



CDSS

WILL LIGHTBOURNE
DIRECTOR

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

744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



EDMUND G. BROWN JR.
GOVERNOR

November 13, 2014

ALL COUNTY LETTER (ACL) NO. 14-85

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

TO: ALL COUNTY WELFARE DIRECTORS
 ALL COUNTY CHILD CARE COORDINATORS
 ALL COUNTY WELFARE TO WORK COORDINATORS
 ALL CONSORTIA MANAGERS
 STAGE ONE ALTERNATIVE PAYMENT PROGRAM PROVIDERS

SUBJECT: REVISED FORMS FOR STAGE ONE CHILD CARE IN THE CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) PROGRAM

The purpose of this letter is to transmit the revised Stage One Child Care forms and Notices of Action (NOAs): Declaration of Exemption from TrustLine Registration and Health and Safety Self-Certification (CCP1), Health and Safety Self-Certification (For license-exempt providers) (CCP4), CalWORKs Child Care Request Form and Reimbursement Rules (CCP7), NOA Child Care Services (NA832), and NOA Child Care Change (NA833). At the request of the County Welfare Directors Association (CWDA), the California Department of Social Services (CDSS) revised the forms and NOAs used for Stage One Child Care at the county level. The CDSS revised the forms and NOAs based on feedback from the CWDA and advocates. The joint effort was undertaken to update and standardize the forms for ease of use and understanding for both the County Welfare Departments (CWDs) and the CalWORKs families.

Summary of Changes

The changes to these forms and NOAs were made to align the language with current Stage One Child Care Program regulations; enhance client comprehension and readability; clarify the requirements for provider reimbursement through wording and design changes; simplify forms by reformatting and eliminating unnecessary words and phrases; improve the flow and continuity of information; and increase the effectiveness and efficiency of the child care services request process.

To be consistent with the CDSS Business Operations Manual, Section 23-400.11, all Stage One Child Care forms are now required with substitutions permitted. Please see the attached document which provides the county assignments for each CDSS Child Care Programs Bureau analyst. Counties may request to substitute a child care form by contacting the county's CDSS Child Care Programs Bureau analyst.

Form Implementation

The CWDs shall begin using the revised forms as soon as administratively feasible. However, CWDs may choose to exhaust their hard copy stock of the earlier version before transitioning to the revised form.

Translations and Camera-Ready Copies

For camera-ready copies in English, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has internet access, you may obtain these publications from the CDSS webpage at <http://www.dss.cahwnet.gov/cdssweb/PG167.htm>.

When translated forms are completed per Manual of Policies and Procedures Section 21-115.2, including Spanish forms, they are posted on an ongoing basis on the CDSS webpage. Copies of the translated forms can be obtained at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

For questions on translated materials, please contact Language Services at (916) 651-8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the [GEN 1365-Notice of Language Services](#) and a local contact number.

If you have any questions regarding this notice, please contact the Child Care Programs Bureau Policy Unit at (916) 657-2144.

Sincerely,

Original Document Signed By:

TODD R. BLAND
Deputy Director
Welfare to Work Division

Attachments

DECLARATION OF EXEMPTION FROM TRUSTLINE REGISTRATION AND HEALTH AND SAFETY SELF-CERTIFICATION

INSTRUCTIONS: This form is for an aunt, uncle, or grandparent who is providing child care. You do not need to be licensed or TrustLine-registered to get state child care reimbursements. But if you are not licensed or TrustLine-registered, you must fill out this form. This form must be completed and returned promptly to the County Welfare Department, Alternative Payment Program, or other payment agency.

COUNTY USE ONLY	
CASE NAME	
CLIENT CASE NUMBER	
WORKER NAME	
WORKER NUMBER	

1. Name of Provider _____ Provider's Date of Birth ____/____/____
(PERSON WHO WILL CARE FOR CHILDREN)
Address _____ City _____ State _____ Zip _____
Phone () _____

The State of California requires proof that you are 18 years of age or older. Please attach a copy of your drivers license or other proof of age.

