STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

May 2, 1985

ALL-COUNTY INFORMATION NOTICE I- 34-85

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: LOWRY V. OBLEDO - NOTIFICATION AND IMPLEMENTATION MATERIALS

REFERENCE: MPP SECTION 50-013

This letter transmits the following notification materials and forms necessary for the counties to comply with the requirements contained in MPP Section 50-013 regulations:

1) Posters

Attached is a copy of the Lowry poster printed both in English and Spanish. A supply of posters will be sent shortly under separate cover. Posters are to be posted in each local county welfare office per MPP Section 50-013.222. Per MPP Section 50-013.221, counties are also to forward a supply of posters by June 1, 1985 to county hospitals with the request that they be posted in a conspicuous location.

2) Claim Form (TEMP 1618) and Supplemental Claim Form (TEMP 1619)

Reproducible copies of the Lowry claim forms are provided in English and Spanish. Each county will need to duplicate these forms in a quantity sufficient to comply with MPP Sections 50-013.224, .321 and .324(a).

There are two claim forms which the county will send in response to claimants' request for an application. The first form (TEMP 1618) will be sent to those claimants for whom case record information is available. The questions asked on this form are minimal and need not be as detailed as those on the second claim form (TEMP 1619) since the existence of a case record validates the receipt of AFDC and provides other needed information. The TEMP 1619 (supplemental claim form) will be sent to those claimants for whom no case record information exists. This form is, necessarily, much more detailed.

3) Worksheets

Attached is a reproducible copy of the Lowry worksheet to be used in computing Lowry retroactive benefits per MPP Sections 50-013.51, .52 and .53. The Worksheet A - Eligibility Checklist is to be used for screening of claims per MPP Section 50-013.4 and for the annual redetermination review per MPP Section 50-013.223. Counties may use the attached worksheet or a modified version of the worksheet. Revisions to the worksheet will not be reviewed or approved by the Department. The Department suggests, however, that all revisions incorporate all items on the state-designed worksheet. The format and wording are at county option.

4) Statistical Form

Attached is a copy of the statistical report (GEN 1172) which will be used to report information required by MPP Section 50-013.229. Although this report is not due until October 1, 1986, we are providing you a copy of this report now so that counties will know exactly what statistics to keep.

Also attached for your information is a copy of the Lowry Medi-Cal stuffer in English and Spanish. This stuffer is scheduled to be mailed by the State to all current AFDC recipients and AFDC-linked Medically Needy (MN) recipients with their Medi-Cal cards June 1, 1985.

This letter transmits all the materials, except the Notices of Action, that counties require in implementing the Lowry v. Obledo retroactive court order per MPP Section 50-013. Reproducible copies of the notices in English will be forwarded via an All County Letter in approximately one week. The Spanish translation will be released in mid-May.

You have been provided an advance copy of the proposed Lowry retroactive regulations. As a result of the Office of Administrative Law (OAL) review we have made some nonsubstantive changes to the proposed regulations which will delay the final filing date. It is anticipated, however, that these regulations will be effective June 1, 1985 as planned. An advance copy of the final rules will be released later this month.

If you have any questions regarding this letter or the attachments, please contact Michiyo Laing of the AFDC Program Development Bureau at (916) 322-5387.

ROBERT A. HOREL
Deputy Director

Attachments

cc: CWDA

WELFARE MAY OWE YOU MONEY!

PLEASE READ THIS:

During February 1977 through August 1982:

	YES	NO
Did you get or ask for AFDC aid?	☐	☐
Were you working when you got or asked for aid?	☐	☐
Did you then pay a sitter to watch your kids?	☐	☐
Was this sitter living with you but not in your grant?	☐	☐
Did you report to the county in writing the payments to the sitter but have them turned down?	☐	☐

If the answer to each question is "YES", a court ruling says we may owe you money. To find out, complete a "Lowry" claim form. (Get one from any county welfare office.) Submit a filled-in form to each county where you asked for aid and to each which gave you aid during the time cited. To be considered, you must do so before June 1, 1986.

If you answered "NO" to any of the questions above, you can't get extra aid.

Need help? Ask at county welfare office or at legal aid.

This notice to be posted June 1, 1985 and removed May 31, 1986.

¡ES POSIBLE QUE EL DEPARTAMENTO DE BIENESTAR LE DEBA DINERO!

POR FAVOR LEA ESTO:

Durante febrero de 1977 hasta agosto de 1982:

	SÍ	NO
¿Recibió o solicitó asistencia de AFDC?	☐	☐
¿Trabajaba cuando recibía o cuando solicitó asistencia?	☐	☐
¿Le pagaba entonces a una niñera para que le cuidara a sus niños?	☐	☐
¿Vivía esta niñera con usted pero no estaba incluida para su pago mensual?	☐	☐
¿Reportó por escrito al condado los pagos a la niñera pero no los aceptó el condado?	☐	☐

Si respondió que "SÍ" a todas y cada una de las preguntas, hay una decisión de la corte que dice que posiblemente le debamos dinero a usted. Para saber si es así, complete una forma de reclamo "Lowry". (Obténgala de cualquier oficina de bienestar del condado.) Presente una forma, ya llenada, a cada condado en el cual haya pedido asistencia y a cada condado que le haya otorgado asistencia durante las fechas indicadas en la parte de arriba. Para que su reclamo sea considerado, tiene que presentarlo antes del 1 de junio de 1986.

Si contestó que "NO" a cualquiera de las preguntas que aparecen arriba, no puede obtener asistencia extra.

¿Necesita ayuda en cuanto al reclamo? Pídasela a la oficina de bienestar del condado o a la oficina de asistencia legal.

This notice to be posted June 1, 1985 and removed May 31, 1986.

LOWRY v. OBLEDO CLAIM FORM

COUNTY USE ONLY

WE MAY OWE YOU MONEY

COMPLETE THE FOLLOWING:

During February 1977 through August 1982:

		YES	NO
1.	Did you receive AFDC or were you discontinued from or denied AFDC because you earned "too much" money?	☐	☐
2.	Did you work while you were on AFDC or when you applied for AFDC?	☐	☐
3.	Did you pay a person who lived with you, but who was not in your grant, to babysit your child(ren) while you worked?	☐	☐
4.	Did you report these costs on your Monthly Income Report (CA 7) or Statement of Facts (CA 2) for at least one month but these costs were turned down because the babysitter lived in your home?	☐	☐

IF YOU ANSWERED "NO" TO ANY OF THESE QUESTIONS, YOU ARE NOT ELIGIBLE FOR BACK BENEFITS. PLEASE THROW THIS FORM AWAY.

If you answered "YES" to all four of these questions, you may be eligible for back payments for child care costs.

To ask for the money we may owe you, answer the questions as best you can on the claim form below and submit the form no later than May 31, 1986.

If you can do so, attach proof of payment for child care for each month you list on the forms.

Use a separate claim form for each county which gave or denied you AFDC money during the months in question. Send the form to the county welfare department of that county.

MY NAME IS:		MY NAME WAS:	
MY ADDRESS WAS:	CITY	STATE	ZIP
MY CASE NUMBER IS/WAS:	MY BIRTHDATE IS:	MY SOCIAL SECURITY NUMBER IS: * — —	
THE COUNTY THAT GAVE ME AFDC WAS:	DO YOU RECEIVE AFDC? ☐ YES ☐ NO	IF "YES", MY WORKER'S NAME IS:	

PART I. When did you receive AFDC or when were you discontinued from or denied AFDC because you earned too much money? *(Check appropriate boxes below)*

YEAR	JAN.	FEB.	MARCH	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
1976												
1977												
1978												
1979												
1980												
1981												
1982												

(Continued on back)

PART II. Answer the questions below about your work-related child care costs in those months between February 1, 1977 and August 31, 1982, for which you are filing a claim. Use additional paper if you need more space.

MONTH AND YEAR	HOURS YOU WORKED THAT MONTH	HOURS YOU USED A BABYSITTER THAT MONTH	CHILDREN FOR WHOM YOU NEEDED CARE		NAME OF BABYSITTER	DID THE BABYSITTER LIVE IN YOUR HOUSE?		AMOUNT PAID TO BABYSITTER	WAS THE BABYSITTER INCLUDED IN YOUR GRANT?	
			NAME	BIRTHDATE		YES	NO		YES	NO

As proof of child care costs, attach one of these: receipts, cancelled checks, a signed statement from the babysitter, or anything else that shows you had these child care costs.

If you cannot attach proof of child care payments, answer the questions below about missing proof of payments.

MONTH AND YEAR	WHY HAVEN'T YOU ATTACHED PROOF OF CHILD CARE PAYMENT?	TELL US HOW YOU TRIED TO GET PROOF

NAME (PRINT)			PHONE NUMBER ( )
ADDRESS	CITY	STATE	ZIP CODE

I declare under penalty of perjury that the above statements are true and correct.

SIGNED ▶	DATE

* The disclosure of your Social Security Number is mandatory under the Social Security Act. It will be used to identify you. It will not be used for any other purpose.

FORMA DE RECLAMO
OWRY vs. OBLEDO

SÓLO PARA USO DEL CONDADO

ES POSIBLE QUE LE DEBAMOS DINERO

COMPLETE LO SIGUIENTE:

De febrero de 1977 a agosto de 1982:

		SÍ	NO
1.	¿Se le descontinuó o se le negó la Asistencia para Familias con Niños Necesitados (AFDC) porque ganaba demasiado dinero, o si no es así, recibía AFDC?	☐	☐
2.	¿Trabajaba usted cuando recibía o cuando solicitó AFDC?	☐	☐
3.	¿Le pagaba a alguna persona que vivía con usted, pero que no estaba incluida en su pago mensual de AFDC, para que cuidara a los hijos de usted mientras usted trabajaba?	☐	☐
4.	¿Reportó estos gastos por lo menos un mes en su Reporte Mensual de Ingresos (CA 7) o en la Declaración de Hechos (CA 2) pero le fueron negados estos gastos porque la niñera vivía en la casa de usted?	☐	☐

SI CONTESTÓ QUE "NO" A CUALQUIERA DE ESTAS PREGUNTAS, USTED NO ES ELEGIBLE PARA RECIBIR BENEFICIOS ATRASADOS. POR FAVOR TIRE ESTA FORMA.

i contestó que "SÍ" a las cuatro preguntas, es posible que sea elegible para recibir beneficios atrasados por concepto de gastos de cuidado de niños.

Para solicitar el dinero que es posible le debamos, conteste las preguntas lo mejor que pueda en la forma de reclamo que hay enseguida y preséntela a más tardar el 31 de mayo de 1986.

Si puede hacerlo, adjunte pruebas del pago por cuidado de niños por cada mes que mencione en las formas.

Use una forma de reclamo por separado por cada condado que le haya pagado o negado fondos de AFDC durante los meses en cuestión. Envíe la forma al departamento de bienestar de ese condado.

MI NOMBRE ES:		MI NOMBRE ERA:	
MI DIRECCIÓN ERA:	CIUDAD	ESTADO	ZONA POSTAL
EL NÚMERO DE MI CASO ES/ERA	LA FECHA DE MI NACIMIENTO ES:	MI NÚMERO DE SEGURO SOCIAL ES: *	
EL CONDADO QUE ME DABA AFDC ERA:	¿RECIBÍA USTED AFDC? ☐ SÍ ☐ NO	SI LA RESPUESTA ES "SÍ", EL NOMBRE DE MI TRABAJADOR(A) ES:	

PARTE I. ¿Cuándo se le descontinuó o se le negó la AFDC porque usted ganaba demasiado dinero, o cuándo recibía AFDC? (marque enseguida las casillas correspondientes)

AÑO	ENERO	FEB.	MARZO	ABRIL	MAYO	JUNIO	JULIO	AGOSTO	SEPT.	OCT.	NOV.	DIC.
1976												
1977												
1978												
1979												
1980												
1981												
1982												

(Continúa en la parte de atrás)

PARTE II. Conteste las siguientes preguntas con respecto a sus gastos de cuidado de niños relativos al trabajo en los meses entre el 1 de febrero de 1977 y el 31 de agosto de 1982, para los cuales usted está presentando un reclamo. Use hojas de papel por separado si necesita más espacio.

MES Y AÑO	HORAS QUE TRABAJÓ ESE MES	HORAS QUE UTILIZÓ NIÑERA ESE MES	NIÑOS PARA LOS QUE NECESITÓ CUIDADO		NOMBRE DE LA NIÑERA	¿VIVÍA LA NIÑERA EN LA CASA DE USTED?		CANTIDAD QUE SE LE PAGABA A LA NIÑERA	¿ESTABA LA NIÑERA INCLUIDA EN SU PAGO MENSUAL DE AFDC?	
			NOMBRE	FECHA DE NACIMIENTO		SÍ	NO		SÍ	NO

Como prueba de los gastos por cuidado de niños, adjunte alguno de los siguientes comprobantes: recibos, cheques negociados, una declaración firmada por la niñera, o cualquier otra cosa que muestre que usted hizo estos gastos por cuidado de niños.

Si no puede adjuntar pruebas de los pagos por cuidado de niños, conteste las siguientes preguntas sobre la falta de pruebas de los pagos.

MES Y AÑO	¿POR QUÉ NO HA ADJUNTADO PRUEBAS DE LOS PAGOS POR CUIDADO DE NIÑOS?	DÍGANOS CÓMO TRATÓ USTED DE OBTENER PRUEBAS

NOMBRE (LETRA DE MOLDE)			NÚMERO DE TELÉFONO
			( )
DIRECCIÓN	CIUDAD	ESTADO	ZONA POSTAL

DECLARO BAJO PENA DE PERJURIO QUE LAS DECLARACIONES ANTERIORES SON VERDADERAS Y CORRECTAS.

FIRMADO	FECHA

* Es mandatorio que revele su número de seguro social en conformidad con el Acta del Seguro Social. Este se usará para identificarle, y no se usará con ningún otro fin.

COUNTY USE ONLY

LOWRY v. OBLEDO
SUPPLEMENTAL CLAIM FORM

WE MAY OWE YOU MONEY

COMPLETE THE FOLLOWING:

During February 1977 and August 1982:

		YES	NO
1.	Did you receive AFDC or were you discontinued from or denied because you earned "too much" money?	☐	☐
2.	Did you work while you were on AFDC or when you applied for AFDC?	☐	☐
3.	Did you pay a person who lived with you, but who was not in your grant, to babysit your child(ren) while you worked?	☐	☐
4.	Did you report these costs on your Monthly Income Report (CA 7) or Statement of Facts (CA 2) for at least one month but these costs were turned down because the babysitter lived in your home?	☐	☐

IF YOU ANSWERED "NO" TO ANY OF THESE QUESTIONS, YOU ARE NOT ELIGIBLE FOR BACK BENEFITS. PLEASE THROW THIS FORM AWAY.

If you answered "YES" to all four of these questions, you may be eligible for back payments for child care costs.

To ask for the money we may owe you, answer the questions as best you can on the claim form below and submit the form no later than May 31, 1986.

If you can do so, attach proof for each of the following for those months between February 1, 1977 and August 31, 1982, for which you are filing a claim.

- Receipt, discontinuance or denial of AFDC
- Children's residence
- Your employment
- Child care payments
- Your reporting of child care costs

Use a separate claim form for each county which gave or denied your AFDC money during the months in question. Send the form to the County Welfare Department of that county.

You may use extra paper if you need to.

MY NAME IS:		MY NAME WAS:	
MY ADDRESS WAS	CITY	STATE	ZIP
MY CASE NUMBER IS/WAS:	MY BIRTHDATE IS:	MY SOCIAL SECURITY NUMBER IS: *	
THE COUNTY THAT GAVE ME AFDC WAS:	DO YOU NOW RECEIVE AFDC? ☐ YES ☐ NO	IF "YES", MY WORKER'S NAME IS:	

PART I. When did you receive AFDC or when were you discontinued from or denied AFDC because you earned too much money? *(Check appropriate boxes below)*

YEAR	JAN.	FEB.	MARCH	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
1976												
1977												
1978												
1979												
1980												
1981												
1982												

(Continued on back)

To prove that you did receive AFDC during the month, please attach one of these: a message from your county welfare department or a state hearing decision showing that you got AFDC during the aid months; or anything else that shows you got aid.

If you cannot attach any proof, answer the questions below about missing proof that you received AFDC, or that you were denied or discontinued from AFDC becuase you earned "too much" money.

WHY HAVEN'T YOU ATTACHED PROOF OF RECEIPT OR DENIAL OF AFDC?	TELL US HOW YOU TRIED TO GET PROOF.

PART II. For whom did you receive or apply for aid? Answer the questions below.

WHEN RECEIVED? (MONTH AND YEAR)	FOR WHOM DID YOU RECEIVE AID?		HOW RELATED?
	NAME	BIRTHDATE	

To prove that the children listed above lived with you, please attach one of these: a copy of school attendance records (it should show the name and address of the school attended); a signed statement from a neighbor stating that your children lived with you; or anything else that shows your children lived with you.

If you cannot attach any proof, answer the questions below about missing proof that your children lived with you in the months in question.

WHY HAVEN'T YOU ATTACHED PROOF OF CHILDREN'S RESIDENCE?	TELL US HOW YOU TRIED TO GET PROOF.

As proof of child care costs, attach one of these: receipts; cancelled checks; a signed statement from the babysitter; or anything else that shows you had these child care costs.

If you cannot attach proof, answer the questions below.

MONTH AND YEAR	WHY HAVEN'T YOU ATTACHED PROOF OF CHILD CARE PAYMENTS?	TELL US HOW YOU TRIED TO GET PROOF.

PART V. In order for you to receive back payments for the child care costs reported in PART IV, you must attach proof if you can that you have reported such child care costs on a Statement of Facts (CA 2) or a Monthly Report (CA 7) for at least one month but such costs were disallowed by the county because the child care provider to whom the child care payments were made lived in your house.

As proof, you may bring a copy of the message from the county showing that you did report the child care costs but the deduction was disallowed, or anything else that shows you met this reporting requirement.

If you cannot attach proof, answer the questions below.

Explain the circumstances in which the child care cost was reported and what the county's response was.

NAME (PRINT)		TELEPHONE NUMBER ( )	
ADDRESS	CITY	STATE	ZIP CODE

I declare under penalty of perjury that the above statements are true and correct.

SIGNATURE ▶	DATE

* The disclosure of your Social Security Number is mandatory under the Social Security Act. It will be used to identify you. It will not be used for any other purpose.

PART III. Did you receive wages in th , months between February 1, 1977 and A st 31, 1982, for which you are filing a claim?

DATE WORKED (MONTH AND YEAR)	HOW MANY HOURS PER WEEK?	HOURLY WAGE	WHO WAS YOUR EMPLOYER?	
			NAME	ADDRESS

To prove that you did work as indicated above, attach one of these: wage stubs; a signed statement from the employer verifying your employment; or anything else that shows you were employed, including tax returns or W 2 forms.

If you cannot attach proof, answer the questions below.

MONTH AND YEAR	WHY HAVEN'T YOU ATTACHED PROOF OF EMPLOYMENT?	TELL US HOW YOU TRIED TO GET PROOF.

PART IV. Answer the questions below about your work-related child care costs in those months between February 1, 1977 and August 31, 1982, for which you are filing a claim.

MONTH AND YEAR	HOURS YOU WORKED THAT MONTH	HOURS YOU USED A BABYSITTER THAT MONTH	CHILDREN FOR WHOM YOU NEEDED CHILD CARE		NAME OF BABYSITTER	DID THE BABY-SITTER LIVE IN YOUR HOME?		AMOUNT PAID TO BABYSITTER	WAS THE BABY-SITTER INCLUDED IN YOUR GRANT?	
			NAME	BIRTHDATE		YES	NO		YES	NO

(Continued on back)

SÓLO PARA USO DEL CONDADO

LOWRY vs. OBLEDO
FORMA SUPLEMENTAL DE RECLAMO

ES POSIBLE QUE LE DEBAMOS DINERO

COMPLETE LO SIGUIENTE:

De febrero de 1977 a agosto de 1982:

		SÍ	NO
1.	¿Recibió usted o se descontinuó o se negó la Asistencia para Familias con Niños Necesitados (AFDC) porque ganaba demasiado dinero?	☐	☐
2.	¿Trabajaba usted cuando recibía o cuando solicitó AFDC?	☐	☐
3.	¿Le pagaba a alguna persona que vivía con usted, pero que no estaba incluida en su pago mensual de AFDC, para que cuidara a los hijos de usted mientras usted trabajaba?	☐	☐
4.	¿Reportó estos gastos por lo menos un mes en su Reporte Mensual de Ingresos (CA 7) o en la Declaración de Hechos (CA 2) pero le fueron negados estos gastos porque la niñera vivía en la casa de usted?	☐	☐

SI CONTESTÓ QUE "NO" A CUALQUIERA DE ESTAS PREGUNTAS, USTED NO ES ELEGIBLE PARA RECIBIR BENEFICIOS ATRASADOS. POR FAVOR TIRE ESTA FORMA.

Si contestó que "SÍ" a las cuatro preguntas, es posible que sea elegible para recibir beneficios atrasados por concepto de gastos de cuidado de niños.

Para solicitar el dinero que es posible le debamos, conteste las preguntas lo mejor que pueda en la forma de reclamo que hay enseguida y preséntela a más tardar el 31 de mayo de 1986.

Si puede hacerlo, adjunte comprobantes de cada una de las cosas siguientes para los meses entre el 1 de febrero de 1977 y el 31 de agosto de 1982 para los cuales esté registrando una petición.

- Su recibo, descontinuación o negación de AFDC
- La residencia de los niños
- Su empleo
- Los pagos por cuidado de niños
- Su reporte del costo de cuidado de niños

Use una forma de reclamo por separado para cada condado que le haya otorgado o negado fondos de AFDC durante los meses en cuestión. Envíe la forma al departamento de bienestar del condado de ese condado.
Puede usar papel extra, si lo necesita.

MI NOMBRE ES:		MI NOMBRE ERA	
MI DIRECCIÓN ERA	CIUDAD	ESTADO	ZONA POSTAL
EL NÚMERO DE MI CASO ES/ERA	LA FECHA DE MI NACIMIENTO ES:	MI NÚMERO DE SEGURO SOCIAL ES. — —	
EL CONDADO QUE ME DABA AFDC ERA:	¿RECIBÍA USTED AFDC? ☐ SÍ ☐ NO	SI LA RESPUESTA ES "SÍ", EL NOMBRE DE MI TRABAJADOR(A) ES:	

PARTE I. ¿Cuándo se le descontinuó o se le negó la AFDC porque usted ganaba demasiado dinero, o cuándo recibía AFDC? (marque enseguida las casillas correspondientes)

AÑO	ENERO	FEB.	MARZO	ABRIL	MAYO	JUNIO	JULIO	AGOSTO	SEPT.	OCT.	NOV.	DIC.
1976												
1977												
1978												
1979												
1980												
1981												
1982												

(Continúa)

Para comprobar que usted recibió AFDC durante el mes, por favor adjunte uno de los siguientes documentos: una declaración de parte de su departamento de bienestar del condado o una decisión de una audiencia con el estado que muestre que usted recibía AFDC durante los meses de asistencia; o cualquier otra cosa que muestre que usted recibía asistencia.

Si no puede adjuntar algún comprobante, conteste las siguientes preguntas sobre la falta de comprobantes de que usted recibía AFDC, o de que se le había negado o descontinuado la AFDC debido a que ganaba "demasiado" dinero.

¿POR QUÉ NO HA ADJUNTADO COMPROBANTES DE QUE RECIBÍA O SE LE NEGÓ LA AFDC?	EXPLIQUE DE QUÉ MANERA TRATÓ DE OBTENER COMPROBANTES.

PARTE II. ¿Para quién recibió o solicitó asistencia? Conteste las siguientes preguntas.

¿CUÁNDO LA RECIBIÓ? (MES Y AÑO)	¿PARA QUIÉN RECIBIÓ ASISTENCIA?		PARENTESCO
	NOMBRE	FECHA DE NACIMIENTO	

Para comprobar que los niños mencionados arriba vivían con usted, por favor adjunte uno de los siguientes documentos: una copia de la documentación de su asistencia a la escuela (debe mostrar el nombre y la dirección de la escuela a la cual asistían); una declaración firmada de un vecino que diga que sus hijos vivían con usted; o cualquier otra cosa que muestre que sus hijos vivían con usted.

Si no puede adjuntar un comprobante, conteste las preguntas siguientes sobre la falta de pruebas de que sus hijos vivían con usted durante los meses en cuestión.

¿POR QUÉ NO HA ADJUNTADO COMPROBANTE DE LA RESIDENCIA DE LOS NIÑOS?	EXPLIQUE DE QUÉ MANERA TRATÓ DE OBTENER COMPROBANTES.

(Continúa)

PARTE III. Recibió usted salarios en estos meses, entre el 1 de febrero de 1977 y el 31 de agosto de 1982, para los cuales está registrando un reclamo?

FECHA EN QUE TRABAJÓ (MES Y AÑO)	¿CUÁNTAS HORAS SEMANALES?	SUELDO POR HORA	¿QUIÉN LE EMPLEABA?	
			NOMBRE	DIRECCIÓN

Para comprobar que usted trabajó según indicó arriba, adjunte uno de los siguientes documentos: talones de pago, una declaración firmada por su empleador que verifique su empleo ahí; o cualquier otra cosa que demuestre que usted estaba empleado, incluso reembolsos de impuestos o formas W-2.

Si no puede adjuntar comprobantes, conteste las siguientes preguntas.

MES Y AÑO	¿POR QUÉ NO HA ADJUNTADO PRUEBA DE SU EMPLEO?	EXPLIQUE CÓMO TRATÓ DE OBTENER PRUEBAS

PARTE IV. Conteste las siguientes preguntas sobre sus costos por cuidado de niños relacionados con su trabajo, en esos meses entre el 1 de febrero de 1977 y el 31 de agosto de 1982, para los cuales está registrando un reclamo.

MES Y AÑO	HORAS QUE TRABAJÓ ESE MES	HORAS QUE UTILIZÓ NIÑERA ESE MES	NIÑOS PARA LOS QUE NECESITÓ CUIDADO		NOMBRE DE LA NIÑERA	¿VIVÍA LA NIÑERA EN LA CASA DE USTED?		CANTIDAD QUE SE LE PAGABA A LA NIÑERA	¿ESTABA LA NIÑERA INCLUIDA EN SU PAGO MENSUAL DE AFDC?	
			NOMBRE	FECHA DE NACIMIENTO		SÍ	NO		SÍ	NO

(Continúa)

Como prueba de los gastos por cuidado de niños, adjunte uno de los siguientes comprobantes: recibos, cheques negociados, una declaración firmada por la niñera, o cualquier otra cosa que muestre que usted hizo estos gastos por cuidado de niños.

