FAX COVER SHEET

To:

From: Olivia Shaw

Company: CDSS

Company: LSNC

Fax: 833-281-0905

Phone: 9165512150

Date: 7/16/2024

Pages w/cover: 3

Subject:

Comments:

AUTHORIZED REPRESENTATIVE

July 8th , 20 24

State of California
Department of Social Services
P.O. Box 944243, M.S. 9-17-37
Sacramento, California 94244-2430

I, Yang Xiong for Kaleb Xiong of
(Name)

9582 Village Tree Dr. Elk Grove, CA 95758
(Address) (City, State and Zip)

have requested Olivia Shaw
(Name)

Legal Services of Northern California
(Organization)

501 12th St. Sacramento, CA 95814
(Address) (City and Zip)

to act on my behalf in my appeal regarding my application for and/or receipt of Medi-Cal / IHSS

(Assistance Program)

I hereby authorize your department to release any or all information relating to this request to this person/organization.

Signed DocuSigned by: Yang Xiong
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IF YOU STILL WANT YOUR HEARING, it is required that you attend the hearing or have someone appear on your behalf. If no such appearance is made at the time scheduled, the entire matter will be dismissed. Even though you appoint someone to represent you, your appearance at the hearing would be helpful to the Administrative Law Judge in arriving at an appropriate decision. If you have authorized someone to act as your representative, that authorization should be in writing, and given to the Administrative Law Judge at the hearing. This Authorized Representative form is enclosed for this purpose. If you want to authorize someone to represent you at the hearing, please complete this form and either bring it to your hearing or have your representative bring it to the hearing on your behalf. You should notify your representative of the time and place of your hearing. You may bring witnesses or other persons who you believe can help you explain your position. You should also bring any documents or other papers that you think important and that you wish to have considered.

Information regarding your request has been sent to your county welfare department or to the California Department of Health Services. Staff from that agency may be contacting you about the agency's decision, the reason for its action, and the reasons for your request in an effort to resolve the problem.

If you have been receiving assistance, your assistance will continue in the same amount if your request was filed before the effective date of the proposed action and you requested continuance of your aid pending.

If you are not now receiving assistance, you will not receive aid pending your state hearing.

CL: Yang Xiong
DOB: 8-8-1973
BEN: Kaleb Xiong
DOB: 3-13-2020
County: 34
Interpretor needed: No
Filed date: 7-16-24
RD: 7-16-24
Issue: IHSS - Needs assessment - Benefits amount
Issue # 2 : Medical - Eligibility - Benefits amount.
AR: Olivia Shaw
KN