2. List the name and address of the family for the children you are providing child care.

Name of Parent/Responsible Adult _____ Phone () _____
Address _____ City _____ State _____ Zip _____

3. Child care will be provided in (*Check one*): Child's Home Provider's Home

I declare under penalty of perjury under the laws of the State of California that I am by blood, marriage or court decree the
 Aunt Uncle Grandparent

of _____, _____, _____,
NAME OF CHILD NAME OF CHILD NAME OF CHILD
_____, _____, _____,
NAME OF CHILD NAME OF CHILD NAME OF CHILD
_____, _____ for whom I am providing child care.
NAME OF CHILD NAME OF CHILD

I understand that because I am an aunt, uncle, or grandparent of the child(ren) listed on this form, I am not required to apply for TrustLine-registration and am not required to complete the Health and Safety Self-Certification.

I understand that giving false or incomplete information can result in being charged with a crime with penalties of fine, imprisonment, or both.

Signature of Provider _____ Date _____

I declare that I am the parent/responsible adult of the child(ren) listed on this form, that I have read the declaration of my child care provider and that I attest that the declaration regarding the provider's relationship to my child(ren) is true.

I declare under penalty of perjury under the laws of the State of California that the information I provided on this page is true and correct to the best of my knowledge. I understand that giving false or incomplete information can result in being charged with a crime which can include penalties of a fine, imprisonment, or both.

Signature of Parent/Responsible Adult _____ Date _____

COUNTY OR APP USE ONLY

Return this form by: _____ to:

HEALTH AND SAFETY SELF-CERTIFICATION (For license-exempt providers)

INSTRUCTIONS: As a license-exempt child care provider (family, friend or neighbor) who is serving a family that receives subsidized child care services, you must fill out this form. Please complete the form, and return it promptly to the County Welfare Department, Alternative Payment Program or other payment agency.

COUNTY USE ONLY	
CASE NAME	_____
CLIENT CASE NUMBER	_____
WORKER NAME	_____
WORKER NUMBER	_____

PART A PROVIDER INFORMATION:

1. Name of Provider _____ Provider's Date of Birth ____/____/____
 Address _____ City _____ State _____ Zip _____
 Phone () _____

The State of California requires proof that you are at least 18 years of age or older. Please attach a copy of your driver's license or other proof of age.

2. Family Receiving Care.
 Name of Parent/Responsible Adult _____ Phone () _____
 Address _____ City _____ State _____ Zip _____

3. Child care will be provided in (*check one*): Child's Home Provider's Home

PART B HEALTH AND SAFETY SELF-CERTIFICATION REQUIREMENTS:

The home where you provide care must meet safety requirements. The health and safety standards are listed below. It is the ongoing responsibility of the parent and the provider to see that these basic standards are met.

If the statement is correct, the parent/responsible adult and provider must put their initials to the left of it. This will certify that the home meets health and safety standards.

- | | Parent/
Responsible
Adult
Initials | Provider's
Initials | |
|----|---|------------------------|--|
| 1. | _____ | _____ | The home where child care is provided has working smoke detectors and fire extinguishers that meet standards set by the State Fire Marshal. |
| 2. | _____ | _____ | The child care provider will not use corporal, harsh, or unusual punishment. |
| 3. | _____ | _____ | The child care provider must allow unlimited parental access to the children while in their care. |
| 4. | _____ | _____ | The child care provider must not have a communicable disease and, must be physically and mentally capable of caring for children. The provider must show proof to the parent that he/she was tested in the last 12 months and is free of active tuberculosis. |
| 5. | _____ | _____ | The home where child care is provided has yard and play areas that have been checked and are safe for children. Children are protected from dangers such as pools, hot tubs, electrical outlets, stairs, poisonous materials, medications, guns and/or ammunition etc. |
| 6. | _____ | _____ | There are at least two local character references that will attest to the good character of the child care provider and his/her ability to provide child care in a safe environment. See part C on the next page. |

Information about health and safety and other basic child care training is available from the local Child Care Resource and Referral Program and other community agencies such as the American Red Cross, Community Colleges, Fire Departments, etc.

The parent and provider are encouraged to use the Health & Safety Information checklist (CCP 6) to ensure that the home where care is to be provided is safe for children.

PART C OTHER INFORMATION

1. Local References

Instructions: List the information below for two local references. The references cannot be a parent of the child. The parent should contact these references to check your good character and ability to provide child care.

