

DEPARTMENT OF HEALTH SERVICES

714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941



December 13, 1996

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Pickle Coordinators

Letter No.: 96-72

REVISIONS TO THE DHS 7020, THE 7021, THE 7025 ENGLISH AND SPANISH, THE
7026 ENGLISH AND SPANISH, AND THE 7027 ENGLISH AND SPANISH

Ref.: All County Welfare Directors Letter (ACWDL) No.: 96-22

The purpose of this ACWDL is to provide the counties with a copy of the DHS 7020 (7/96), the DHS 7021 (11/96), the DHS 7025 (7/96) English, the DHS 7025 (7/96) Spanish, the DHS 7026 (8/96) English with the new NA Back 7, the DHS 7026 (8/96) Spanish with the new NA Back 7, the DHS 7027 (8/95) English with the new NA Back 7, and the DHS 7027 (8/95) Spanish with the new NA Back 7.

The changes/additions are as follows:

1. DHS 7020 (7/96) - We have added "For the aged, blind, or disabled who are potentially Pickle eligible." This addition clarifies Pickle Amendment eligibility.
2. DHS 7021 (11/96) - We have moved the phrase "...if negative, enter on C.2" from Part B. 5 to Part C.3 which was incorrect on the 2/96 version.
3. DHS 7025 (7/96) English and Spanish - We added "DO NOT THROW AWAY YOUR PLASTIC ID CARD. YOU MAY BE ABLE TO USE IT AGAIN." This added beneficiary identification card (BIC) information.
4. DHS 7026 (8/96) English and Spanish - We revised the form, added the new NA Back 7, and added BIC information as follows: "DO NOT THROW AWAY YOUR BENEFITS ID CARD (BIC). YOU MAY BE ABLE TO USE IT AGAIN."
5. DHS 7027 (8/95) English and Spanish - We added the new NA Back 7, and the language, "You have or will receive a plastic Benefits Identification card (BIC). TAKE THIS PLASTIC ID CARD TO YOUR MEDICAL PROVIDER WHENEVER YOU NEED CARE. This card is good as long as you are eligible for Medi-Cal. DO NOT THROW AWAY YOUR PLASTIC ID CARD." This revision was inadvertently omitted from Pickle Handbook Number 13.

All County Welfare Directors
All County Administrative Officers
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All County Pickle Coordinators
Page 2

The 11/96 version of the DHS 7021 will be in the Department of Health Services Warehouse, 1037 North Market Boulevard, Suite 9, Sacramento, California 95834 by December 15, 1996. At that time, all previous versions of the DHS 7021 will be recycled. Also, in order to conserve paper, we intend to exhaust all existing stock of the other forms and use the revisions as needed since the changes/additions are not substantive. A small supply of the DHS 7027 (8/95) English and Spanish are already in the warehouse and can be ordered at any time. Lastly, all of the above mentioned Pickle form revisions will be included in the Pickle Handbook update Number 14.

If you have any questions, please contact Sylvia Finberg at (916) 255-0950.

Sincerely,

ORIGINAL SIGNED BY

FRANK S. MARTUCCI, CHIEF
Medi-Cal Eligibility Branch

Enclosures

SCREENING WORK SHEET

For aged, blind, or disabled persons who are potentially Pickle eligible
(Individuals in long-term care are not eligible under the Pickle program.)

Person's Name	Case Name	Case Number
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Date SSI/SSP last received (must be verified in accordance with Title 22, California Code of Regulations, Section 50167 unless person is on your list/Medi-Cal Eligibility Data System [MEDS]). _____

NOTE: If SSI/SSP was never received or was received prior to April 1977, do not continue. The person is not eligible as a Pickle person.

Screening Process:

	YES	NO
1. Does this person currently receive Title II benefits (RSDI*/ Social Security)?.....	☐	☐
2. Since April 1977, has this person received or been entitled to receive both RSDI and SSI/SSP in the same month?	☐	☐
Has this person been discontinued from SSI/SSP?	☐	☐
4. Has this person received an RSDI COLA increase in any month since SSI/SSP was discontinued?.....	☐	☐

If the answer to *all* of the above questions is yes, the individual is a potential Pickle person. Complete the evaluation on the Financial Eligibility Work Sheet to determine if actual Pickle eligibility exists.

If the answer to any of the above questions is no, the person is currently ineligible as a Pickle person. In that situation, this form, noting the reason for ineligibility, and the verified date of last receipt of SSI/SSP, must be retained permanently in the case file.

Reason for ineligibility _____

RSDI: Retirement, Survivors, and Disability Insurance under Social Security.

Worker Signature	Worker Number	Screening Date	County Use
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FINANCIAL ELIGIBILITY WORK SHEET (Individual or Couple, Applicant With an Ineligible Spouse)

Applicant's Name	Case Number
Applicant's Name	

PART A. NEEDS TEST

1. Applicant's total earned and unearned income (MC 176M, Part I, Line 14): \$ _____
 2. Title II COLA disregard amount: \$ _____
 3. Total countable income (subtract A.2 from A.1) \$ _____
- (If single applicant or couple pass the screening work sheet, proceed to Part F.):

PART B. INELIGIBLE SPOUSE'S UNEARNED INCOME

1. Ineligible spouse's total unearned income—do not include public assistance income: \$ _____
2. Title II COLA disregard amount: \$ _____
3. Countable unearned income (subtract B.2 from B.1): \$ _____
4. Allocation for ineligible children. (If no children, enter zero in B.4.c.)
Do not include Pickle-eligible children.

CHILD #1	CHILD #2	CHILD #3	CHILD #4
Name	Name	Name	Name

- a. Allocation (couple Federal Benefit Rate [FBR] minus individual FBR):
- b. Subtract child's income:
- c. Total allocation: _____ + _____ + _____ + _____ = \$ _____
5. Remaining unearned income (subtract line B.4.c. from B.3): \$ _____

PART C. INELIGIBLE SPOUSE'S EARNED INCOME

1. Ineligible spouse's gross earned income: \$ _____
2. Unused portion of allocation for ineligible child(ren): \$ _____
3. Remaining earned income (subtract C.2 from C.1, if negative, enter on C.2): \$ _____

PART D. INELIGIBLE SPOUSE'S TOTAL INCOME AFTER ALLOCATIONS (Add B.5 and C.3) (If less than the difference between the FBR for a couple and the FBR for an individual, deeming not applicable. Make no entry for ineligible spouse's income in Part E.):

\$ _____

PART E. COMBINED INCOMES (Eligible individual or couple and/or ineligible spouse after ineligible child allocations)

1. Applicant's gross unearned income (including any applicable ISM-DHS 7044). (If VTR, ISM is zero, use "household of another" SSI/SSP payment level in F.1): \$ _____
2. Applicant's Title II COLA disregard amount: \$ _____
3. Applicant's countable unearned income (subtract line E.2 from line E.1): \$ _____
4. Ineligible spouse's unearned income (line B.5) (if B.5 is less than 0, use 0): \$ _____
5. Combined unearned income (add lines E.3 and E.4): \$ _____
6. Subtract general income exclusion: \$ -20
7. Combined countable unearned income: \$ _____
8. Earned income of applicant and spouse (use amount from line C.3 for ineligible spouse): \$ _____ **Total Unearned**
9. Subtract balance of general exclusion not offset by unearned income (line E.6): \$ _____
10. Remaining earned income: \$ _____
11. Subtract work expense exclusion: \$ -65
12. Remaining earned income: \$ _____
13. Subtract 1/2 remaining earned income: \$ _____
14. Countable earned income: \$ _____ **Total Earned**
15. Total countable income (add lines E.7 and E.14): \$ _____ **Combined Total**

PART F. PICKLE ELIGIBILITY CALCULATION

1. Current SSI/SSP payment level for an individual or a couple: \$ _____
2. Enter total countable income (line A.3 or E.15): \$ _____

If line F.2 is less than or equal to F.1, the applicant is Pickle eligible. If ineligible, enter in Tickler System.

