

GENERAL NOTICE OF ACTION

COMMONWEALTH OF KENTUCKY

DATE

KAMES-TL-4

CABINET FOR HUMAN RESOURCES

DEPARTMENT FOR SOCIAL INSURANCE

CASE NUMBER

"An Equal Opportunity Employer M/F/H"

CASELOAD CODE

KIM-105 09/92

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IF ANY OF THE AMOUNTS LISTED BELOW ARE WRONG OR CHANGE, YOU SHALL REPORT IT TO YOUR WORKER WITHIN 10 DAYS. PLEASE SEE THE BACK OF THIS LETTER FOR IMPORTANT INFORMATION ABOUT CHANGES YOU SHALL REPORT IF YOU RECEIVE ASSISTANCE AND INFORMATION ABOUT REQUESTING A HEARING IF YOU ARE DISSATISFIED WITH ANY ACTION TAKEN ON YOUR CASE.

IF YOU WANT LEGAL HELP OR ADVICE, CALL YOUR ATTORNEY OR YOUR LOCAL LEGAL AID OFFICE AT:

WORKER'S NAME

ADDRESS

PHONE NUMBER

CITY, STATE, ZIP

CLIENT NAME

CASE NUMBER

The Cabinet for Human Resources administers the Food Stamp, Aid to Families with Dependent Children and Medical Assistance Programs in accordance with State and Federal laws and regulations. We are required to take prompt action whenever we are informed of a change affecting eligibility or amount of assistance of any recipient and to give advance notice to the recipient of any action to be taken.

You have the right:

1. To discuss your situation in detail with your worker at the Department for Social Insurance.
2. To present any information you have to show the proposed action should not be taken.
3. To receive fair and impartial treatment regardless of age, sex, race, religious beliefs, political affiliation, national origin or handicap.

FROM THE DATE OF THIS NOTICE, YOU HAVE 40 DAYS TO REQUEST A HEARING ON PROPOSED AFDC OR MEDICAL ASSISTANCE CHANGES AND 30 DAYS FOR COMPLETED AFDC OR MEDICAL ACTIONS AND 90 DAYS TO REQUEST A HEARING ON FOOD STAMP ACTIONS.

HEARING PROCESS

An impartial hearing officer shall conduct the hearing. You may tell your story in your own way. You may be represented by an authorized representative, such as legal counsel, relative, friend, or other spokesman, or you may represent yourself. You may bring witnesses and documents with you to the hearing to help you establish facts. The hearing shall be orderly but informal. You or your representative shall be permitted to hear all evidence and examine all documents and records used at the hearing. You shall be informed of your right for further appeal.

You may request a fair hearing by completing and returning this section to your worker, calling your worker by telephone or writing the Department of Social Insurance at 275 E. Main Street, Frankfort, Kentucky 40621.

( ) I wish to request a fair hearing because \_\_\_\_\_

( ) I do not wish my benefits continued at the present rate pending the hearing results.

I understand that if my benefits are continued, my household shall owe the value of extra benefits received if the hearing decision is not in my favor.

CLIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ DATE RECEIVED \_\_\_\_\_

PENALTIES

If you purposely hold back information or fail to report changes within 10 days you may be barred from program participation and/or subject to prosecution for fraud.

Any changes in the following must be reported within 10 days of the time you learn of them:

1. Family income (amount and source)
2. Household members
3. Your address
4. Employment
5. Dependent care expenses
6. Sale of property or other increase in resources
7. School attendance for yourself

Food Stamp recipients must also report: 1. Number of vehicles 2. Shelter, utility or medical costs 3. Child over 16.

AFDC and Medicaid recipients must also report: 1. School attendance for yourself or child over 6 2. Discharge of someone in long term care 3. Return of parent to the home 4. Number of vehicles

You may report changes by filling out the lines below and taking or mailing to your worker or you may report changes by phone.

I wish to report the following changes: \_\_\_\_\_ This change is for the month(s) of \_\_\_\_\_

YOUR MEDICAL CARD

Any person whose name is shown on the medical card may receive needed medical services. However you must never permit anyone not named on the card to use it. If you receive emergency medical care before you receive your Medical Assistance ID card, you must present the card as soon as received to the provider of the medical services. If you or any member of your case is pregnant, the pregnant individual may continue to receive medical assistance.

LET US HELP YOU KEEP YOUR FAMILY HEALTHY

You are invited to get a free health and dental check-up for your children and you, if you are under 21 years of age. The health check-up includes: eye and hearing test; a test for kidney problems, TB, low blood, growth and development; nutrition and general health will also be checked; and immunizations (shots) will be given if needed. If any problems are found during the check-up, your children and you (if you are under 21) will receive help in getting treatment for these problems. Contact your local health department for assistance in making an appointment for the check-up and in arranging transportation.