Name _____	Name _____
Address _____	Address _____
City/State _____	City/State _____
Phone () _____	Phone () _____

2. Other adults in the home where child care is provided

Instructions: Complete the information below for all other adults in the home where child care is provided.

Name _____	Related to	<input type="checkbox"/> child	<input type="checkbox"/> you	Relationship _____
Name _____	Related to	<input type="checkbox"/> child	<input type="checkbox"/> you	Relationship _____
Name _____	Related to	<input type="checkbox"/> child	<input type="checkbox"/> you	Relationship _____
Name _____	Related to	<input type="checkbox"/> child	<input type="checkbox"/> you	Relationship _____

3. Statement of Ability to Provide Child Care

Instructions: Describe your ability to provide child care and list your experience and qualifications.

PART D PROVIDER/PARENT STATEMENT

Additional important information for the parent/responsible adult/provider:

- If you choose to have child care provided in your home (in-home care), you are considered the employer and are responsible for paying at least the state’s minimum wage, social security tax, Medicare and state worker’s compensation insurance for your provider. You may also be responsible for unemployment taxes.
- You may be required to withhold federal or state income taxes from the child care provider’s earnings. The provider is responsible for reporting income and payment of any federal or state income taxes.
- If you have selected a new provider who is required to register with TrustLine, this provider is not eligible for reimbursement until he/she is registered with TrustLine. License-exempt child care providers who are required to be TrustLine registered can get retroactive reimbursement for up to 120 days from the date child care services were requested and provided, if the provider later becomes TrustLine-registered.
- For more information about your responsibilities as an employer, contact your local office of the Employment Development Department at (888-745-3886). For general information about the local child care resource and referral program you may call toll free at (800-KIDS R WE) (800-543-7793).

1. PROVIDER’S STATEMENT: All information I provided on this form is true and correct to the best of my knowledge. If I am providing child care in my home, I certify that my home meets health and safety requirements listed in Part B. I understand that health and safety training information is available from the local Child Care Resource and Referral program and other community agencies. I understand that I am not an employee of the County Welfare Department, Alternative Payment Program or other payment agency.

I declare under penalty of perjury under the laws of the State of California that the information I provided on this page is true and correct to the best of my knowledge. I understand that giving false or incomplete information can result in being charged with a crime which can include penalties of a fine, imprisonment, or both.

Signature of Provider _____ Date _____

PART D. PROVIDER/PARENT STATEMENTS (CONTINUES)

2. PARENT/RESPONSIBLE ADULT STATEMENT: I have interviewed and approved this child care provider. I understand the statements provided on this form. I understand it is my responsibility to make sure that the child care provided to my child(ren) and the place where care is provided is safe. I also understand that the State of California, County Welfare Department, Alternative Payment Program (APP) or other payment agency did not and will not check the safety of the child care provided by this provider. If the county or APP/Agency cannot fully reimburse what my provider charges because it is over the limit set by the State, I will make a co-payment to the provider for the difference owed. I can also change to a provider that charges less.

I declare under penalty of perjury under the laws of the State of California that the information I provided on this page is true and correct to the best of my knowledge. I understand that giving false or incomplete information can result in being charged with a crime which can include penalties of a fine, imprisonment, or both.

Signature of Parent/Responsible Adult _____ Date _____

COUNTY OR APP USE ONLY

Return this form by: _____ to:

CalWORKs CHILD CARE REQUEST FORM AND REIMBURSEMENT RULES

CalWORKs Child Care Coverage

Eligible CalWORKs recipients can get their child care paid for by the state. To be eligible, you must be working or participating in an approved county welfare-to-work (WTW) activity. This includes any county approved CalWORKs activities or employment listed in your WTW plan. For your child care to be reimbursed, you must be found eligible for child care, and your provider has to meet certain requirements. The child care must be with an eligible provider. These are licensed child care providers, or providers who are not licensed but have their background checked and become registered through a program called "TrustLine". A grandparent, aunt, or uncle of the children, does not need a background check, but must turn in a form called a Declaration of Exemption From TrustLine Registration (CCP1).