Eligibility Worker Signature	Worker Number	Computation Date	County Use
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NOTICE OF ACTION**COUNTY INFORMATION****SECOND NOTICE
(503 LEADS NOTICE
OF ACTION)**

DATE:

TO: Medi-Cal Beneficiaries Discontinued
From SSI/SSP on January 1

FROM: County Welfare Department

RE: Your Medi-Cal benefits will end

You were notified by the Social Security Administration (SSA) in December that your SSI/SSP was discontinued as of January 1 of this year. The reason your SSI/SSP checks were stopped is because you received an increase in your Social Security benefits. Although this increase made you ineligible for your SSI/SSP checks, you also were notified by the State Department of Health Services that you would continue to receive Medi-Cal until the county welfare department determines whether you will be able to get a zero share of cost Medi-Cal card under the Pickle Amendment. The county must evaluate your Pickle eligibility for Medi-Cal.

However, you have not responded to the State Department's notice and we were unable to reach you by telephone. Therefore, your Medi-Cal will automatically be discontinued on April 30.

If you have information that you would like to be considered, please contact your county eligibility worker immediately.

IF YOU DISAGREE WITH THIS ACTION AND YOU WANT TO APPEAL THE DISCONTINUANCE, YOU MAY REQUEST A STATE HEARING BY FOLLOWING THE INSTRUCTIONS ON THE BACK OF THIS NOTICE.

NOTE: THIS NOTICE WILL NOT AFFECT ANY MEDI-CAL BENEFITS YOU MAY ALREADY BE RECEIVING UNDER ANOTHER MEDI-CAL PROGRAM. DO NOT THROW AWAY YOUR PLASTIC ID CARD. YOU MAY BE ABLE TO USE IT AGAIN.

If your SSI/SSP checks have been started again since January 1 of this year, please ignore this letter.

This notice is a result of a court decision in the case of *Lynch v. Rank*, U.S. District Court, Northern District of California, Number C-83-2340 WHO.

For additional information contact:

NOTIFICACIÓN DE ACCIÓN**COUNTY INFORMATION**
SECOND NOTICE
(503 LEADS NOTICE
OF ACTION)

FECHA:

PARA: Beneficiarios de Medi-Cal suspendidos
de los programas SSI/SSP el 1° de enero

DE: Departamento de Asistencia Pública del Condado (County Welfare Department)

REF.: Sus beneficios de Medi-Cal serán suspendidos

La Administración del Seguro Social (SSA) le informó en diciembre que su SSI/SSP fue suspendido a partir del 1° de enero de este año. Sus cheques de SSI/SSP fueron suspendidos porque usted recibió un aumento en sus beneficios del Seguro Social. A pesar de que ese aumento ya no le da derecho a recibir cheques de SSI/SSP, usted también fue notificado por el Departamento de Servicios de Salud del Estado de que usted continuaría recibiendo beneficios de Medi-Cal hasta que el departamento de asistencia pública del condado determine si usted puede obtener una tarjeta de Medi-Cal sin parte del costo bajo la enmienda Pickle. El condado deberá evaluar su elegibilidad bajo el programa Pickle para Medi-Cal.

Sin embargo, usted no ha respondido a la notificación del Departamento del Estado ni tampoco hemos podido ponernos en contacto con usted a través del teléfono. Por lo tanto, sus beneficios de Medi-Cal serán suspendidos automáticamente a partir del 30 de abril.

Si usted tiene información que le interesaría que fuera tomada en consideración, comuníquese con su trabajador de elegibilidad inmediatamente.

SI NO ESTÁ DE ACUERDO CON ESTA ACCIÓN Y DESEA APELAR LA SUSPENSIÓN, PUEDE SOLICITAR UNA AUDIENCIA ESTATAL SIGUIENDO LAS INSTRUCCIONES AL REVERSO DE ESTA HOJA.

