

NOTICE OF FORM CHANGE NO. 03-250

DATE

12-29-2003

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 377.2 (9/03) English and Spanish
Food Stamp Notice Of Expiration Of Certification - Quarterly Reporting**

ORDER UNIT SET	<input type="checkbox"/> Free <input checked="" type="checkbox"/> Sold	ESTIMATED PRICE ENG = \$.39 / SP = \$.65	INITIAL SUPPLY SENT <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised	DATE OF FORM 9/03	REPLACES	<input type="checkbox"/> 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 9/03

USE FORM IN ACCORDANCE WITH

 All County Letter No. 03-18 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Form printed: 8 1/2 x 11, 2-part carbon interleaved set, 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.

FOOD STAMP NOTICE OF EXPIRATION OF CERTIFICATION - QUARTERLY REPORTING

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

• Case Name :
• Case Number :
• District :
• Worker :
• Phone :
• Date of Notice :

1. **Your current food stamp certification period will end on:**_____.

Your application for recertification is being processed.

2. **If you want to continue receiving food stamp benefits after the end of your current certification period, without a break in benefits, you must:**

Submit your complete Quarterly Report (QR 7/SAWS QR 7) so it is received no later than_____, fill out the attached application and submit it to the county welfare department by no later than your recertification interview (see 3 below).

Submit your complete Quarterly Report (QR 7/SAWS QR 7) so it is received no later than_____.

Fill out and submit an application so it is received by the county welfare department no later than_____.

3. **To be sure your application for recertification is processed promptly, you must:**

Appear for an interview on:_____ at:

You may bring your complete Quarterly Report (QR 7/SAWS QR 7) to your recertification interview if you wish.

Call for an interview appointment.

Mail/bring your application to:

Call for an application.

Do the following so we can finish processing your application:

IF YOU REAPPLY LATER THAN THE DATE SPECIFIED IN NO. 2 ABOVE, YOU MAY HAVE TO WAIT UP TO 30 DAYS BEFORE FINAL ACTION IS TAKEN ON YOUR APPLICATION. **In addition, your benefits may be prorated for the first month of the first quarter of your new certification period.**

If you have a good reason for not applying on time, you should tell the county welfare department. You may be entitled to have any lost benefits restored if the county welfare department decides you had a good reason.

IF YOU MISS YOUR SCHEDULED INTERVIEW AND YOU HAVE A GOOD REASON, YOU SHOULD TELL THE COUNTY WELFARE DEPARTMENT. IF THE COUNTY WELFARE DEPARTMENT DECIDES THAT CIRCUMSTANCES BEYOND YOUR CONTROL PREVENTED YOU FROM ATTENDING THE INTERVIEW, A SECOND INTERVIEW WILL BE SCHEDULED.

You have the right to request an application from the county welfare department at any time and to have the county welfare department accept your application. If you and/or your authorized representative are unable to reapply in person at the county welfare department and you have a good reason for not being able to do so, you should call the county welfare department at the above number. We can arrange to have a worker interview you or your authorized representative at home or by telephone.

The above action is required by the following Food Stamp Manual Section(s):

You have the right to request a state hearing if you disagree with any of these requirements. See the back of this notice for a hearing request.

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

