**Refugee Cash Assistance Termination**

**Notice of Decision**

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

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| **Current Worker** | | | |
| Worker Name | | | Telephone Number |
| Worker County | Worker Region (if applicable) | | |
| **Case** | | | |
| Case Name | | Case Number | Date of Notice of Decision |
| **Job Seeker** | | | |
| Job Seeker Name | | | Telephone Number |
| Job Seeker Address | | | |
| **Reason(s) for Termination** | | | |
| This notice is to inform you that your application for Refugee Cash Assistance (RCA) and/or Refugee Medical Assistance (RMA) will end effective       due to the following reason(s): | | | |
| Your income of       exceeds the maximum limits.  You have been in the United States more than 12 months.  You have been determined eligible for W-2 or SSI benefits and will receive financial assistance through that program.  You are participating in the Refugee Match Grant Program and will not be eligible for RCA before      , 4 months after your date of entry to the country. You may apply for RCA after this date.  Other | | | |
| **Important Information** | | | |
| * Your final RCA benefit will be in the amount of $       for the period       through      . * Please direct any questions regarding your RCA and/or RMA to your worker listed above. If you think this decision is wrong, call your worker for an explanation at the number listed above. * You must notify your worker of any changes such as employment or change of residence within 10 days. Failure to do so may result in negative decision taken on your case. * If you will need a language translator, sign language interpreter or other accommodation for a disability, please contact your worker. | | | |
| **Appeal Rights** | | | |
| You have a right to appeal an agency decision. If you think an agency decision is wrong, call your worker for an explanation. Also, you can ask for a Fair Hearing if you think the decision is wrong. The directions for requesting a Fair Hearing can be obtained from your worker, or you may send a written request with your name, address, phone number, social security number and reason for the appeal to: Division of Hearings and Appeals, PO Box 7875, Madison WI 53707- 7875. If you request a Fair Hearing before the effective date of any change, benefits will be continued until the final decision is made. Benefits will not continue beyond the 12-month eligibility period. If the Fair Hearing confirms that you are not eligible for benefits, you will have to pay back the benefits you receive in error. You must send a request for a Fair Hearing within 45 days of the date of notice of decision, or the Hearing Examiner will not consider the request. | | | |