

NOTICE OF FORM CHANGE NO. 04-206

DATE

07-12-2004

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 **NA 960X QR (4/04) English and Spanish**
Notice Of Action - Stop Aid; Report Not Received

ORDER UNIT MASTER ONLY	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised	DATE OF FORM 4/04	REPLACES NA 960X English and Spanish	<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 checked="" type="checkbox"/> Destroy
USE NEW FORM <input type="checkbox"/> When supply available in DSS Warehouse	<input checked="" type="checkbox"/> Use new form effective <u> </u> Date of this notice
USE FORM IN ACCORDANCE WITH <input type="checkbox"/> All County Letter No.	<input checked="" type="checkbox"/> Other (specify) ACIN I-30-04

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Print form: 8 1/2 x 11, two sided, NA BACK 9.

NA 960X QR replaces the NA 960X

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.

NOTICE OF ACTION

COUNTY OF _____

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

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 is stopping your:

- Cash Aid
- Food Stamps

Here's why:

As of the 11th of this month, the County has not received your quarterly report (QR 7) due this month.

TO STOP THIS ACTION, the County must RECEIVE your COMPLETE report no later than the FIRST WORKING DAY OF NEXT MONTH.

The information you give us may change or stop your cash aid.

YOU MUST RETURN THE QR 7 IF YOU WANT TO CONTINUE TO GET CalWORKs CASH AID.

You and your family may still continue to get Medi-Cal if your cash aid stops and:

- you have earnings from a job, a business you started or a pay raise.
- you have started to receive or had an increase in child/spousal support payments.

Medi-Cal: This notice DOES NOT change or stop Medi-Cal Benefits. If there is a change in your Medi-Cal benefits, you will receive another notice. **Keep using your plastic Benefits Identification Card(s).**

Rules: These rules apply. You may review them at your welfare office - Cash Aid: MPP 40-105.1, 40-181.242, 44-315.8, ; Food Stamps: 63-504.3, 63-504.27.

Food Stamps Only:

You must report any new household members and their social security numbers. If you have already reported a new member but not their social security number, it must be reported now.

If you need help in completing the quarterly report, the County will help you to do so. Please contact the County and ask for help.

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

NOTIFICACION DE ACCION

CONDADO DE _____

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

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

(ADDRESSEE)

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¿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 solicita una audiencia antes que esta acción entre en vigor.

A partir de _____, el Condado discontinuará:

- su asistencia monetaria
- sus estampillas para comida

La razón es la siguiente:

Hasta el 11 de este mes, el Condado no había recibido su reporte trimestral (el formulario QR 7) el cual se tiene que recibir este mes.

PARA PARAR ESTA ACCION, el Condado tiene que RECIBIR su reporte COMPLETO a más tardar el PRIMER DIA HABIL DEL PROXIMO MES.

Es posible que la información que usted nos proporcione cambie o descontinúe su asistencia monetaria.

Estampillas para comida solamente:

Usted tiene que reportar todos los nuevos miembros de su grupo para fines de estampillas para comida así como el número de Seguro Social de cada uno. Si usted ya ha reportado un miembro nuevo pero todavía no ha reportado su número de Seguro Social, tiene que reportarlo ahora.

Si necesita ayuda para completar el reporte trimestral, el Condado le ayudará a hacerlo. Por favor, comuníquese con el Condado y pida ayuda.

USTED TIENE QUE DEVOLVER EL FORMULARIO QR 7 SI QUIERE CONTINUAR RECIBIENDO ASISTENCIA MONETARIA PROVENIENTE DE CalWORKs (Programa de California de Oportunidades de Trabajo y Responsabilidad hacia los Niños).

Es posible que usted y su familia todavía continúen recibiendo beneficios de Medi-Cal (Programa de Asistencia Médica de California) si se descontinúa su asistencia monetaria y usted:

- tiene ingresos ganados de un empleo, de un negocio que haya empezado, o de un aumento en el salario.
- ha empezado a recibir o ya ha tenido un aumento en los pagos de mantenimiento de hijos/esposa(o).

Medi-Cal: Esta notificación NO cambia ni suspende sus beneficios de Medi-Cal. Si hay un cambio en sus beneficios de Medi-Cal, recibirá otra notificación. **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: en relación a la asistencia monetaria - Manual de Prácticas y Procedimientos (MPP) 40-105.1, 40-181.242, 44-315.8; en relación a las estampillas para comida - MPP 63-504.27, 63-504.3

