

Please fill the following form.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COUNTY OF RIVERSIDE

**WELFARE TO WORK FAMILY
REUNIFICATION PLAN**

Date:

Case Name:

Case Number:

Worker Name:

Worker ID:

Worker Phone Number:

As of _____, your cash aid was reduced because all of your children were removed from your assistance unit. You were informed of this action in a separate notice on _____.

You may still participate in the California Work Opportunity and Responsibility to Kids (CalWORKs) Welfare to Work program because the county has determined that your participation will assist to reunify your family.

The CalWORKs Welfare to Work services that you need to reunify your family will be provided:

- As part of a family reunification plan. If you have any questions about this plan, please call your child welfare worker at (____) _____.
- As part of a family reunification plan and as part of a CalWORKs Welfare to Work plan. If you have any questions about family reunification plan, please call your child welfare worker at (____) _____. If you have any questions about the Welfare to Work plan, please call your Welfare to Work worker at (____) _____.
- As part of a CalWORKs Welfare to Work plan. If you have any questions about this plan, please call your Welfare to Work worker at (____) _____.

State Hearing: You have the right to ask for a state hearing if you disagree with any of the decisions made by the county participating in Welfare to Work.

Rules: These rules apply to the above action(s): Manual of Policies and Procedures Section 42-711.51 and 42-711.6. Y



California Health & Human Services Agency

California Department of Social S

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 (800) 743-8525 (or TDD (800) 952-8349) *OR*
 - **Fax** fill out this page/fax to (833) 281-0905 *OR*
- Fill out this page, and deliver it by one of the following
 - o **In-person:**
 - o **Mail to:** CDSS State Hearings Division, PO Box 9442
21-37 Sacramento CA 94244-2430
 - o **Email to:** SHDCSU@DSS.ca.gov

HEARING REQUEST

1. My hearing issue involves _____ (benefit program) and Riverside _____ 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:

NA Back 9 (5/22) Required Form - No Substitute Permitted

WTW 34 (4/04) REQUIRED FORM-SUBSTITUTE PERMITTED



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