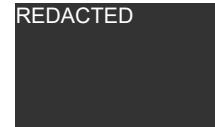


NOTICE DATE:
CASE NAME:
CASE NUMBER:
WORKER NAME:
WORKER ID:
TELEPHONE NUMBER:
CUSTOMER ID:

February 18, 2020
ROBERT COLACO



CALFRESH NOTICE OF CHANGE FOR SEMI-ANNUAL REPORTING HOUSEHOLD

ROBERT COLACO
PO BOX 1949
LITTLE ROCK, CA 93543-5949

Questions? Ask your worker.

As of 03/01/2020, the County is changing your CalFresh benefits from \$355.00 to \$319.00.

Here's Why:

You have already been told about an overissuance of CalFresh benefits that you must repay.

You still owe \$1,684.00.

Your new CalFresh amount is figured on the next page of this notice.

You do not have to use any SSI benefits you get to repay this overissuance.

EBT: Keep your plastic Golden State Advantage card if you use Electronic Benefits Transfer (EBT), even if your aid is terminated. Please do not throw it away.

Medi-Cal: This Notice of Action does not change or stop Medi-Cal benefits. If there is any change in your Medi-Cal benefits, you will receive another Notice of Action. Keep your plastic Benefits Identification Card(s).

Your new CalFresh amount is figured on this notice.

Your CalFresh household size is 2. Your IRT is \$1,832.00.

EBT: Keep your plastic Golden State Advantage card if you use Electronic Benefits Transfer (EBT), even if your

Rules: These rules apply; you may review them at your local welfare office: MPP Section 63-801.44, 63-801.73

State Hearing: If you think this action is wrong, you can ask for a hearing. The back page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

CalFresh Budget

Report Month 03/2020

Household Size 2

Total Countable Earned Income	<u>\$0.00</u>
Adjusted Countable Earned Income	<u>\$0.00</u>
Total Countable Unearned Income	<u>\$0.00</u>
Net Countable Income	<u>\$0.00</u>

Standard Deduction	<u>\$167.00</u>
Dependent Care	<u>\$0.00</u>
Homeless Shelter Deduction	<u>\$0.00</u>
Excess Medical Expense for Aged/Disabled	<u>\$0.00</u>
Total Deductions	<u>\$167.00</u>

Preliminary Adjusted Income	<u>\$0.00</u>
Housing Expenses	<u>\$0.00</u>
Utility Expenses	<u>\$0.00</u>
Adjusted Net Income	<u>\$0.00</u>

CalFresh Allotment	<u>\$355.00</u>
Less Overissuance	<u>-\$36.00</u>
Total CalFresh Allotment	<u>=\$319.00</u>



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 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: This 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 you 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:**
Appeals & Hearing Section
P.O. Box 18890
Los Angeles, CA 90018

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.

Neighborhood Legal Services of Los Angeles County (NLSLA)
(800) 433-6251

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 LOS ANGELES 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

COUNTY OF LOS ANGELES

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Continuation Page

NOTICE DATE:
CASE NAME:
CASE NUMBER:
WORKER NAME:
WORKER ID:
TELEPHONE NUMBER:
CUSTOMER ID:

February 18, 2020
ROBERT COLACO

REDACTED


aid is terminated. Please do not throw it away.

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