



CDSS

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STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

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ARNOLD SCHWARZENEGGER
GOVERNOR

March 30, 2010

ALL COUNTY INFORMATION NOTICE NO. I-18-10

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY CHILD CARE COORDINATORS
ALL COUNTY WELFARE TO WORK COORDINATORS
ALL CONSORTIA MANAGERS
STAGE ONE ALTERNATIVE PAYMENT PROGRAM PROVIDERS

SUBJECT: REVISED CHILD CARE SERVICES NOTICE OF ACTION (NA 832) IN
THE CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO
KIDS (CalWORKs) PROGRAM

REFERENCE: ALL COUNTY LETTER 08-04

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

The purpose of this notice is to transmit the revised Notice of Action for Child Care Services (NA 832) and to provide instructions on how to complete the form. The California Department of Social Services (CDSS) revised the NA 832 form based on feedback and recommendations from the California Welfare Directors' Association (CWDA) and welfare advocates. The joint effort was undertaken to improve the form for ease of use and understanding for both the County Welfare Departments (CWDs) and the California Work Opportunity and Responsibility to Kids (CalWORKs) families.

In addition to transmitting the revised NA 832, this letter is intended to serve as a reminder to CWDs that they must provide a written notice of action to a client whenever approvals, denials, discontinuances or other changes are made to the client's child care subsidy authorization or payment. The written notification must comply with the CalWORKs child care regulation at Manual of Policies and Procedures (MPP) Section 47-420, as well as adequate and timely noticing provisions at MPP Section 22-001, 22-071, and 22-072. Under no circumstance is verbal notification to the client acceptable as the sole form of notification to clients regarding actions taken on child care services or payments.

Summary of Changes

The changes to the NA 832 form were made to enhance client comprehension and readability; clarify the Trustline requirements for provider reimbursement through wording and forms design changes; simplify the form by reformatting and eliminating unnecessary words and phrases; improve the flow and continuity of information described on the NA 832; and increase the effectiveness and efficiency of the child care services request process.

Form Implementation

CWDs shall begin using the revised NA 832 as soon as administratively feasible. However, CWDs may choose to exhaust their hard copy stock of the earlier version before transitioning to the revised form.

Instructions for Completion

The instructions for the NA 832 are as follows:

CHILD CARE SERVICES:

- **First box** is checked if the approved activities are longer than 30 days. Enter the start date and the end date.
- **Second box** is checked if the approved activities are less than 30 days.

CHILD CARE REIMBURSEMENT:

- **First box** is checked if the recipient has chosen a provider who has already been Trustline (TL) registered or who is exempt from TL.
 - If the first box is checked, the table must be filled out for each eligible child. (If there are more than four children, a second page may be printed.)
- **Fill out the table for each child:**
 - **Child Name:** Enter the first and last name of the child.
 - **Provider Name:** Enter the first and last name of the provider or the name of the licensed facility.
 - **Child Care Hours:** Enter description of child care need.
 - Example:
 - 8 hours per day for 1 week
 - 6 hours per day M-F
 - 8 hours for 3 days per week
 - **Rate:** Enter the reimbursement rate and specify whether this is hourly/daily/monthly etc.
 - **Payment limit:** Enter the maximum reimbursement amount for the child.

- **Second box** is checked if the recipient's license-exempt provider is required to be TL registered.
- **Third box** must be checked if the second box is checked in order to enter the provider's name.

Translations and Camera-Ready Copies

Camera-ready copies of all child care program forms will be available as soon as possible from CDSS in Spanish, Chinese, Vietnamese, Cambodian, and Russian. Asian and Russian translations may be ordered from the CDSS Language Services Bureau at (916) 651-8876. Spanish forms can be obtained from the department's Forms Management Office by emailing fmudss@dss.ca.gov. Many of the translated forms can also be retrieved via the Internet by accessing the CDSS website at:

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

If you have any questions regarding this notice, please contact Ms. McCaulie Feusahrens, Child Care Policy Analyst, at (916) 657-2144.

Sincerely,

Original Document Signed By:

VENUS GARTH, Chief
Child Care and Refugee Programs Branch

Attachment

NOTICE OF ACTION CHILD CARE SERVICES

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone: _____
Address : _____

(ADDRESSEE)

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Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

CHILD CARE SERVICES

- As of _____ until _____, the county has approved your need for child care services.
- If this box is checked, your approved activity/program is less than 30 days. Your child care will end on _____. You will not receive another notice informing you when child care services will end.

For child care reimbursement/payment information please go to the next section below.

CHILD CARE REIMBURSEMENT/PAYMENT

- You have chosen an eligible child care provider (licensed/license-exempt) who is Trustline (TL) registered or who is exempt from TL.

The county may reimburse child care services provided only for the hours and days you attend your approved activity/program as follows:

Child Name:	Child Name:
Provider Name:	Provider Name:
Child Care Hours:	Child Care Hours:
Rate:	Rate:
Payment Limit:	Payment Limit:

Child Name:	Child Name:
Provider Name:	Provider Name:
Child Care Hours:	Child Care Hours:
Rate:	Rate:
Payment Limit:	Payment Limit:

The child care rate type and payment limit listed on this notice are figured based on the information you have provided and what your child care provider charges or the most we can pay based on your area's child care costs, whichever is less.

- You have selected a license-exempt provider who is not eligible for the reimbursement of child care services provided until he or she becomes registered with TL.
- Your provider, _____ (name), must apply for TL registration, Health and Safety Certification, and complete the TL process by passing the background check and being placed on the TL registry to be eligible for reimbursement. [See forms CCP 4 and CCP 7]

REMINDERS

You must tell us before you change child care providers (except in an emergency) or we may not be able to approve and reimburse the new provider for child services provided.

If you choose child care in your home (in-home care), you are the employer and are responsible for social security tax, state insurance, and unemployment taxes.

If you do not choose in-home child care, the provider is responsible for reporting income and payment of any federal or state income taxes.

For more information contact your local child care resource and referral program at (800) 543-7793.

NOTICE

As of February 1, 2008, license-exempt child care providers who are required to be TL registered, are entitled to receive retroactive reimbursement for up to 120 calendar days from the date child care services were requested and provided, whichever is later, if the provider subsequently becomes TL registered.

NOTES

Rules: These rules apply. You may review them at your welfare office: CalWORKs MPP Sections 47-260, 47-430, 47-620, 47-630; Education Code Sections: 8350-8353, 8357; Welfare & Institutions Code Sections 11322.9, 11323.6, 11323.8, and 11324.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: Cash Aid Food Stamps Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- Fill out this page.
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- Send or take this page to:

OR

- Call toll free: 1-800-952-5253 or for hearing or speech impaired who use TDD, 1-800-952-8349.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

Cash Aid Food Stamps Medi-Cal

Other (list) _____

Here's Why: _____

- If you need more space, check here and add a page.
- I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

- I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE