California Department of Education
Early Education and Support Division
Form CD-7617, (Rev. 10/13)

NOTICE OF ACTION-TERMINATION

URGENT INFORMATION FOR PARENTS

If you do not agree with the action described below, you may file an appeal. Instructions for filing an appeal are provided on the reverse side of this Notice of Action (NOA). Your appeal request must be received by the agency on or before the deadline: _____ **If you do NOT appeal by the deadline, the agency will proceed with the action as described below.**

Please keep a copy of this notice for your records.

1. PARENT INFORMATION

_____
Parent A Name

_____
Parent B Name

_____
Address

_____
City, State, Zip

_____
Phone Number

2. AGENCY INFORMATION

_____
Agency Authorized Representative Name

_____
Agency Authorized Representative Signature Date

530-241-1140
Agency Phone Number

Shasta Head Start, Child Development Inc.
Agency Name

375 Lake Blvd, Suite #100 Redding CA 96003
Agency Address City, State, Zip

3. ACTION:

The _____ child care services for the child(ren) listed below will be terminated.
Program type(s)

The last day of services will be: _____.
Effective Date

_____ *Name of child*	_____ *Date of birth*	_____ *Name of child*	_____ *Date of birth*
_____ *Name of child*	_____ *Date of birth*	_____ *Name of child*	_____ *Date of birth*
_____ *Name of child*	_____ *Date of birth*	_____ *Name of child*	_____ *Date of birth*
_____ *Name of child*	_____ *Date of birth*	_____ *Name of child*	_____ *Date of birth*

4. REASON FOR ACTION. Your services are being terminated because:

- ☐ You are not eligible because you have not provided all required documents to establish your eligibility (*EC* 8263(a)(1); 5 *CCR*, sections 18084-18092, 18100
- ☐ You have not provided all required documents to establish your need (*EC* 8263(a)(2); 5 *CCR*, sections 18084-18092, 18100
- ☐ You did not provide requested documentation (5 *CCR*, sections 18084-18092, 18100)
- ☐ You failed to report changes in family circumstances (5 *CCR*, Section 18102)
- ☐ You failed to comply with contractor delinquent fee or repayment plan policies (5 *CCR*, sections 18105, 18109, 18114-18116)
- ☐ You failed to comply with recertification requirements (5 *CCR*, Section 18103)
- ☐ Your child(ren) no longer meets age eligibility requirements for the _____ program
  Program Type
- ☐ You failed to comply with contractor written policies (5 *CCR*, sections 18105, 18221, 18222)
- ☐ Agency could not verify your eligibility or need (5 *CCR*, sections 18084-18092, 18100))
- ☐ Other (explained below)

5. WHY CHILD CARE WILL BE TERMINATED: _____

_____

_____

6. ISSUANCE:

☐ Given to Parent: _____ _____ _____ Date Parent Initials Agency Initials	☐ Mailed to Parent: : _____ _____ _____ Date Tracking No. (If Applicable) Agency Initials

INSTRUCTIONS FOR FILING AN APPEAL

If you disagree with the action set forth on the reverse side of this NOA, you may appeal it to a hearing officer, who shall be higher in authority than the person issuing this NOA. Your request for a local appeal hearing must be received by the agency on or before the ***DEADLINE***: _____. If you file an appeal, the intended action will be suspended and any services you currently receive will continue until the review process has been completed.**_**If you do not submit an appeal request before the deadline listed above, you will lose your appeal rights and the action will become effective on the date listed on the reverse side of this NOA.**_**

STEP 1: To request a local appeal hearing, please fill in the boxes:

Parents Name:		Phone Number:
Address	City/State	Zip Code
Optional- Explain why you believe the action indicated on the reverse of this NOA is incorrect (you may attach additional pages if necessary):		
☐ Check box if you have an authorized representative (someone who will attend the hearing on your behalf).	☐ Check box if you need an interpreter at the hearing. Language needed:	
Name of authorized representative:	Parent Signature	Date

STEP 2: Make a copy of this page and fax, mail or hand deliver to the agency as follows:

FOR AGENCY USE ONLY

Agency Name: Shasta Head Start		
Mailing Address: 375 Lake Blvd., Suite #100	City/State: Redding, CA	Zip Code: 96003
Agency Contact (name): Hearing Officer	Contact E-mail:	
Contact Telephone # (530) 241-1036	Fax (530) 241-2703	

If you prefer, you may provide the appeal information to the agency in a separate document or by telephone. You may also request that your hearing be recorded**.** **Please keep a copy of both sides of this form for your records.****

STEP 3: The agency will notify you of the time, and location of your hearing within 10 days of your request. If the time and place of the hearing are not convenient for you, please contact the agency immediately to reschedule**.**_**_***If you do not get written notification of the date, time and location of your appeal hearing within 10 calendar days of submitting your request, please contact the local agency listed above immediately.***_**

STEP 4: Arrive at the scheduled hearing at least 10 minutes in advance. You shall have an opportunity to explain the reason(s) you believe the NOA was incorrect. ****_***If neither you nor your authorized representative appear at the time and location of the scheduled hearing, you will be deemed to have abandoned your appeal, the intended action on the NOA will no longer be suspended and the action will become effective.***_**

STEP 5: Within 10 calendar days after your local appeal hearing, you will be issued a local hearing decision letter. ****_***If you do not receive the decision letter, please contact the local agency listed above immediately.***_**

STEP 6: If, after your local hearing, you disagree with the local hearing decision letter, you may ask for a review by the Early Education and Support Division (EESD). To request a review, write a letter explaining why you believe the local agency's decision letter is incorrect. Your request must include: 1) your letter, 2) a copy of this NOA, and 3) a copy of the agency's decision letter**. The EESD must receive the request within 14 calendar days from the date on the written decision letter.**

Mail or fax your appeal to:

California Department of Education
Early Education and Support Division
1430 N Street, Suite 3401
Sacramento, CA 95814
Attn: Appeals Coordinator
FAX 916-323-6853

You may contact the EESD at 916-322-6233 for additional assistance.