CAL-LEARN REGISTRATION/PROGRAM INFORMATION/ ORIENTATION APPOINTMENT NOTICE

DATE:
CASE NAME:
CASE NUMBER:
PHONE NUMBER:
REGISTRANT'S NAME:

EXPLANATION OF THE CAL-LEARN PROGRAM

The Cal-Learn Program is designed to encourage and assist teen parents to stay in or return to school.

REGISTRANT

You have been registered for the Cal-Learn program. You must participate in Cal-Learn unless you are exempt.

You must participate in the Cal-Learn program if you are pregnant or a custodial parent under the age of 19 and do not have a high school diploma or equivalent.

If you turn 19 while you are in the Cal-Learn program and have not graduated from high school or equivalent, you may be able to continue participating in the program until you turn 20 years old.

WHAT CAL-LEARN MEANS TO YOU

- The Cal-Learn Program encourages teenage CalWORKs recipients who are pregnant or already a parent to stay in or return to school. Participants may receive cash for meeting program requirements.
- Cal-Learn participants will receive case management services and assistance with child care and transportation costs.
- Your case manager will:
  - Help you with needed health care and services available in the community.
  - Tell you about the different kinds of child care and where to find child care.
  - Ensure that you understand Cal-Learn requirements and what will happen if you do not meet these requirements.
  - Help you to develop an educational plan.
  - Watch your progress and help you to make necessary changes to your school program.

The next step for you will be to attend a Cal-Learn orientation.

You have been scheduled to attend orientation on_____

at_____o'clock at_____

_____.

If you cannot keep this appointment, please call your Cal-Learn case manager: _____at_____ by_____to schedule another appointment.

This notice is not notification of the program requirements. The Cal-Learn program requirements will be given to you during the orientation.

YOU MUST GO TO ORIENTATION EVEN IF YOU BELIEVE YOU MAY BE EXEMPT OR DEFERRED.

If you think this action is wrong you may ask for a hearing. The Cal-Learn hearing rights information on the back of this form tells you how. You can also call your Cal-Learn worker if you think this notice is wrong.

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 <u>before</u> 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 benefits 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:

<u>Welfare to Work</u>:

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.

<u>Cal-Learn</u>:

- 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:**

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.

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 ☐ 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 <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE