

DEPARTMENT OF SOCIAL SERVICES

February 10, 2000

ALL COUNTY INFORMATION NOTICE NO. I-07-00

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY PROBATION OFFICERS

SUBJECT: KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (Kin-GAP)
PROGRAM FORMS AND NOTICES OF ACTION (NOA)

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 All County Information Notice (ACIN) is to transmit the new forms and NOAs for the Kin-GAP Program. These forms and NOAs were developed by a workgroup of State and county staff. The county staff were identified by the County Welfare Directors' Association (CWDA). Camera ready copies of the forms and NOAs are attached to this ACIN; supplies will also be available from the California Department of Social Services (CDSS) Warehouse. Counties should submit orders on a GEN 727A to CDSS Warehouse, P.O. Box 22429, Sacramento, California 95822-3799.

Forms

The following new forms will be used for the Kin-GAP Program:

- KG 1 – Kin-GAP Mutual Agreement for 18 Year Olds. This form is used to obtain an 18 year old child's agreement to remain in the Kin-GAP Program until their graduation from high school or their 19th birthday, whichever is sooner, and should be used in lieu of the SOC 155B.
- KG 2 - Statement of Facts Supporting Eligibility for Kinship Guardianship Assistance Payment Program. This form is completed by the legal guardian and is used to collect information necessary to determine foster care eligibility at the time of application and redetermination, and should be used in lieu of the SAWS 2, CA 2, or the FC 2.
- KG 2A – Rights, Responsibilities, and Other Important Information. This form advises relative legal guardians of their rights and responsibilities with respect to the Kin-GAP Program and should be used in lieu of the SAWS 2A.

- KG 7 -- Monthly Eligibility Report. This form is used on a monthly basis, where there are changes to the child's case which affect eligibility, to gather information relative to the child's case and should be used in lieu of the CW 7. The information gathered will be used to determine eligibility to receive Kin-GAP benefits.
- SOC 369 - "Agency-Relative Guardianship Disclosure". This form is used to inform relative foster parents of the funding options available if legal guardianship is established.

Other forms such as the SAWS 1, CA 2.1, etc. should be used where appropriate/necessary.

NOAs

The following NOAs have been developed for Kin-GAP Program:

- Approval NOA -- informs the relative/child that Kin-GAP and Medi-Cal benefits have been approved.
- Denial NOA -- informs the relative/child that Kin-GAP has been denied and the reasons why.
- Change NOA -- informs the relative/child that Kin-GAP payment has been changed and the reasons why.
- Discontinuance NOA -- informs the relative/child that Kin-GAP has been discontinued and the reasons why.
- Discontinue due to Excess Property NOA -- informs the relative/child that Kin-GAP has been discontinued because the child has too much property. Include a property worksheet with this NOA.
- Discontinuance due to Improper Use of a Restricted Account NOA -- informs the relative/child that Kin-GAP has been discontinued because of an improper use of the money in the child's restricted account.
- Underpayment/Overpayment NOA -- informs the relative/child that there has been an overpayment or underpayment and that the child's aid will be adjusted accordingly.

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For camera-ready copies of English messages and English and Spanish forms, call Forms Management Unit (FMU) at 657-1907 or CALNET at 437-1907. If your office has Internet access, you may obtain various forms and Notice of Form Change (GEN 127) from the CDSS web page at: <http://www.dss.cahwnet.gov>. To accommodate agencies without Internet access, copies will be available by contacting FMU.

For all translated messages and Russian and Asian (Cambodian, Chinese and Vietnamese) versions of forms, call Language Translation Services (LTS) at (916) 654-1282 or CALNET 464-1282. If you need several forms, fax your request to (916) 657-3429 or e-mail your request to Isu@dss.ca.gov. Your Forms Coordinator now receives all translations as soon as they become available, if your county is on the LTS mailing list. Once you have established an e-mail address, please contact FMU by telephone or e-mail at, fmu@dss.ca.gov. FMU will then place you on their e-mail list.

If you have questions about these forms, NOAs, or eligibility to Kin-GAP, please contact your Foster Care Funding Consultant at (916) 324-5809. Services questions pertaining to the Kin-GAP Program should be directed to the Foster Care Policy Bureau at (916) 445-0813.

Sincerely,

WESLEY A. BEERS
Acting Deputy Director
Children and Family Services Division

Enclosures

c: CWDA

Kin-GAP MUTUAL AGREEMENT FOR 18 YEAR OLDS

CASE NAME

BIRTH DATE

CASE NUMBER

I request that the _____ County Welfare Department maintain my Kin-GAP payment until the completion of my education/training by age 19.

Recognizing my responsibility, I agree to:

1. Assist the welfare department in determining my financial need and eligibility while receiving a Kin-GAP payment.
2. Keep the agency informed of my progress with my education/training program.
3. Give reasonable notice if I leave my guardian's home for more than a temporary absence.

SIGNATURE OF Kin-GAP YOUTH

CHILD ELIGIBILITY WORKER

ADDRESS

ADDRESS

HOME PHONE

OFFICE PHONE

ALTERNATE

DATE

STATEMENTS OF FACTS SUPPORTING ELIGIBILITY FOR KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (Kin-GAP) PROGRAM: *The legal guardian should complete in ink all questions to the left of the heavy black line with information about the child for whom they are the legal guardian. If there are multiple children, one form per child should be completed.*

1. Child Name _____ 2. Male Female

3. Address _____

4. Birth date _____ 5. Birthplace _____

6. Social Security # _____ Applied For? Yes No

7. Citizen of U.S.? Yes No 8. Alien Status: _____

9. Does the child have medical insurance? Yes No

If yes, list policy number, company name, and name of policy:

10. Does the child have real or personal property? Yes No

If yes, list property type (land, cash, auto, motorcycle, life insurance, trust fund, bank account, bond, etc.) and its value:

11. Does the child have income? Yes No Unknown*
If yes, list amounts below. If application pending, check associated box.

INCOME TYPE	AMOUNT	PENDING
Social Security		<input type="checkbox"/>
Child Support		<input type="checkbox"/>
Railroad Retirement		<input type="checkbox"/>
SSI/SSP		<input type="checkbox"/>
Veteran's Benefits		<input type="checkbox"/>
Salary/Wages		<input type="checkbox"/>
Other (specify)		<input type="checkbox"/>
Total Amount/Month		<input type="checkbox"/>

* If unknown, please explain:

12. Name of School or Training Program:

13. If child has salary/wages, is the child attending school at least half-time? Yes No

14. Does the child have an Independent Living Program Plan? Yes No

15. Does the child attend school on a full-time basis? Yes No

COMPLETE BELOW FOR CHILDREN 17 AND OLDER

16. Expected graduation/completion before 19th birthday? Yes No

ELIGIBILITY WORKER ONLY

- APPLICATION
- REDETERMINATION

CASE NAME

CASE NUMBER

VERIFICATION

AGE

SOCIAL SECURITY NUMBER

CITIZENSHIP/ALIEN STATUS

DHS 6155

CHILD'S PROPERTY

CHILD'S INCOME/PENDING INCOME

ILP

VERIFIED BY SCHOOL **YES**

SCHOOL ATTENDANCE

GRADUATION

- (17) Does the mother or father of this child live in the same home as the child? Yes No
- (18) Does this child have a child(ren) of his/her own? Yes No
- (19) Do you have guardianship of the child which was granted by a California court? Yes No

Directions: Complete number 20 when applying for aid or if there are any changes in this information since the last time you completed this form.

20 PARENTAL INFORMATION			
Name	PARENT 1	PARENT 2	PARENT 3
Relationship			
Maiden Name			
Date of Birth			
Birthplace			
Social Security #			
Address			
Telephone #			
U.S. Citizen (yes or no)			
Veteran (Branch, Years in Service, Serial #)			

VERIFICATION

GUARDIANSHIP VERIFIED

CHILD SUPPORT REFERRAL

- NOT ELIGIBLE
- ELIGIBLE
- FEDERAL
- NONFEDERAL
- OTHER

LEGAL GUARDIAN:
I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

 SIGNATURE OF LEGAL GUARDIAN

 COUNTY WHERE SIGNED DATE

SIGNATURE OF ELIGIBILITY WORKER DATE

 SIGNATURE OF ELIGIBILITY WORKER SUPERVISOR DATE



RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

For the Kin-GAP Program

These pages give you your rights and responsibilities and other important information. The county needs your facts and the child's facts to see if the child is eligible for Kin-GAP cash aid, food stamps, and/or Medi-Cal/State CMSP and to figure how much the child will get if the child is eligible. If you need more information or have questions, ask your worker.

Kin-GAP cash aid includes Kinship Guardianship Assistance Payment (Kin-GAP) Program.

Medi-Cal/State-run County Medical Services Program (CMSP) includes Full Medi-Cal/State CMSP benefits and Restricted Medi-Cal/CMSP emergency and pregnancy related care only.

YOUR RIGHTS

1. To be treated equally without regard to race, color, national origin, religion, political affiliation, marital status, sex, disability, or age. You may file a complaint of discrimination if you feel the child has been discriminated against by first speaking with your county's designated civil rights representative or by writing to the

State Civil Rights Bureau
744 P Street, MS 15-70
P.O. Box 944243
Sacramento, CA 94244-2430

or by calling **collect** (916) 654-2107 or for the hearing impaired TDD (916)-654-2098.

2. To tell the county if the child has a disability and needs help applying for or continuing to receive Kin-GAP cash aid, benefits, and services.
3. To ask for help to complete the application for any other cash aid, food stamp, or Medi-Cal/State CMSP form.
4. To ask for forms and notices to be translated if you don't read English.
5. To be treated with courtesy, consideration and respect.
6. To be interviewed promptly by the county when you apply and to have the eligibility determined within 45 days.
7. To discuss the child's case with the county and to review the child's case yourself when you request to do so.
8. To be told the rules for getting Kin-GAP cash aid right away. If we think you might be eligible, you will get an interview within one day.
9. To get Medi-Cal/State CMSP as soon as possible if the child has a medical emergency or is pregnant, if eligible.
10. To continue getting Kin-GAP and Medi-Cal benefits without a break if you move from one county to another if the child stays eligible.
11. To be told the rules for retroactive Medi-Cal/State CMSP eligibility.
12. Where available, to choose prepaid health plan (PHP), fee-for-service coverage (if available), Health Maintenance Organization (HMO), or Medi-Cal when the child is eligible for Medi-Cal/State CMSP.
13. To ask to have the child's Medi-Cal Benefits Identification Card (BIC), replaced if lost in the mail, damaged, or destroyed. The county will tell you if you are eligible. The child's BIC may also be replaced if lost or stolen.
14. To ask for extra money if the child's income drops or stops.
15. To ask for payments for clothing, housing or essential household items which are lost, damaged or otherwise unavailable due to sudden and unusual circumstances.
16. To ask for payments for ongoing special needs like a special diet, transportation for ongoing medical care, special laundry service, telephone for the hard of hearing, high utility bills, etc.
17. To be notified in writing when the child's application is approved, denied, or when the child's benefits change or stop.
18. To have the child's records kept confidential by the county and state, unless the child is getting Kin-GAP or Medi-Cal and there is a felony arrest warrant issued for the child, or as otherwise provided by law.
19. To talk with someone from the county or file a formal complaint with the state if you don't agree with an action taken by the county. You may call toll-free at 1-800-952-5253 or for the hearing impaired, TDD 1-800-952-8349.
20. To ask for a State Hearing within 90 days of the county's action and, if you think the child was not getting the right State CMSP services.
21. To ask for a State Hearing, you can write to your county or call the State toll-free telephone numbers listed in Item 19 above.
22. To appeal all State CMSP eligibility issues, you can **only write** to your county.
23. To be represented at a State hearing by yourself, a household member, friend, attorney, or other person of your choice. NOTE: You may get free legal help at your local legal aid office or welfare rights group.

YOUR RESPONSIBILITIES

Citizenship/Immigration Status

To sign under penalty of perjury that the child applying for Kin-GAP cash aid is a U.S. citizen, U.S. national or has lawful immigration status. Information you give us on immigration status will be checked with the U.S. Immigration and Naturalization Service (INS). Information we get from INS may affect the child's eligibility.

Social Security Number (SSN) Rules

The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration and other agencies. Differences may be checked out with employers, banks or others. Making false statements or failing to report all facts or situations which affect eligibility and aid payments for Kin-GAP and Medi-Cal/State CMSP may result in repayment of benefits and/or criminal or civil action.

Kin-GAP and Food Stamps: You must give us the SSN for each applicant or recipient of Kin-GAP and/or food stamps. If you refuse to give us either a SSN or proof of application for a SSN, the child will not be able to get Kin-GAP. For Kin-GAP, you must give proof of application for a SSN within 30 days of application for Kin-GAP and give the SSN to the county when you get it.

Verification(s)

To give proof to support the child's eligibility. If you can't get proof, you will need to give the name of some other person or agency we may contact to get the proof. We will help you get proof when you can't get it.

Cooperation

To cooperate with county, state and federal staff. For Kin-GAP, a county worker can come to your home at any time to check out your facts, including seeing each family member, without calling ahead of time. The child may not get benefits or your benefits may be stopped if you don't cooperate.

Kin-GAP AND MEDI-CAL

To apply for any benefits or income anyone is eligible to get, such as: Unemployment (UIB) or Disability benefits, Veterans benefits, or Social Security etc.

Child/Spousal and Medical Support

To cooperate with the county and the District Attorney/Family Support Division (DA/FSD) to:

- identify and locate any absent parent in your case;
- tell the county or the DA/FSD any time you get information about the absent parent, such as place of residence or work location;
- determine the paternity of any child in your case when needed;
- obtain medical support money from any absent parent and, obtain child support money;
- give the DA/FSD any medical support money and, any child/spousal support money the child gets;
- tell the county about medical coverage or money for medical services paid by either parent.

MEDI-CAL

Benefits Identification Card (BIC)

- **To never throw the child's BIC away** (unless we give the child a new BIC). You need to keep the child's BIC even if the child stops getting Medi-Cal. The child can use the same BIC if the child gets Kin-GAP or Medi-Cal again.
- To take the BIC to the child's medical provider when the child is sick or has an appointment.
- To take the BIC to the medical provider who treated the child in an emergency situation as soon as possible after the emergency.

Health Care Coverage/Insurance

- To tell the county and any health care provider of any health care coverage/insurance the child has.
- To retain any health insurance available to the child at no or reasonable cost.
- To use any prepaid health plans, health maintenance organization or health care insurance plans the child has before using Medi-Cal/State CMSP, unless the plan does not offer the medical service needed. You need to use them because Medi-Cal will not pay for any service paid for and/or provided by these medical insurance plans.

YOUR REPORTING RESPONSIBILITIES

You must report all changes related to the child to the county. If you're not sure how to report changes, what changes to report, or what proof we need, ask your worker.

HOW YOU MUST REPORT

For Kin-GAP, you must report all changes related to the child to the county within 5 days AND turn in a complete Monthly Eligibility Report by the 5th of each month.

WHEN YOU MUST REPORT

For Kin-GAP, you must report when:

1. The child gets money (including lump sums) from work, relatives, Social Security, Unemployment Insurance Benefits (UIB), Veterans benefits, tax refunds, accident or injury settlements, or any other source.
2. The child gets medical support money.
3. The child's job or training program changes.
4. The child's income or source of income changes, starts, or stops, including self-employment.
5. The child age 16 or older starts or stops school, college, or training.
6. The child moves out of your home.
7. Either parent of the child moves into the home, even for a short period of time.
8. You and/or the child moves to another address, plans to move (including out of state), or gets a new mailing address. If you move to another county and you want to keep getting benefits, you must tell the county giving you aid and/or benefits.
9. The child gets payments or allowances for job, training, or school expenses, such as educational grants and loans, transportation to and from job or training, etc.
10. The child gets married, separated, divorced, or died.
11. The child gets, sells, gives away or transfers real property, such as a home, buildings or land; or business or personal property, such as money, a bank account, a motor vehicle, a boat, a trust fund, etc.
12. The child's physical or mental illness begins or ends.
13. The child's citizenship or immigration status changes or the child gets a letter, form or new card from the INS.
14. The child becomes pregnant, gives birth, or ends a pregnancy.
15. The child or you goes to or gets out of jail/prison or juvenile hall.
16. The child's health care coverage/insurance changes or becomes available as a result of employment.