. no puede adjuntar pruebas, conteste las siguientes preguntas.

MES Y AÑO	¿POR QUÉ NO HA ADJUNTADO PRUEBAS DE LOS PAGOS POR CUIDADO DE NIÑOS?	EXPLIQUE CÓMO TRATÓ DE OBTENER PRUEBAS

PART V. Para que usted pueda recibir los pagos atrasados por los costos por cuidado de niños reportados en la PARTE IV, debe adjuntar comprobantes, si puede, de que había reportado dichos gastos por cuidado de niños en una Declaración de Hechos (CA 2) o un Reporte Mensual (CA 7) por lo menos un mes, pero tales costos no fueron tomados en cuenta por el condado debido a que la persona que proveía dicho cuidado de niños y a cuyo nombre se hacían los pagos por cuidado de niños vivía en la casa de usted.

Como comprobante, puede traer una copia de la declaración del condado que muestre que usted sí reportó al condado los costos por cuidado de niños pero que no se le permitió dicha deducción, o cualquier otra cosa que demuestre que usted cumplió con este requisito de reportar.

Si no puede adjuntar comprobantes, conteste las siguientes preguntas.

Explique las circunstancias bajo las cuales reportó el costo del cuidado de niños y cuál fue la respuesta del condado.

NOMBRE (LETRA DE MOLDE)		NÚMERO DE TELÉFONO ( )	
DIRECCIÓN	CIUDAD	ESTADO	ZONA POSTAL

Declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.

FIRMA	FECHA

* *Es mandatorio que revele su número de seguro social en conformidad con el Acta de Seguro Social. Este se usará para identificarle, y no se usará con ningún otro fin.*

LOWRY v. OBLEDO Worksheet A - Eligibility Checklist

CLAIMANT NAME	CASE NUMBER

FROM: ____ / ____ THROUGH ____ / ____ OR CLAIM MONTH ____ / ____

MONTH YEAR MONTH YEAR MONTH YEAR

Instructions: This is to be used for screening of claims (50-013.4) and for the annual redetermination review (50-013.22).

When used for screening of claims, there should be an acceptable verification for each of the following (either in the case record or submitted with the claim form.) In absence of verification, there must be 1) good reason(s) for the inability of the claimant to obtain verification and 2) a sworn statement. Complete this checklist for each month for which eligibility must be established or for an entire claim period if appropriate. If "YES" is checked for every question, complete an appropriate worksheet for each month for which retroactive benefits are to be computed. If "NO" is checked for any of the questions below, the claim shall be denied and an appropriate Notice of Action mailed to the claimant.

When used at the annual redetermination review to determine potential eligibility of recipients for Lowry retroactive benefits, there may not be acceptable verification readily available in the case record for each of the following items.

If "YES" is checked for every question, provide recipients a claim form.

During February 1977 through August 1982: (Check one)

		YES	NO
(1)	Was the claimant discontinued from or denied AFDC due to excess income or did he/she receive AFDC?	|___|	|__|
(2)	Did the claimant's children reside with him/her?	|___|	|__|
(3)	Did the claimant work while he/she was on AFDC or when he/she applied for AFDC?	|___|	|__|
(4)	Did the claimant pay a person who lived with him/her, but who was not included in his/her grant, to babysit his/her child(ren) while he/she worked?	|___|	|__|
(5)	Did the claimant report these costs on his CA 7 or CA 2 for at least one month but these costs were disallowed because the babysitter lived in his/her home?	|___|	|__|

EW SIGNATURE, ID NUMBER AND DATE

LOWRY v. OBLEDO Worksheet B - Case Record or Case Data Not Available (50-013.52)

CLAIMANT NAME	CASE NUMBER	CLAIM MONTH AND YEAR

Instructions: Use this worksheet when case records or case data are not available.

This worksheet should also be used for the claim months following the month of denial or termination.

DETERMINATION OF RETROACTIVE PAYMENT

1. Lowry child care cost $_____

2. Maximum aid payment for _____ (number) $_____

3. Retroactive payment: Lesser of 1 or 2 $_____

EW SIGNATURE, ID NUMBER AND DATE

LOWRY v. OBLEDO Worksheet C - Denial or Discontinued Case Prior to December 1, 1981 (50-013.531)

CLAIMANT NAME	CASE NUMBER	CLAIM MONTH AND YEAR

Instructions: This worksheet should be used only for the month of denial or discontinuance if the case data are available. For the claim months following the month of denial or discontinuance, use Worksheet B.

