RESET FIELDS

NOTICE TO APPLICANT

YOUR RECENT APPLICATION HAS BEEN REVIEWED AND YOUR ELIGIBILITY HAS BEEN DETERMINED FOR THE BENEFITS SHOWN BELOW

BENEFIT	ELIGIBLE	NOT ELIGIBLE	PENDING	
☐ ASSISTANCE CHECK				After the first check which may be a special amount you will receive $_____ ☐ Twice a Month ☐ Once a Month ☐ In the Mail ☐ At the Bank
☐ MEDICAL ASSISTANCE				☐ You have a patient pay liability of $_____ for the period beginning _____ and ending _____. ☐ Effective Date _____
☐ FOOD STAMPS				You will receive $_____ for the month(s) of _____ then you will receive food stamps in the amount of $_____ a month from _____ to _____ ☐ In the Mail ☐ At the Bank
☐ NURSING HOME CARE				Level of care authorized _____ you are expected to pay $_____ a month toward your care.
☐ SOCIAL SERVICES ☐ OTHER (Specify)				

THE FOLLOWING PERSONS ARE INCLUDED

LINE NO.	NAME	ASST. CHECK	FOOD STAMPS	MED. ASST.	SOC. SERVICE

LINE NO.	NAME	ASST. CHECK	FOOD STAMPS	MED. ASST.	SOC. SERVICE

THIS ACTION HAS BEEN TAKEN BECAUSE OF THE FOLLOWING FACTS AND REGULATIONS | Regulation | Reason Code

THE FOLLOWING ITEMS WERE TAKEN INTO CONSIDERATION IN DETERMINING THE AMOUNT OF YOUR BENEFITS

☐ FOOD STAMPS — Number of Persons ▶

Name	GROSS MONTHLY EARNED INCOME
	$
	$
	$
Name	**GROSS MONTHLY UNEARNED INCOME**
	$
	$
	$

TOTAL GROSS MONTHLY INCOME	$
GROSS MONTHLY DEPENDENT CARE COSTS	$
GROSS MEDICAL COSTS	$

Telephone		Water/Sewage	
Electric		Garbage/Trash	
Gas		Utility Installation	
Oil		Other	

GROSS UTILITY COSTS/UTILITY STANDARD*	$
RENT/MORTGAGE	$
TAXES	$
INSURANCE COST ON HOME	$
TOTAL SHELTER COST	$

☐ ASSISTANCE CHECK — Number of Persons ▶

Name	GROSS MONTHLY EARNED INCOME
	$
	$
	$
Name	**GROSS MONTHLY UNEARNED INCOME**
	$
	$
	$

TOTAL GROSS MONTHLY INCOME	$
GROSS MONTHLY DEPENDENT CARE COSTS	$

☐ MEDICAL ASSISTANCE — Number of Persons ▶

Name	GROSS MONTHLY EARNED INCOME
	$
	$
	$
Name	**GROSS MONTHLY UNEARNED INCOME**
	$
	$
	$

TOTAL GROSS MONTHLY INCOME	$
NET MONTHLY INCOME/NET SEMI-ANNUAL INCOME	$
INCOME LIMIT	$

CO	RECORD NUMBER	CAT	CTR DIG	DIST

Worker's Signature | Mailing Date | Telephone Number

LEGAL HELP IS AVAILABLE AT

If you do not understand our decision or have any questions, contact your worker.

☐ CLIENT ☐ APPEAL COPY ☐ CASE RECORD COPY

YOUR RIGHT TO APPEAL AND TO A FAIR HEARING

You have the right to appeal any Departmental action or failure to act and to have a hearing if you are dissatisfied with any decision to refuse, discontinue, change, suspend, or reduce assistance or food stamps. However, if a change in your **ASSISTANCE CHECK, SOCIAL SERVICES,** or **MEDICAL ASSISTANCE** is caused by State or Federal law requiring mass grant adjustment for classes of recipients, you will not be granted a hearing unless you are appealing the correctness of your grant computation. If you are only challenging the law, your appeal will be dismissed by the Department but may be appealed to a higher court.