School Attendance and Immunizations

You must provide proof when requested by the county that:

- all school-age children receiving Kin-GAP are attending school, and
- Kin-GAP children under the age of 6 have received age appropriate immunizations.

Proof of Facts

If you ask for Kin-GAP within one year of the date it stopped, the county must look at your prior case file to see if it already has the proof needed to determine your eligibility when:

- you cannot get the proof, or
- there is a cost to you to get the proof, or
- processing your application would be delayed because it would take too long for you to get the proof.

If you ask for Kin-GAP within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

If you have new changes since the child last got Kin-GAP, the county will need new proof.

OTHER IMPORTANT INFORMATION

Kin-GAP Only

Welfare to Work Activities

The child will need to take part in certain Welfare to Work activities to keep getting Kin-GAP. The county will tell you how many hours a week the child must take part in these activities or if you and/or the child are exempt from these rules.

Income Disregards

If the child is participating in the Independent Living Program (ILP), any income earned as part of the program is exempt. When the child has income other than ILP, the child may be entitled to other income deductions.

CalWORKs Child Care Program

In some cases, a Kin-GAP minor parent may be eligible to child care assistance to work or participate in county-approved welfare-to-work activities such as attending education or job training programs.

California Department of Education (CDE) Child Care

Child care benefits are also available from CDE. Contact your local Resource and Referral Agency for more information.

Transitional Medi-Cal (TMC)

The child may get Medi-Cal for up to 12 months if the child goes off Kin-GAP because the child is working. The Child must have gotten Kin-GAP for at least three of the last six months before cash aid stopped. To get more than six months of TMC, the child's income must be under certain limits and the child must meet TMC reporting rules.

Kin-GAP MONTHLY REPORTING

Budgeting Rules

The amount of Kin-GAP that the child can get depends on the child's income and allowable expenses. What you report on the Monthly Eligibility Report will be used to figure the amount of Kin-GAP the child gets two months later.

Property Limit

There is a \$2000.00 limit on the amount of property (e.g., bank accounts, stocks, etc.) that the child can have and still get Kin-GAP. The individual vehicle value limit is \$4650. If the child has only one vehicle which is registered, and it has a value of less than \$4650, it will not be counted as part of the limit. If the child's vehicle is worth more than \$4650, anything over the limit will be used as part of the total property limit to determine eligibility, unless the vehicle is needed by the household for certain reasons. Your worker can tell you what these are. If the child has a vehicle that is unregistered, its value will be figured differently and your worker can explain to you how it is done.

***Transfer of Assets Rule**

The child can sell, exchange or change the form of their property holdings, if they get fair market value for the property (asset). If they do not get fair market value for the asset, the child will get a period of ineligibility. The period of ineligibility is figured by subtracting the amount received from the fair market value of the asset and then dividing that amount by the need standard for the family. The amount is rounded down to the next lower whole number.

Cal-Learn

Cal-Learn helps pregnant and/or parenting teens under the age of 20, who are getting Kin-GAP and do not have a high school diploma or its equivalent to stay in or return to school. Teens in the Cal-Learn Program may get cash bonuses for good grades and graduation from high school. Cal-Learn teens may get help with child care, transportation, and other services. Cash penalties may be subtracted from their Kin-GAP payment for not going to school or for getting poor grades.

AVAILABLE SERVICES

Women, Infants and Children (WIC) Supplemental Nutrition Program

The WIC Program is only for pregnant and breast feeding women, infants and children under age 5, who are at medical-nutritional risk. For more facts about WIC, call your local county health department or the phone number for "WIC" in the telephone book.

Voter Registration

If the child wants to register to vote, ask your worker to send you a registration form. If the child needs help filling it out, ask your worker. You can mail the form yourself. The child's eligibility for aid will not be affected whether or not the child registers. Your worker will not tell the child how to vote.

Other Benefits

You or any one in your household may apply for any other benefit program such as CalWORKs, Food Stamps, Medi-Cal, Adoptions Assistance Payment Program, In-Home Supportive Services, Homeless Assistance, etc.

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting Kin-GAP benefits, you can be legally prosecuted, and can be charged with committing a felony if more than \$400 is wrongly paid out for Kin-GAP, or Medi-Cal because you did not report all of the facts or changes in income, property, or family status.

Kin-GAP Penalties

If you do not follow Kin-GAP rules, you may be fined up to \$10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, the child's Kin-GAP can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

RELATIVE LEGAL GUARDIAN CERTIFICATION	ELIGIBILITY WORKER'S CERTIFICATION
<ul style="list-style-type: none"> I understand my rights and responsibilities and agree to comply with my responsibilities. I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect the child's eligibility or benefit level. I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (KG 2A). 	<p>I certify that the relative legal guardian appears to understand:</p> <ul style="list-style-type: none"> his/her rights and responsibilities and the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect the child's eligibility or benefit level. <p>I also certify that the applicant/recipient was given a copy of:</p> <ul style="list-style-type: none"> The Rights, Responsibilities, and Other Important Information (KG 2A).
Signature (Relative Legal Guardian)	Date
Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number
	Date

MONTHLY ELIGIBILITY REPORT

THIS REPORT IS FOR THE MONTH OF _____

For Kin-GAP

- Complete, sign, and return this report by the 5th of the month, only when the child has any income, or any other changes which may affect the child's case. **You do not need to fill out this form if the child has no income or no changes.**
- You must report **within 5 days** any change that may affect the child's eligibility for or the amount of the child's Kin-GAP.
- This report is only for this Kin-GAP child. If you or other members of the household receive other types of aid, such as CalWORKs or Food Stamps, you must comply with the reporting requirements of the other programs(s).
- Facts you report may result in the child's benefits going up, down, or being stopped. Failure to report may result in an overpayment which must be repaid.

Need Help? Call your worker.

Worker: _____

Phone: _____

① Did the child receive income from any source? <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> • If "YES", complete below. Include wages and tips; child support; social security or veteran's benefits; interest or dividends; insurance or legal settlements; cash, gifts, loans, or scholarships; any government benefits like Social Security Income/State Supplementary Payment (SSI/SSP); veterans or railroad retirement; other private or government disability or retirement; or anything else. 						
Employer's Name (✓)	Gross Amount	\$	\$	\$	\$	\$
	Actual Date Received					
<input type="checkbox"/> Job <input type="checkbox"/> Training	No. of Hours Worked					
Source of Income	Gross Amount	\$	\$	\$	\$	\$
	Date Received					
② Did the child move out of your home? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, when? _____						
③ Did either of the child's parents move in to your home? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, when? _____						
④ Is the child pregnant or have a child(ren) of his/her own? <input type="checkbox"/> YES <input type="checkbox"/> NO						

COUNTY USE ONLY

E.W. INITIALS

DATE:

AGENCY-RELATIVE GUARDIANSHIP DISCLOSURE

ONE COPY TO: Relative Caregiver
Child's Social Services Record
Child's Eligibility Record

NOTE: THIS DISCLOSURE MUST BE COMPLETED PRIOR TO ANY CHANGE IN CUSTODIAL STATUS OF RELATIVE FOSTER PARENT

NAME OF CHILD:		CAREGIVER'S NAME:
DATE PLACED WITH THIS RELATIVE:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

Initial Here:

_____ I understand that I am not required to change custodial status from relative caregiver to legal guardian. However, if I decide to become a legal guardian, court dependency may be dismissed.

_____ I have been provided a Guardianship Pamphlet.

1. **AFDC-Foster Care to Kin-GAP**
Initial Here:

_____ I understand that by becoming a relative legal guardian of _____:

- The child's payment will change from \$ _____ to \$ _____ per month.
- The child will no longer be eligible to receive an AFDC-Foster Care payment.
- The child will no longer be eligible to receive a clothing allowance or a specialized care increment.

N/A

2. **AFDC-FC to CalWORKs**
Initial Here:

_____ I understand that by becoming a relative legal guardian of _____:

- The child's payment will change from \$ _____ to \$ _____ per month.
- The child will not receive an AFDC-Foster Care payment.
- The child will not receive a clothing allowance or a specialized care increment.

N/A

3. **CalWORKs to Kin-GAP**
Initial Here:

_____ I understand that by becoming a relative legal guardian of _____:

- The child's payment will change from \$ _____ to \$ _____ per month.
- The child cannot get both CalWORKs and Kin-GAP payments.

N/A

4. **Remain CalWORKs**
Initial Here:

_____ I understand that by becoming a relative legal guardian of _____:

- The child will not receive an AFDC-Foster Care or Kin-GAP payment.
- The child will remain eligible to CalWORKs.

N/A

Services

If you become guardian of this child and the court dependency is terminated:

Initial Here:

- _____ I understand that the child and I will no longer be assigned a social worker;
- _____ I understand that the child and I will no longer be required to go to court;
- _____ I understand that the child will no longer have a court appointed attorney;
- _____ I understand that I am not prevented from adopting this child at any time in the future;
- _____ I understand that I may still contact the county if I need assistance at _____;
- _____ Other: _____

Some Important Kin-GAP Information

These are some of the important things you should know about Kin-GAP:

Initial Here:

- _____ I understand the child's Kin-GAP payment will be stopped:
 - * If the child or I move out of state;
 - * If either parent of the child moves in to my home; and/or
 - * If a child who is 16 years or older fails to meet school attendance requirements.

- _____ I understand that the child will be required to participate in the CalLearn Program if the child becomes pregnant or has a child of their own.
- _____ I understand that I will be required to complete an annual review of the child's circumstances with the county and to report any changes which may affect the child's eligibility for the program.
- _____ I understand that if I move to another county, the child's rate may change.

I have read the above and understand all of the permanency options that are available to me (adoption, legal guardianship, long-term foster care). After considering all the options, I have voluntarily chosen legal guardianship with the associated payment noted above.

I have chose option # 1 2 3 4 *(Circle one)*

SIGNATURE OF SOCIAL WORKER: 		SIGNATURE OF RELATIVE LEGAL GUARDIAN: 	
TITLE/AGENCY:			
ADDRESS:		ADDRESS:	
TELEPHONE NUMBER ()	DATE:	TELEPHONE NUMBER ()	DATE:

BASIC APPROVAL

(ADDRESSEE)

┌

└

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

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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use to approve Kin-GAP and Medi-Cal.

The County has approved your Kin-GAP cash aid and Medi-Cal for _____. The Kin-GAP cash aid payment for your first month of aid is \$ _____.

Your first day of Kin-GAP cash aid is _____. Your first day of Medi-Cal is the first day of the month you applied for aid or met all eligibility requirements.

- The Kin-GAP cash aid payment for your first month of aid is only for a part of a month. It is for the time from your first day of Kin-GAP cash aid, shown above, through the end of the month. If nothing changes, next month's Kin-GAP cash aid will be for a full month.

Your ongoing Kin-GAP amount is figured in the next column.

Medi-Cal Cards: Soon you will get a plastic Benefits Identification Card in the mail for each eligible person. Take the card(s) to your medical provider when needing care. **DO NOT THROW AWAY YOUR CARDS.** They will be good as long as you get Medi-Cal.

NOTICE OF ACTION - CHANGE

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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use when there is a change in the amount of Kin-GAP paid.

As of _____, the County is changing your Kin-GAP cash aid from \$ _____ to \$ _____ per month.

Here's why:

The aid you got was for _____.

- There was a change in the amount of income received.
- The child's age changed.
- You will get an infant supplement on behalf of _____.
- You will get a special need for _____.
- You are no longer eligible to receive _____.
- Because you moved to _____ County.
- Other _____.

NOTICE OF ACTION - DISCONTINUE

(ADDRESSEE)

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

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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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use to discontinue Kin-GAP case when there is no longer an eligible child in the home. Specify the Name of the child in the space provided.

As of _____, the County is stopping your Kin-GAP cash aid for _____.

Here's why:

- He/she no longer lives with you.
- He/she no longer meets the age rules.
- His/her parent(s) is living in the home.
- The child has too much income.
- The child has too much property. See attached page.
 - If the County figured that the child's car or other vehicle was worth more than you think it's worth, you can give the County proof that it is worth less. Ask the County how. If you can prove it is worth less the child may get Kin-GAP cash aid.
- The legal guardianship was terminated.
- You moved out of the State of California.
- You did not return your completed redetermination paperwork.
- Other.

