene que adjuntar pruebas del cambio.

SUSPENSION

A partir de _____, sus beneficios de estampillas para comida se suspenderán porque:

No recibirá beneficios de estampillas para comida para _____.

Durante este período de suspensión, usted tiene que seguir completando y presentando su reporte trimestral (QR 7) para que podamos determinar si tendrá derecho a recibir beneficios el mes siguiente al último mes de la suspensión. Si no sigue presentando su QR 7 completado durante el período de suspensión, se terminará su participación en el Programa de Estampillas para Comida.

TERMINACION

A partir de _____, sus beneficios de estampillas para comida se descontinuarán porque:

Basándose en la razón por la cual se descontinuaron sus beneficios, su grupo para fines de estampillas para comida también es descalificado para participar en el Programa de Estampillas para Comida hasta _____. Usted puede presentar una nueva solicitud para beneficios al final de este período de descalificación.

COMENTARIOS