The state reimburses child care for children under 13, and for older children with disabilities that prevent them from being left alone. In two-parent families, if a parent is home and able to care for the children, the state will not reimburse the child care. The parent is considered available to provide care unless he/she is working, doing a county approved WTW activity, or has a condition, verified by a doctor, that prevents him/her from caring for the child. For 11 or 12 year old children, the preferred child care placement is in a program such as the After School Education and Safety Program. To get information on these programs, go to www.cde.ca.gov/ls/ba/as, or you may call the Child Care Resource and Referral Agency listed below.

You must tell your worker as soon as possible if you need child care.

IMPORTANT: The state will not pay for retroactive CalWORKs child care provided more than 30 calendar days before the date you ask your worker to get child care. If you pick a provider who must be registered with TrustLine, the state cannot pay them until they are registered. Once registered, the state can pay them for actual care provided up to 120 calendar days from the day you asked for child care reimbursements. This is why you must tell your worker as soon as possible when changing your provider, to make sure the TrustLine-registration process gets started immediately.

Child Care Request

To ask for child care, sign and return this form to your worker.

Please check one of the following:

- I need child care assistance at this time so I can go to work or attend my WTW activity.
- I do not need child care at this time. I understand that I must request child care from my worker if I need it in the future.
- Before or after school care such as the After School Education and Safety Program will meet all or part of my child care needs for my 11 or 12 year old child. If this does not meet all of your child care needs, additional child care can be provided.

I understand that CalWORKs child care is available for me to work and to attend my county approved WTW activity. If I need help to find and/or choose a child care provider, I can contact the local Child Care Resource and Referral agency listed below:

Name: _____ Telephone: (_____) _____

Address: _____

I understand that I must tell my worker as soon as I need child care. I understand that CalWORKs will help reimburse for child care only after I ask for the child care. My worker's telephone number is: (____) _____.

I understand that after I ask for child care, I have to give my worker certain information to see whether I am eligible. I understand that I need to request child care within 30 calendar days from the first day I received child care services from my provider

I understand that if I choose a child care provider who is required to be TrustLine-registered, the provider is not eligible for reimbursement if they do not obtain TrustLine-registration.

I understand that my child care provider has to meet certain requirements to be reimbursed, and if my child care provider does not meet these requirements, I must pay for any child care services I get from that person.

I have read this notice or have had it read to me. I understand that if I have any questions or need additional information regarding this notice, I can ask my worker.

CASE NAME	CASE NO.
SIGNATURE	DATE
WORKER NAME	PHONE

NOTICE OF ACTION CHILD CARE SERVICES

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. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

CHILD CARE SERVICES

- You are approved for child care services starting on _____ for _____.
(DATE) (NAME OF CHILD(REN))
- Your approved activity/program is less than 30 days. Your child care will end on _____. You will not get another notice when child care services will end. If you get another activity/program, we will send a new child care approval notice.

CHILD CARE REIMBURSEMENT

- You have chosen an eligible child care provider (licensed/license-exempt) who is TrustLine-registered or who is exempt from TrustLine.

The county may reimburse child care services only for the hours and days you do your approved activity/program as follows:

CHILD NAME:	CHILD NAME:
PROVIDER NAME:	PROVIDER NAME:
CHILD CARE HOURS:	CHILD CARE HOURS:
RATE:	RATE:
REIMBURSEMENT LIMIT:	REIMBURSEMENT LIMIT:
CHILD NAME:	CHILD NAME:
PROVIDER NAME:	PROVIDER NAME:
CHILD CARE HOURS:	CHILD CARE HOURS:
RATE:	RATE:
REIMBURSEMENT LIMIT:	REIMBURSEMENT LIMIT:

The child care rate, type and reimbursement limit are based on information you gave us. The rate is the most we can reimburse based on what your child care provider charges or your area's child care costs, whichever is less. You are responsible to pay any difference above this rate.

NOTICE

If you have selected a new provider who is required to register with TrustLine, this provider is not eligible for reimbursement until he/she is registered with TrustLine. License-exempt child care providers who are required to be TrustLine-registered shall be entitled to receive retroactive reimbursement for up to 120 calendar days from the date child care services were requested and provided, whichever is later, if the provider later becomes TrustLine-registered.

REMINDERS

You must tell us before you change child care providers (except in an emergency) or we may not be able to approve and reimburse the new provider for child care services.