DETERMINATION OF RETROACTIVE PAYMENT

1. Gross earned income for all family members $_____
   a. Minus $30 -_____
   b. Subtotal =_____
   c. Minus 1/3 of Subtotal (b) above -_____
   d. Minus mandatory deductions -_____
   e. Minus work related expenses -_____
   f. Minus Lowry child care cost -_____
   g. Net earned income $=_____
2. Plus unearned income for all family members +_____
3. Minus child support paid -_____
4. Net nonexempt income: (g) plus 2 minus 3 $=_____
5. a. Maximum aid payment for _____ (number) $_____
   b. Minus net nonexempt income (from 4) -_____
   c. Retroactive payment $=_____

EW SIGNATURE, ID NUMBER AND DATE

LOWRY v. OBLEDO Worksheet D - Denial or Discontinued Case December 1, 1981 or After (50-013.52)

CLAIMANT NAME	CASE NUMBER	CLAIM MONTH AND YEAR

Instructions: This worksheet should be used only for the month of denial or discontinuance if the case data are available. For the claim months following the month of denial or discontinuance, use Worksheet B.

DETERMINATION OF RETROACTIVE PAYMENT

1. Gross earned income for all family members $_____
   a. Minus work expense disregard[1/] -_____
   b. Minus Lowry child care cost -_____
   c. Minus $30 (if applicable) -_____
   d. Subtotal $=_____
   e. Minus 1/3 of Subtotal (d) above (if applicable) -_____
   f. Net earned income $=_____
2. Plus unearned income for all family members +_____
3. Minus child support paid -_____
4. Net nonexempt income: (f) plus 2 minus 3 $=_____
5. a. Maximum aid payment for _____ (number) $_____
   b. Minus net nonexempt income (from 4) -_____
   c. Retroactive payment $_____

1/ The Turner mandatory deductions are not applicable to Lowry as Turner did not take effect until September 1, 1982.

EW SIGNATURE, ID NUMBER AND DATE

LOWRY v. OBLEDO Worksheet E - Received AFDC Prior to December 1, 1981 (50-013.532(a))

CLAIMANT NAME	CASE NUMBER	CLAIM MONTH AND YEAR

Instructions: Use Part I of this worksheet for those cases that received aid prior to December 1, 1981 if the case data are available.

Use Part II of this worksheet for zero base grant (ZBG) cases.

DETERMINATION OF RETROACTIVE PAYMENT

Part I: Received AFDC Payments.

1. Lowry child care cost $_____
2. Original net nonexempt income _____
3. Retroactive payment : Lesser of 1 or 2 $_____

Part II: Zero Base Grant (ZBG) Cases.

1. Lowry child care cost $_____
2. Original net nonexempt income $_____
3. Maximum aid payment for _____ (number) -_____
4. (2) - (3) $=_____
5. Subtract the amount on Line 4 from Line 1 -_____
6. Retroactive payment $_____

EW SIGNATURE, ID NUMBER AND DATE

LOWRY v. OBLEDO Worksheet F - Received AFDC December 1, 1981 or After (50-013.532(b))

CLAIMANT NAME	CASE NUMBER	CLAIM MONTH AND YEAR

Instructions: This worksheet should be used for those cases that received aid December 1981 or after, provided that the case data are available. Use this worksheet also for zero base grant cases during this period.

DETERMINATION OF RETROACTIVE PAYMENT

1. Gross earned income for all family members $_____
   a. Minus work expense disregard[1/] -_____
   b. Minus Lowry child care cost -_____
   c. Minus $30 (if applicable) -_____
   d. Subtotal =_____
   e. Minus 1/3 of Subtotal (d) above (if applicable) -_____
   f. Net earned income $=_____
2. Plus unearned income for all family members +_____
3. Minus child support paid -_____
4. Net nonexempt income: 1(f) plus 2 minus 3 $_____
5. a. Maximum aid payment for _____ (number) $_____
   b. Minus net nonexempt for income (from 4) -_____
   c. Grant that should have been paid: 5(a) - 5(b) $_____
6. Minus grant that was originally paid $-_____
7. Retroactive payment: 5(c) - 6 $_____

1/ The Turner mandatory deductions are not applicable to Lowry as Turner did not take effect until September 1, 1982.

EW SIGNATURE, ID NUMBER AND DATE

LOWRY v. OBLEDO Worksheet G - Recalculation of Overpayment Prior to December 1, 1981
(50-013.532(c))

CLAIMANT NAME	CASE NUMBER	CLAIM MONTH AND YEAR

Instructions: This worksheet should be used for recalulation of an overpayment that occurred during the claim month prior to December 1, 1981 provided that the case data are available.

DETERMINATION OF RETROACTIVE PAYMENT

1. Original overpayment occurred in the claim month and collected at later time. $_____

2. Grant considering allowing Lowry child care costs

   a. Gross earned income for all family members $_____

      (1) Minus $30 -_____
      (2) Subtotal =_____
      (3) Minus 1/3 of subtotal (2) above -_____
      (4) Minus mandatory deductions -_____
      (5) Minus work-related expenses -_____
      (6) Minus Lowry child care cost -_____
      (7) Net earned income $_____

   b. Plus unearned income for all family members +_____
   c. Minus child support paid -_____
   d. Net nonexempt income $_____
   e. Maximum aid payment for _____ (number) $_____
   f. Minus net nonexempt for income -_____
   g. Grant that should have been paid $_____

3. Grant originally paid $_____

4. a. If lines 3 is greater than Line 2(g):
      Line 3 $_____
      Line 2(g) -_____
      Lowry overpayment $_____

      Original overpayment collected (line 1) $_____
      Lowry overpayment (above) -_____
      Retroactive payment $_____

   OR

   b. If line 2(g) is greater than Line 3:
      Line 2(g) $_____
      Line 3 -_____
      Lowry underpayment $_____

      Lowry underpayment (above) $_____
      Plus original overpayment collected (Line 1) +_____
      Retroactive payment $_____

EW SIGNATURE, ID NUMBER AND DATE

LOWRY v. OBLEDO Worksheet H - Recalculation of Overpayment December 1, 1981 or After
(50-013.532(c))

CLAIMANT NAME	CASE NUMBER	CLAIM MONTH AND YEAR

Instructions: This worksheet should be used for recalculation of an overpayment that occurred during the claim month, December 1981 or after, provided that the case data are available.