NOTA: ESTA NOTIFICACIÓN NO AFECTARÁ OTROS BENEFICIOS DE MEDI-CAL QUE USTED PUDIERA ESTAR RECIBIENDO BAJO OTRO PROGRAMA DE MEDI-CAL. NO TIRE SU TARJETA DE IDENTIFICACIÓN DE PLÁSTICO. TAL VEZ PUEDA VOLVER A USARLA DE NUEVO.

Si usted ha vuelto a recibir cheques de SSI/SSP desde el 1° de enero de este año, entonces ignore el contenido de esta carta.

Esta notificación es producto de una decisión tomada por la corte en el caso de **Lynch v. Rank**, U.S. District Court, Northern District of California, Number C-83-2340 WHO.

Para mayor información, comuníquese con:

**MEDI-CAL
NOTICE OF ACTION
DENIAL/DISCONTINUANCE
(PICKLE AMENDMENT)**

(County Stamp)

State Number: _____

District: _____

Notice for: _____

(Name)

We have reviewed your case and the information that you gave us and we find that you are NOT currently eligible, under the Pickle Amendment, to receive NO COST Medi-Cal benefits because:

The Pickle Amendment provides Medi-Cal benefits, without any cost, for people who, at any time after April 1977, received both Social Security and SSI/SSP checks in the same month, *and* who now receive only Social Security, *and* who would be eligible for SSI/SSP if they had not received cost of living increases in their Social Security benefits.

NOTE: THIS DENIAL WILL NOT AFFECT ANY MEDI-CAL BENEFITS THAT YOU MAY BE CURRENTLY RECEIVING UNDER ANY OTHER MEDI-CAL PROGRAM.

DO NOT THROW AWAY YOUR BENEFITS ID CARD (BIC). YOU MAY BE ABLE TO USE IT AGAIN.

IF YOU DISAGREE AND WANT TO APPEAL THIS DECISION, YOU MAY REQUEST A STATE HEARING BY FOLLOWING THE INSTRUCTIONS ON THE BACK OF THIS NOTICE.

This notice is a result of a court decision in the case of *Lynch v. Rank*, Number C83-2340 WHO U.S. District Court, Northern District of California.

If you have any questions about this notice or if there are additional facts which you have not reported to us, please contact your eligibility worker immediately. We will answer your questions or make an appointment to see you in person. Please remember that you may reapply at any time.

Eligibility Worker_____
Phone_____
Date

Si Ud. necesita una traducción de este aviso en español, pongase en contacto con su oficina de bienestar del condado.

To Ask For a State Hearing

**MEDI-CAL
NOTIFICACIÓN DE ACCIÓN
DENEGACIÓN/SUSPENSIÓN
(PICKLE AMENDMENT)**

(County Stamp)

Número del Estado: _____

Distrito: _____

Notificación para: _____

(Nombre)

Después de revisar su caso, así como la información que usted nos proporcionó, hemos determinado que, conforme a la enmienda "Pickle Amendment", usted actualmente NO es elegible para obtener beneficios de Medi-Cal SIN COSTO debido a lo siguiente:

La enmienda "Pickle Amendment" otorga beneficios de Medi-Cal, sin ningún costo, a aquellas personas que en cualquier momento después de abril de 1977, recibieron cheques tanto del Seguro Social como del SSI/SSP durante el mismo mes, y que actualmente reciben solamente asistencia del Seguro Social, y que serían elegibles para obtener asistencia de SSI/SSP si no hubieran obtenido un ajuste en los beneficios otorgados por el Seguro Social para compensarles por el aumento en el costo de vida.

NOTA: ESTA DENEGACIÓN NO AFECTARÁ NINGUNO DE LOS BENEFICIOS QUE ACTUALMENTE LE OFRECE MEDI-CAL BAJO CUALQUIER OTRO PROGRAMA DE MEDI-CAL.

NO TIRE SU TARJETA DE BENEFICIOS (BIC). PODRÍA SERLE ÚTIL EN OTRA OCASIÓN.

SI USTED NO ESTÁ CONFORME Y DESEA APELAR ESTA DECISIÓN, PUEDE SOLICITAR UNA AUDIENCIA CON EL ESTADO SIGUIENDO LAS INSTRUCCIONES AL REVERSO DE ESTA NOTIFICACIÓN.

Esta notificación es el resultado de la decisión de la corte en el caso de *Lynch v. Rank*, Número C83-2340 WHO Corte de Distrito de los Estados Unidos, Distrito del Norte de California.

Si tiene alguna pregunta acerca de esta notificación o si existe información adicional que no nos haya proporcionado comuníquese con su trabajador de elegibilidad inmediatamente. Responderemos a todas sus preguntas o le daremos una cita para atenderlo personalmente. Recuerde que usted puede volver a solicitar este tipo de beneficios en cualquier momento.

Trabajador de Elegibilidad

Teléfono

Fecha

Para pedir una audiencia con el estado

- Para conservar sus mismos beneficios mientras espera una audiencia**

- Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualquier asistencia monetaria o estampillas para comida que usted haya recibido de más.

Es posible que pueda obtener asesoría legal gratuita en la oficina local de asesoramiento legal (legal aid) o del grupo de derechos de las personas que reciben asistencia pública.

A BACK 7 (SP)

Fecha: _____

NOTICE OF MEDI-CAL ELIGIBILITY
PICKLE AMENDMENT

Your application for Medi-Cal benefits, without a share of cost, under the Pickle Amendment has been approved. You are entitled to receive no-share-of-cost Medi-Cal benefits beginning _____.

You have or will receive a plastic Benefits Identification card (BIC). TAKE THIS PLASTIC ID CARD TO YOUR MEDICAL PROVIDER WHENEVER YOU NEED CARE. This card is good as long as you are eligible for Medi-Cal. DO NOT THROW AWAY YOUR PLASTIC ID CARD.

For additional information, contact:

To Ask For a State Hearing

- You only have 90 days to ask for a hearing. The 90 days started the day after we gave or mailed you this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- Your Transitional Child Care (TCC) will stay the same until the hearing or the end of your eligibility period, whichever is earlier. **For all other child care programs, your benefits will NOT stay the same until your hearing.**
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

o Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child and/or Medical Support: The District Attorney's office will help you collect support even if you are not on cash aid. There is no cost for this help. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They 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.

aring File: If you ask for a hearing, the State Hearing Office will set a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 150).

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send or take this page to:

Your worker will get you a copy of this page if you ask. Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call: 1-800-952-8349.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department
of _____ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Child Care☐ Other (list) _____

Here's why:

☐ Check here and add a page if you need more space.

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

NAME _____

ADDRESS _____

☐ I need a free interpreter.
My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My case number: _____

My Signature: _____

Date: _____

NOTIFICACION DE ELEGIBILIDAD PARA MEDI-CAL
PICKLE AMENDMENT

[]

L]

Su solicitud para obtener beneficios de Medi-Cal, sin tener que pagar parte del costo, bajo la enmienda "Pickle Amendment" ha sido aprobada. Usted tiene derecho a obtener beneficios de Medi-Cal sin tener que pagar parte del costo a partir de _____.

Usted tiene o recibirá una tarjeta de plástico de Identificación de Beneficios (BIC). PRESENTE ESTA TARJETA DE IDENTIFICACION DE PLASTICO A SU MEDICO SIEMPRE QUE NECESITE CUIDADO MEDICO. Esta tarjeta es válida mientras usted sea elegible para Medi-Cal. NO TIRE SU TARJETA DE IDENTIFICACION DE PLASTICO.

Para información adicional, favor de llamar a:

Para pedir una audiencia con el estado

- Usted tiene solamente 90 días para solicitar una audiencia. Los 90 días comenzaron un día después de la fecha en que le dimos o enviamos esta notificación.
- Si desea seguir recibiendo los mismos beneficios, tiene menos tiempo para pedir una audiencia.

