Gail Steele Multi-Service Center
PO BOX 12941
OAKLAND, CA 94604

COUNTY OF ALAMEDA

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

NOTICE DATE:	October 22, 2024
CASE NAME:	K M Zubair
CALHEERS CASE NUMBER:	5196119964
SAWS CASE NUMBER:	4912738
WORKER NAME:	B. Smith
WORKER ID:	01LS040R02
TELEPHONE NUMBER:	(510) 265-8241
CUSTOMER ID:	4048712150

NOTICE OF ACTION
MEDI-CAL APPROVAL

K M Zubair
39939 Stevenson Cmn, Fremont
Fremont, CA 94538

Dear K M Zubair,

We have reviewed your eligibility for health coverage. We used the information you gave us and state and federal data to make this decision.

K M Zubair

You qualify for Medi-Cal because your household income is below the Medi-Cal limit. Your eligibility for Medi-Cal begins 09/01/2024. Your Medi-Cal coverage will continue unless you are found no longer eligible. This could happen at the time your eligibility is renewed or when your situation changes.

We counted your household size and income to make our decision. For Medi-Cal, your household size is 1 and your monthly household income is $0.00. The monthly Medi-Cal income limit for your household size is $1,732.00. Your income is below this limit, so you qualify for Medi-Cal.

Title 42, C.F.R. §§435.119, 435.603; is the regulation or law we relied on for this decision.

Do you have any changes?

Over the next year, you must report any life changes that affect your eligibility for Medi-Cal. You must report within **10** days after the change happened. For example, you must contact us if:

- Your income changes.
- Your household changes, such as you marry, divorce, become pregnant, or have or adopt a child; a person moves into or out of your home; or you change who will be on your tax return.
- You qualify for other health insurance.
- You move. If you move to a new county, you can report your change to your old or new county.

You may report changes to your local county office in person or by mail, fax, phone, or electronically. The contact information is on the first page of this notice.

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. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.

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YOUR HEARING RIGHTS

YOUR HEARING RIGHTS (See also PUB 412 at www.cdss.ca.gov/inforesources/state-hearings)
You can ask for a hearing if you disagree with a county/agency action or failure to act. You have **90 days** to do so, starting the day after the date of the notice. After 90 days, you must prove you had a good reason for asking late. You can also ask for a hearing to review your benefits for the past 90 days. If you ask for a hearing before the date of the change, your benefits will continue unchanged. CalFresh will end if you don't recertify when due.

- **Online** at acms.dss.ca.gov Click "Create an account" to have an ACMS account and get documents online; or click "Submit Appeal without Account" to file without an account *OR*
- **Call** toll free 1-855-795-0634(or TDD 1-800-952-8349) *OR*
- **Fax** fill out this page/fax to 1-916-651-2789 *OR*
- Fill out this page, and deliver it by one of the following:
  - **In-person:** California Department of Social Services
    State Hearings Division, ACAB
    744 P Street, MS 9-17-97
    Sacramento, CA 95814
  - **Mail to:** CDSS State Hearings Division, PO Box 944243, MS 21-37 Sacramento CA 94244-2430
  - **Email to:** SHDCSU@DSS.ca.gov

HEARING REQUEST

1. My hearing issue involves _____ (benefit program) and ALAMEDA _____ County/Agency.
2. I want a hearing because: _____
   _____
3. Print name of person who needs a hearing: _____ Birthdate: _____
4. Mailing Address: _____ Phone number: _____
   ☐ I want to get hearing notices from the State Hearing Division by email. **Email Address:** _____
5. **Name/Signature:** _____ _____ **Date Signed** _____
6. Interpreter: ☐ I want a **free** interpreter for the _____ language or dialect.
7. Disability Accommodation for hearing? ☐ No ☐ Yes (explain): _____
8. Your Hearing will be scheduled by phone. If you want your hearing conducted by a different method, tell us how:
   ☐ By Telephone ☐ By Video *(you see judge on your phone/computer)* ☐ In person at the county hearing site
   ☐ I have no phone or internet access. I want to go and use the phone or video at hearing site for my hearing.
9. I need a faster scheduled hearing due to ☐ Denial of CalWORKs or CalFresh emergency benefits
   ☐ Medical Emergency ☐ Eviction/homelessness ☐ Other (explain): _____
10. If you timely appeal before the action listed in the notice takes place, your aid may stay the same. For CalWORKs (including Child Care) and CalFresh, if the county action was correct, you have to pay back any extra aid.
    ☐ Check to have your aid lowered or stopped pending the hearing for: ☐ CalWORKs ☐ Childcare ☐ CalFresh
11. You can have a friend, relative, legal counsel or other person help with your hearing. **If they have agreed:**
    NAME: _____ Email: _____
    Address: _____ Phone: _____
12. **To Get Help:** These groups below may be able to give you legal advice or represent you at the hearing:

(510) 250-5270 Bay Area Legal Aid
1735 Telegraph Avenue, Oakland, CA 94612
(855) 693-7285
Toll Free: (800) 551-5554
East Bay Community Law Center
2921 Adeline Street, Berkeley, CA 94703
(510) 548-4040

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