

(to be sent on Volag letterhead)

Reduction or Termination of Benefits

To: _____
Address: _____
Address: _____
Notification Date _____

You have not been in compliance with your Family Self-Sufficiency Plan. The following actions that have caused you to be out of compliance are:

- Irregular attendance at Colorado Refugee English classes at Emily Griffith Opportunity School or District 11 ESL classes
- Failure to attend activities listed on your Family Self-Sufficiency Plan or failure to be available for job search and other employment related activities.
- Refusal to fill out employment applications and/or go to interviews for a suitable job
- Refusal to accept a suitable job when offered
- Failure to report to work after being hired
- Missed appointments with case management staff or employment staff
- Quit a suitable job without good reason
- Fired from job
- Failure to report income
- Other

A conciliation hearing to discuss the circumstances of your non-compliance is scheduled on _____ at _____ with _____, and your case manager. Non-compliance with your Family Self-Sufficiency Plan or not attending the conciliation meeting will result in:

CARES cash assistance:

- Reduction of monthly CARES cash assistance for 3 months (From \$____ to \$____)
- Reduction of monthly CARES cash assistance for 5 months (From \$____ to \$____)
- Termination of monthly CARES cash assistance.

Services are also sanctioned, including employability services and case management services. Case management for significant health and mental health services would continue.

At the conciliation you may speak for yourself or be represented by a relative, friend, lawyer (at your expense) or other spokesperson, if they have your written authorization to do so.

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You have the right to bring an interpreter who is acceptable both to you and to our agency. You must notify our agency three days prior to the conciliation if you plan to bring an interpreter, otherwise one will be provided at no cost to you.

If you wish to appeal the results of the conciliation meeting, you may request a State-level Hearing by sending a completed Request for Colorado Refugee Services Program State Hearing form or written request (in English or in your language) to the State Refugee Coordinator, Colorado Refugee Services Program, 789 Sherman St., Suite 440, Denver, CO 80203. This request must be postmarked within 15 calendar days of the date on the letter that states the results of the conciliation meeting. If your request for appeal is later, your right to a State-level Hearing will be cancelled.

You will continue to receive an unreduced CARES cash assistance payment until a decision is made on your appeal.

If you have any questions about this letter, please contact your case manager at

_____.

Sincerely,

Case Manager

(Revised September 2007)