COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

NOTICE OF ACTION - APPROVAL, CHANGE OR DISCONTINUED

For Kinship - Guardians Only

Notice Date: _____
Case Name: _____
Number: _____
Worker Name: _____
Number: _____
Telephone: _____
Address: _____
_____

(ADDRESSEE)

Questions? Ask your Worker.

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.

APPROVAL

☐ The County has approved your Kin-GAP aid.

As of , the county is **Approving** Kin-GAP aid of $ per month.

This aid is for: _____.

☐ The cash aid payment for your first month of aid is only for a part of a month. It is for the time from your first day of cash aid, shown above, through the end of the month. If nothing changes, your ongoing cash aid amount will be .

CHANGE

As of , the county is **Changing** your Kin-GAP aid from $ to $.

This aid is for: _____.

Here's why: Your rate is based on a level of care determination as defined in AB 403 and WIC section 11461.

☐ Your case had a rate increase.

☐ Your case had a rate decrease.

☐ Your case has been issued an Infant Supplemental Payment.

☐ Your case has been issued a Supplemental Care Increment.

☐ The child has countable income.

_____ for _____
(Income Type) (Child's Name)

of $ is effective .

This is counted as income in the Kin-GAP budget calculation

☐ Other: _____

☐ The _____ is effective . The first month
(Rate/ISP/SCI)
the amount is only for part of the month. If nothing changes ongoing this amount will be $.

☐ Due to funding requirements, you may receive multiple checks for this benefit month. The sum of these checks will be equal to the amount listed above.