

REPLACEMENT OR DISASTER SUPPLEMENT AFFIDAVIT (CF 303)

Instructions: Check the box(es) that apply to your household, then sign and return this form. Note, this form must be submitted within 10 days of your reported food-loss or your household may not be eligible to receive replacement benefits.

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.

CURRENT HOUSEHOLD INFORMATION

Name: _____
Address: _____
Phone: _____

DISASTER SUPPLEMENT

My household resides in a federally declared disaster area with individual assistance and I have experienced one or more adverse effects as a result of the disaster.

HOUSEHOLD AFFIDAVIT

I, _____, declare that the household:

I declare that my statement is true and correct to the best of my knowledge. I also understand that if I give wrong or incomplete facts I may be disqualified from the CalFresh Program, fined, imprisoned, or all three.

ELECTRONIC BENEFITS TRANSFER (EBT)

EBT card was not received in the mail at the address below and the benefits have been transacted by an unauthorized person:

Signature Of Responsible Household Member Or Representative _____ Date _____

Mailing Address (Number, Street, P.O. Box)

City State Zip

EBT card was reported lost/stolen to the county or to EBT hotline and the county, or the EBT hotline failed to cancel the EBT card and the benefits have been transacted by an unauthorized person. Reported on _____ at _____
Date Time

COUNTY USE ONLY

Case Name: _____
Case Number: _____
Worker: _____
Date CF 303 Received: _____

REPLACEMENT/DISASTER SUPPLEMENT

APPROVED - EBT Replacement Date _____
 APPROVED - Benefit Replacement Date _____
Benefit Replacement Amount \$ _____
 APPROVED - Disaster Supplement Date _____
Disaster Supplement Amount \$ _____
 DENIED - Reason for Denial (Explain)

REPLACEMENT

Food destroyed in household misfortune or disaster. What happened and when:

Signature (Person Authorizing Or Denying Request) _____ Date _____

Rules: These rules may apply and you may review at your welfare office MPP 16-515 and 16-517.

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 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:

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:**

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		Date of Birth	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