DETERMINATION OF RETROACTIVE PAYMENT

1. Original overpayment occurred in the claim month and collected at later time. $_____

2. Grant considering allowing Lowry child care costs

   a. Gross earned income for all family members $_____

      (1) Minus Work Expense Disregard[1/] -_____
      (2) Minus Lowry child care cost -_____
      (3) Minus $30 (if applicable) -_____
      (4) Subtotal =_____
      (5) Minus 1/3 of Subtotal (4) above (if applicable) -_____
      (6) Net earned income $_____

   b. Plus unearned income for all family members +_____
   c. Minus child support paid -_____
   d. Net nonexempt income $_____
   e. Maximum aid payment for _____ (number) $_____
   f. Minus net nonexempt for income -_____
   g. Grant that should have been paid $_____
   h. Grant that was originally paid $_____

3. a. If lines 2(h) is greater than Line 2(g):
      Line 2(h) $_____
      Line 2(g) -_____
      Lowry overpayment $_____

      Original overpayment collected (line 1) $_____
      Lowry overpayment (above) -_____
      Retroactive payment $_____

   OR

   b. If line 2(g) is greater than Line 2(h):
      Line 2(g) $_____
      Line 2(h) -_____
      Lowry underpayment $_____

      Lowry underpayment (above) $_____
      Plus original overpayment collected (Line 1) +_____
      Retroactive payment $_____

1/ The Turner mandatory deductions are not applicable to Lowry as Turner did not take effect until September 1, 1982.

EW SIGNATURE, ID NUMBER AND DATE

STATISTICAL REPORT

LOWRY V. OBLEDO

SEND ONE COPY TO: Department of Social Services
Statistical Services Branch
744 P Street, M.S. 12-81
Sacramento, California 95814
(916) 322-2230

NAME OF COUNTY SUBMITTING REPORT	THIS REPORT IS DUE ON OR BEFORE:
	October 1, 1986

THIS REPORT IS

☐ ORIGINAL SUBMISSION ☐ SUBSEQUENT REPORT NO. _____ ☐ REVISION NO. _____

REPORTING PERIOD

FROM: June 1, 1985 TO: September 30, 1986

1. Number of claims received	
2. Number of claims granted (in full or in part)	
3. Number of claims denied (in total)	
4. Total amount of benefits paid (including retroactive payments offset by outstanding collectable overpmts.)	$
5. Number of claims pending disposition, if any, as of the date of this report.	
*Questions concerning this report should be directed to the Statistical Services Branch at (916) 322-2230, or ATSS 492-2230.	

PERSON TO CONTACT REGARDING THIS REPORT	TELEPHONE NUMBER	DATE

PLEASE READ THIS:

WELFARE MAY OWE YOU MONEY!

During February 1977 through August 1982:

Did you get or ask for AFDC aid?

Were you working when you got or asked for aid?

Did you then pay a sitter to watch your kids?

Was this sitter living with you but not in your grant?

Did you report to the county in writing the payments to the sitter but have them turned down?

If the answer to each question is "YES", a court ruling says we may owe you money. To find out, complete a "Lowry" claim form. (Get one from any county welfare office.) Submit a filled-in form to each county where you asked for aid and to each which gave you aid during the time cited. To be considered, you must do so before June 1, 1986.

Please do not send in this form; it is not a claim form.

Need help? Ask at county welfare office or at legal aid.

State of California
Health and Welfare Agency
Department of Social Services

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State of California
Health and Welfare Agency
Department of Social Services

POR FAVOR LEA ESTO:

PUEDA SER QUE EL DEPARTAMENTO DE BIENESTAR LE DEBA DINERO!

Desde febrero de 1977 hasta agosto de 1982

¿Recibió o solicitó asistencia de AFDC?

¿Estaba trabajando cuando recibió o solicitó asistencia?

¿Contrató entonces a una niñera para que le cuidara a los niños?

¿Vivía dicha niñera con usted pero no estaba incluida como parte de su hogar al recibir su pago mensual?

¿Reportó usted por escrito al condado los pagos a su niñera pero el condado no los permitió?

Si responde que "Sí" a cada una de las preguntas, según una orden de la corte posiblemente le debamos dinero. Para saber si se lo debemos, complete una forma de reclamo de "Lowry". (Pídala en cualquier oficina de bienestar del condado.) Presente una forma, ya llenada, a cada condado donde solicitó asistencia y a cada condado que le otorgó asistencia durante el tiempo indicado arriba. Para que su petición sea considerada, tiene que presentarla antes del 1 de junio de 1986

Por favor no envíe esta forma, pues no es una forma de reclamo

¿Necesita ayuda? pídasela a una oficina de bienestar del condado o de asistencia legal.

Estado de California
Agencia de Salud y Bienestar
Departamento de Servicios Sociales

POR FAVOR LEA ESTO:

PUEDA SER QUE EL DEPARTAMENTO DE BIENESTAR LE DEBA DINERO!

Desde febrero de 1977 hasta agosto de 1982

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Departamento de Servicios Sociales