Para conservar sus mismos beneficios mientras espera una audiencia

Tiene que solicitar la audiencia antes que la acción entre en vigor.

- Su asistencia monetaria permanecerá sin cambios hasta que se lleve a cabo su audiencia.
- Su Medi-Cal permanecerá sin cambios hasta que se lleve a cabo su audiencia.
- Sus estampillas para comida permanecerán sin cambios hasta que se lleve a cabo la audiencia o hasta el fin de su período de certificación; lo que ocurra primero.
- Sus pagos del Programa de Transición de Cuidado de Niños (TCC) permanecerán sin cambios hasta que se lleve a cabo la audiencia o hasta el fin del período en que usted reúna los requisitos; lo que ocurra primero. Con respecto a todos los otros programas de cuidado de niños, sus beneficios NO permanecerán sin cambios hasta que se lleve a cabo su audiencia.
- Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualquier asistencia monetaria o estampillas para comida que usted haya recibido de más.

ara que se descontinúen ahora sus beneficios

Si usted desea que se descontinúe su asistencia monetaria o sus estampillas para comida mientras espera una audiencia, marque una o ambas casillas.

- ☐
- Asistencia monetaria
- ☐
- Estampillas para Comida

ara obtener ayuda

Puede obtener información acerca de sus derechos a una audiencia o asesoría legal gratuita llamando al teléfono de información del estado.

Número gratuito: 1-800-952-5253

Si es sordo y usa TDD: 1-800-952-8349

Es posible que pueda obtener asesoría legal gratuita en la oficina local de asesoramiento legal (legal aid) o del grupo de derechos de las personas que reciben asistencia pública.

ra información

Intenimiento de hijos y/o mantenimiento médico: La oficina del Fiscal del Distrito le ayudará a cobrar mantenimiento de hijos aun cuando esté recibiendo asistencia monetaria. Este servicio es gratuito. Si en la actualidad están cobrando mantenimiento de hijos a su nombre, ellos continuarán haciéndolo hasta que usted les dé aviso por escrito diciéndoles que paren. Le enviarán a usted cualesquier cantidades debidas de mantenimiento que cobren. Se quedarán con las cantidades debidas cobradas que se le deban al condado.

Asignación familiar: Su oficina de bienestar le proporcionará una asignación cuando usted la solicite.

ente de la audiencia: Si usted solicita una audiencia, la oficina de audiencias con el estado, formará un expediente. Usted tiene el derecho de examinar ese expediente. El Estado puede dar su expediente al departamento de bienestar, al Departamento de Salud y Servicios Humanos de los Estados Unidos y al Departamento de Agricultura de los Estados Unidos. (Sección 10950 del Código de Bienestar e Instituciones)

La mejor manera de solicitar una audiencia es llenando esta página. Haga una copia del frente y del reverso para sus archivos. Luego envíe esta página a:

Su trabajador(a) le dará a usted una copia de esta página si la pide. Otra manera de solicitar una audiencia es llamando al 1-800-952-5253. Si es sordo y usa TDD, llame al: 1-800-952-8349.

PETICION PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción tomada por el Departamento de Bienestar del Condado de _____, acerca de mi(s) _____.

- ☐ Asistencia monetaria ☐ Estampillas para Comida
☐ Medi-Cal ☐ Cuidado de Niños ☐ Otro (anote)

La razón es la siguiente: _____

- ☐ Marque aquí y agregue otra hoja si necesita más papel.
- ☐ Quiero que la persona mencionada abajo me represente en esta audiencia. Le doy permiso a esta persona que vea mis expedientes o que vaya a la audiencia en mi lugar.

NOMBRE _____

DIRECCION _____

- ☐ Necesito un intérprete sin costo para mí.

Mi idioma es el: _____

Mi nombre: _____

Dirección: _____

Teléfono: _____

Mi No. de caso: _____

Mi firma: _____

Fecha: _____