NOTICE OF ACTION - DENIAL

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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use to deny Kin-GAP when there is no eligible child in the home. In the action line, enter the date of application.

The County has denied your application for Kin-GAP cash aid dated_____.

Here's why:

You are not eligible for Kin-GAP for one or more of the following reasons:

- The child you are caring for is over 18.
- The child has not lived with you for at least 12 months.
- A legal guardianship has not been established for this child.
- The juvenile court dependency has not been dismissed.
- The child's income is over the limit.
- The child's property is over the limit. See attached page.
 - If the County figured that the child's car or other vehicle was worth more than you think it's worth, you can give the County proof that it is worth less. Ask the County how. If you can provide it is worth less the child may get Kin-GAP cash aid.
- Other_____.

NOTICE OF ACTION - DISCONTINUE PROPERTY

(ADDRESSEE)

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

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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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use to discontinue Kin-GAP cash aid when the real property is now accessible to the recipient and must be counted in the property limits.

As of _____, the County is stopping your Kin-GAP aid for _____.

Here's why:

The child owns property that is worth more than the \$ _____ limit. We must use the value of all the countable real property the child owns. The value of this property now counts against the child.

The child's countable property is figured on this page.

The child may still continue to get Medi-Cal if the child's Kin-GAP cash aid stops. Please complete and send in the enclosed Transitional Medi-Cal (TMC) form.

NOTICE OF ACTION - DISCONTINUE RESTRICTED ACCOUNT

(ADDRESSEE)

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

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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use to discontinue Kin-GAP cash aid and apply penalty period when there has been misuse of a restricted account. Fill in the effective date of the discontinuance. Fill in the Kin-GAP child's name. Fill in the date of the end of the period of ineligibility. Check the applicable box(es). Print the computation on the right hand side of the NA 290 and fill in the computation section.

As of _____, the County is stopping your Kin-GAP aid for _____ until _____.

Here's why:

- The child got money from the child's restricted account. Then, within 30 days of the time the child got the money, the child didn't:
 - Spend the money on an allowable expense.
 - Put back into the account the part of the money that wasn't needed for the child's allowable expense.
 - Give the County proof of the amount the child took out of the account.
 - Give the County proof of the balance in the account before the child took out the money.
 - Give the County proof of what the child did with the money.

If any boxes above are checked, it is because you were late and missed a deadline. To stop this county action (and restart the child's Kin-GAP cash aid before the end of the time period), you must prove to the County that you had a good reason for being late. Let your worker know right away.

- The child got money from his/her restricted account and spent some or all of it on expenses that are not allowed.
- Interest was paid out on the child's restricted account.

1. Restricted Account(s) Total..... \$ _____
2. Spending Allowed..... - _____
3. Subtotal = _____
4. Basic Need, ____ Persons \$ _____
5. Special Needs + _____
6. Basic Need Subtotal = _____
7. Period of Months = _____

The child may still continue to get Medi-Cal if the child's Kin-GAP aid stops.

Please complete and send in the enclosed Transitional Medi-Cal (TMC) form.

NOTICE OF ACTION - CHANGE UNDER/OVERPAYMENT

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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

INSTRUCTIONS: Use to notify of an overpayment and subsequent grant adjustment. Specify the amount owed and the reason for the overpayment and the appropriate reg cites.

Attach the appropriate Continuation Page (NA 274B, C, D or E) to show the overpayment computation. Attach the NA 275 to show the grant adjustment amount.

As of _____, The County is changing your Kin-GAP cash aid for _____ from \$ _____ to \$ _____. You were overpaid a total of \$ _____.

Here's why:

You do not have to use any Social Security or SSI benefits you get to repay this overpayment.

The next page(s) show how much Kin-GAP cash aid you should have been paid for each month you were overpaid, the total amount you owe, and how much will be taken out of each month's Kin-GAP cash aid amount.

Your new Kin-GAP cash aid amount is figured on this page.

WARNING: If you think this overpayment is wrong, this is your last chance to ask for a hearing. The back of this page tells how. If the child stays on aid, the County can collect a Kin-GAP overpayment by lowering the child's monthly grant.

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