

## NOTICE OF ACTION AND RIGHT TO REQUEST A STATE HEARING ON INTERIM ASSISTANCE

<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	State No.: County No.: Worker No.: District: Date: Case Name: Interpreter Needed: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Language</span> <span>Dialect</span> </div>
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This office was notified of your initial Supplemental Security Income/State Supplementary Payment (SSI/SSP) for the period \_\_\_\_\_ through \_\_\_\_\_. As per your agreement, we billed the Social Security Administration (SSA) in the amount of \$\_\_\_\_\_ to repay the amount of Interim Assistance you received for that same period while SSA completed your application for Supplemental Security Income payments. SSA will notify you about how the remaining SSI money (if any) due you will be released by SSA.

### SSI/SSP PAYMENT

If you disagree with the amount of SSI/SSP payment, contact your local Social Security Office. The amount of the initial SSI/SSP payment is subject to the SSA appeal process. Request for reconsideration must be filed within 60 days after the date the notice of the initial determination is received by you.

### INTERIM ASSISTANCE PAYMENT

If you disagree with the amount billed to the SSA, please contact the California Department of Social Services. This action is subject to the state hearing provision described on the reverse side of this form.

### COMMENTS:

The law and/or regulations governing this action are:

Department of Social Services/Eligibility Assistance Standards Manual Section (EAS) 46-337  
 42 U.S. Code, Section 1383(g)  
 20 CFR 416.1910

If you have any questions please contact me.

COUNTY/STATE REPRESENTATIVE	AGENCY
TELEPHONE	DATE:

# YOUR HEARING RIGHTS

## To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.

## To 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

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

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

## Other Information

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the State Hearing Officer. You have a right to examine the materials that make up the file. Any information you provide may be shared with the departments whose action you are appealing and the U.S. Department of Health and Human Services. Authority: W&IC 10950.

I will bring this person to the hearing to help me (name and address, if known):

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I need an interpreter at no cost to me. My language or dialect is: \_\_\_\_\_

My name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

My signature: \_\_\_\_\_

Date: \_\_\_\_\_

# HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

You may also call 1-800-952-5253.

## HEARING REQUEST

I want a hearing because of an action by \_\_\_\_\_ about the interim assistance said department deducted from my SSI/SSP payment.

Here's why: \_\_\_\_\_

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