If you choose child care in your home (in-home care), you are considered the employer. This means you may be responsible for paying at least the state's minimum wage, social security tax, Medicare taxes and state worker's compensation insurance for your provider. You may also be responsible for unemployment taxes.

If you do not choose in-home child care, the provider is responsible for reporting income and payment of any federal or state income taxes.

For more information contact your local child care resource and referral program at (800) 543-7793.

Rules: These rules apply. You may review them at your welfare office: CalWORKs MPP Sections 47-260, 47-430, 47-620, 47-630; Education Code Sections: 8350-8353, 8357; Welfare & Institutions Code Sections 11322.9, 11323.6, 11323.8, and 11324, or visit www.cdss.ca.gov or www.leginfo.ca.gov.

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, 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 benefits 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 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
 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 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

NOTICE OF ACTION CHILD CARE CHANGE

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. Your benefits may not be changed if you ask for a hearing before this action takes place. If you and the county disagree or if you have not heard back from your worker, do not wait to ask for a hearing. You must ask for the hearing before a certain number of days. See the back of this notice for more information and to find out how to ask for a hearing.

As of _____ the child care for _____ is changed for the following reason:
DATE
NAME OF CHILD

- The county has changed the reimbursement rate from \$ _____ per _____ to \$ _____ per _____.
- The county has changed your reimbursement method for Cal-Learn CalWORKs child care from _____ to _____, because _____.
- Your child care provider has changed. Your Cal-Learn CalWORKs child care at _____ has been paid until _____. Reimbursement for _____ starts after that date.

HERE'S WHY:

- Your child care rate changed
- Your child care provider changed.
- Your child's age has changed.
- Your child care hours changed.
- The State of California changed reimbursement limits.
- You asked for this change.
- Other:

Your new child care reimbursement is figured on this notice.

The county will only reimburse child care for the hours and days you go to your approved activity/program. The county will only reimburse for child care to providers who are registered with TrustLine, or are exempt from TrustLine-registration.

If you have selected a new provider who is required to register with TrustLine, this provider is not eligible for reimbursement until registered with TrustLine. License-exempt child care providers who are required to be TrustLine-registered can get retroactive-reimbursement for up to 120 calendar days from the date child care services were requested and provided, if the provider later becomes TrustLine-registered.

Rules: These rules apply. You may review them at your welfare office: CalWORKs MPP Sections 47-260, 47-430.2, 47-620.32; Welfare and Institutions Code Sections 11322.9, 11323.6, 11323.4, 11323.8. Education Code Sections 8350-8353, 8357, or visit www.cdss.ca.gov or www.leginfo.ca.gov.

You must tell us before you change child care providers except in an emergency or we may not be able to reimburse the new provider.

Child(ren): _____
\$ _____ rate
X _____ hours days weeks month
= \$ _____ per _____
Provider name: _____

Child(ren): _____
\$ _____ rate
X _____ hours days weeks month
= \$ _____ per _____
Provider name: _____

Child(ren): _____
\$ _____ rate
X _____ hours days weeks month
= \$ _____ per _____
Provider name: _____

Child care for children not listed here stays the same.

The rates listed above are what your child care provider charges or the most we can reimburse based on your area's child care costs, whichever is less. You are responsible to pay any difference above this rate.

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, 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 benefits 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 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
 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:

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OTHER INFORMATION

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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.)**

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- 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.

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If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

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Cash Aid CalFresh 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

**CHILD CARE PROGRAMS BUREAU
COUNTY ASSIGNMENTS
(916) 657-2144**

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County Assignment	El Dorado Lassen Merced Napa Sacramento Sierra Yuba Kings	Fresno Inyo Mono San Benito Sonoma Tuolumne Humboldt	Butte Colusa Madera Riverside San Bernardino San Francisco San Mateo Santa Clara	Alpine Imperial Marin Monterey San Diego Sutter Ventura
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County Assignment	Calaveras Kern Mariposa Placer Santa Barbara Tulare Modoc Siskiyou	Alameda Del Norte Glenn Orange Shasta Santa Cruz San Luis Obispo	Contra Costa Los Angeles Mendocino Plumas Amador San Joaquin	Lake Nevada Tehama Trinity Yolo Solano Stanislaus