



NOTICE DATE: August 10, 2023
CASE NAME: KRISTINA GONGORA
CALHEERS CASE NUMBER: 5152670336
SAWS CASE NUMBER: 0227060
WORKER NAME: Norma Gamboa
WORKER ID: 13SS0A5504
TELEPHONE NUMBER: (442) 265-5354
CUSTOMER ID:

NOTICE OF ACTION MEDI-CAL APPROVAL

KRISTINA GONGORA
PO BOX 904
WESTMORLAND, CA 92281-0904

Dear KRISTINA GONGORA,

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

KRISTINA GONGORA

You qualify for Medi-Cal because your household income is below the Medi-Cal limit. Your eligibility for Medi-Cal begins 09/01/2023. 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 \$1,677.00. 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.

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.

- 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.



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:**
California Department of Social Services
State Hearings Division, ACAB
744 P Street, MS 9-17-97
Sacramento, CA 95814

OR Fax to: 1-916-651-2789

- **Call toll free: 1-855-795-0634** 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.

California Rural Legal Assistance
449 BROADWAY AVE
EL CENTRO, CA 92243
(760) 353-0220

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 IMPERIAL 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

