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

COUNTY OF

FOOD STAMP NOTICE OF CHANGE FOR CHANGE 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 Change Report (DFA 377.5). 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 month'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 did not change as a result of the document(s)/information we received because:

☐ **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.

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: ________________________________

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☐ **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