At the hearing you can present to the Hearing Officer the reasons why you think the decision of the County Assistance Office is incorrect and present evidence or witnesses in your own behalf. You have the right to represent yourself or to have anyone represent you. A staff member of the County Assistance Office will refer you for free legal help upon request.

If you need an interpreter at the hearing because you do not speak English or you have limited understanding of English, or you have a hearing impairment, the Department will arrange for an official interpreter at no cost to you. You may bring a friend or relative to assist you at the hearing, but the interpreter provided by the Department will be the official interpreter. **If you require any reasonable or special accommodation because of a hearing impairment (or other disability), the necessary arrangements will be made to provide the accommodation**. You must make the request for an interpreter or other accommodation in advance of the hearing.

If you and your representative would like to meet with County Assistance Office staff to discuss the matter informally or to present information which might change the proposed action, please call your worker. This will not delay or replace your fair hearing.

If the decision affects your **ASSISTANCE CHECK, SOCIAL SERVICES,** or **MEDICAL ASSISTANCE**, you must request a hearing within **30 days** of the mailing date of this notice. If your request is not postmarked or received within the **30-day** time limit, your appeal will be dismissed without a hearing.

If this decision affects your **FOOD STAMPS**, you must request a hearing within **90 days** from the beginning date of the change of the benefit. If your request is not postmarked or received within the **90-day** time limit, your appeal will be dismissed without a hearing.

HOW TO REQUEST A FAIR HEARING:
To appeal and request a hearing for **ASSISTANCE CHECKS**, **MEDICAL ASSISTANCE** or **SOCIAL SERVICES**, you may call your worker; but, you must also put the appeal in writing as follows: **(1)** Fill out and sign one copy of this form. Give the reason for your appeal; **and** Give your telephone number; **and** Give your exact address; **and (2)** Mail or take this form to the CAO at the address on the front side of this form. To appeal and request a hearing for **FOOD STAMPS**, you may call your worker; or put the appeal in writing; or do both. If you put the appeal in writing, follow the instructions above.

PLEASE CHECK THE BOX NEXT TO THE TYPE OF HEARING YOU WANT:

- ☐ I want a Telephone Hearing. I and my witnesses and anyone helping me will be at this phone number: _____.
- ☐ I want a Telephone Hearing. I and my witnesses and anyone helping me **will be at the County Assistance Office (CAO)**.
- ☐ I want a Face-to-Face Hearing. I and my witnesses and anyone helping me will be in the hearing room with the Judge and the caseworker and CAO staff.
- ☐ I want a Face-to-Face Hearing. I and my witnesses and anyone helping me will be in the hearing room with the Judge. The caseworker and other staff will be on the phone from the CAO.

PLEASE CHECK BELOW IF YOU NEED HELP BECAUSE OF A HEARING PROBLEM OR A DISABILITY OR YOU NEED AN INTERPRETER:

- ☐ I have a hearing impairment or a disability. Describe accommodations needed _____.
- ☐ I need an interpreter. There will be no cost to me. What language? _____.

I WANT TO REQUEST A HEARING BECAUSE:

DATE	CLIENT REPRESENTATIVE SIGNATURE	TELEPHONE #	DATE	CLIENT SIGNATURE	TELEPHONE #

CLIENT ADDRESS

HEARING LOCATIONS

PHILADELPHIA FOR:	Bucks, Chester, Delaware, Montgomery, Philadelphia.
PITTSBURGH FOR:	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland.
HARRISBURG FOR:	Adams, Berks, Centre, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, York, Lehigh.
PLYMOUTH FOR:	Bradford, Clinton, Lackawanna, Monroe, Sullivan, Tioga, Wyoming, Carbon, Columbia, Luzerne, Pike, Susquehanna, Wayne.

☐ **CLIENT** ☐ **APPEAL COPY** ☐ **CASE RECORD COPY**