NOTICE OF ACTION
Continued

COUNTY OF

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

Notice Date: _____
Case Name: _____
Case Number: _____
Worker Name: _____
Worker Number: _____
Telephone: _____
Worker Hours: _____
24 Hour Information: _____
Address: _____

Questions? Ask your worker or call the number above.

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.

You reported income that you do not expect to change. When you get paid every week or every other week, here is how we figure your monthly income:

First, we add all the income you got in the month and divide by the total number of payments you got. Then, we multiply that amount by the average number of payments in a month.

- If you get paid every week, you may get paid 4 or 5 times in a month. 4.33 is the average number of payments in a month.
- If you get paid every other week, you may get paid 2 or 3 times in a month. 2.167 is the average number of payments in a month.

Here's your information:

_____ Income Reported	$_____
	$_____
	$_____
	$_____
	+$_____
Total Reported	=$_____
# of Payments Reported	÷_____
Weekly Amount	=$_____
Multiplied by	x_____
Monthly Amount	=$_____

Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

1. Total Self-Employment Income . . . . . $ _____
2. Self-Employment Expenses:
   a. 40% Standard . . . . . - _____
   OR
   b. Actual . . . . . - _____
3. Net Earnings from Self-Employment . . . . . = _____
4. Total Disability-Based Unearned Income (DBI) (Assistance Unit + Non-Assistance Unit Members) . $ _____
5. $225 DBI Disregard (if #4 is greater than $225) . . . . - _____
6. Nonexempt Unearned Disability-Based Income . . . . = _____
   OR
7. Unused DBI Disregard (up to $112) . . . . . = _____
8. Net Earnings from Self-Employment (from above) . . + _____
9. Total Other Earned Income . . . . . + _____
10. Unused Amount of $225 (from #7) or $112 (whichever is less) . . . . . - _____
11. Subtotal . . . . . = _____
12. Earned Income Disregard 50%. . . . . - _____
13. Subtotal . . . . . = _____
14. Nonexempt Unearned Disability-Based Income (from #6) . . . . . + _____
15. Subtotal . . . . . = _____
16. Other Nonexempt Income (Assistance Unit + Non-Assistance Unit Members) . . . . . + _____

Net Countable Income . . . . . = _____

Section B. Your Cash Aid, Month of _____

1. Maximum Aid _____ Persons (Assistance Unit + Non-Assistance Unit Members) . . $ _____
2. Special Needs (Assistance Unit + Non-Assistance Unit Members) . . . . . + _____
3. Net Countable Income from Section A (above) . . . . . - _____
4. Subtotal . . . . . = _____
5. Maximum Aid _____ Persons (Assistance Unit only) (Excluding MFG, or Penalized Persons) . . . . . $ _____
6. Special Needs (Assistance Unit only) . . . . . + _____
7. Maximum Aid Subtotal . . . . . = _____
8. **Full Month Aid Subtotal** (Lowest Amount on Line 4 or 7) . . . . . = _____
9. Line 8 Prorated for Part of Month . . . . . = _____
10. Adjustments: 25% Child Support Penalty(ies) . . . . . - _____
    Other Penalties . . . . . - _____
    Overpayment . . . . . - _____
    School Bonus ($100 or $500) . . . . . + _____
11. **Monthly Cash Aid Amount** (Line 8 or 9 Adjusted) . . . . . $ _____
12. Current Cash Aid Amount (If This Amount is more Than #11, Your Cash Aid Will Not Change) . . . . . = _____

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 have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh (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 CalFresh (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, CalFresh (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 ☐ CalFresh (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 ☐ CalFresh (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