

# NOTICE OF ACTION

## Food Stamps Termination

COUNTY OF SAN FRANCISCO



P.O. Box 7988  
San Francisco, California 94120-7988  
San Francisco County

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

2835 123627/8-3525/LETTER1.47 20

VENG

Rebecca Ackerman



As of 06/30/2013, the County is stopping your cash aid and/or Food Stamps.

Here's why:

As of the 11th of this month, the County has not received your quarterly report (QR 7) due this month.

**TO STOP THIS ACTION, the County must RECEIVE your COMPLETE report no later than the FIRST WORKING DAY OF NEXT MONTH.**

The information you give us may change or stop your cash aid and/or Food Stamps.

If you turn in a complete QR 7 anytime next month that shows you are eligible for cash aid and/or CalFresh benefits, your benefits will start from the day you turn in the form.

**Medi-Cal:** This notice DOES NOT change or stop Medi-Cal benefits. If there is a change in your Medi-Cal Benefits, you will receive another notice. Keep using your plastic Benefits Identification Card(s).

Food Stamps Only:

You must report any new household members and their social security numbers. If you have already reported a new member but not their social security number, it must be reported now.

If you need help in completing the quarterly report, the County will help you to do so. Please contact the County and ask for help.

NA 960 X QR (7/04) CW/RCA/FS Disc - No  
Quarterly Status Report on File

Notice Date	:	06/12/2013
Case Name	:	Rebecca Ackerman
Case Number	:	1373241
Worker Name	:	Food Assistance
Worker Number	:	VENG
Telephone	:	(415) 558-1001
Worker Hours	:	8:00 AM- 12:00 PM, 12:00 PM - 5:00 PM
24Hour Information	:	
Address	:	1235 Mission ST San Francisco CA 94103-2705

Questions? Ask your Worker.

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

**Rules:** These rules apply. You may review them at your welfare office: Food Stamps Manual Section(s): 63-103(n), 63-508.6. MPP: 40-105.1, 40-181.22

## 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:**

Appeals Unit, Department of Human Services  
P.O. Box 7988  
NA  
San Francisco, CA 94120-7988

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.

BAY AREA LEGAL AID  
1035 Market Street  
6th Floor  
San Francisco, CA 94103  
(415) 982-1300

Coalition of CA Welfare Rights  
1901 Alhambra Blvd  
Sacramento, CA 95816  
(916) 736-0616

GAAP  
ENGLISH CALFRESH ONLY  
276 Golden Gate Avenue  
San Francisco, CA 94102-3706  
(415) 928-8191

**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:

- 
- 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 \_\_\_\_\_