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

October 16, 1992

ALL-COUNTY INFORMATION NOTICE I-54-92

TO: ALL COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL
[X] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[ ] Initiated by SDSS

SUBJECT: FORMS, NOTICES, AND CHARTS RELEVANT TO THE AFDC/RCA PROGRAM CHANGES REQUIRED BY THE RECENTLY ENACTED STATE BUDGET

REFERENCE: ALL COUNTY INFORMATION NOTICE (ACIN) I-49-92
ALL-COUNTY LETTER NO. 92-78

The purpose of this letter is to provide you with information and materials you will need to implement AFDC changes required by the recently enacted State Budget and the accompanying Legislation, SB 485, Chapter 722, Statutes of 1992 as well as the 1991 amendments to Welfare & Institutions Code Section 11201.5 (100 Hour Rule). As we informed you in ACIN I-49-92, the changes which could take effect as early as December 1, 1992 are:

MAXIMUM AID PAYMENT (MAP) REDUCTION

The provision requires a 1.3 percent reduction to the MAP levels. For your information the 1.3 percent reduction is computed against the June 1992 MAP levels and then subtracted from the October 1992 level. This reduction, along with the 4.5 percent reduction effective October 1, 1992, produces a 5.8 percent total reduction to the MAP that was in effect prior to October 1, 1992.

RELOCATION FAMILY GRANT (RFG)

This provision restricts the grant amount to either the California computed grant or the MAP amount from the prior state of residence (plus California special needs, if applicable), whichever is less. This rule provides that when an AU does not contain any member who has lived in California for at least 12 months, the AU's grant will be determined using the RFG rule. The RFG rule will continue to apply until at least one member of the AU has resided in California for 12 consecutive months.

ELIMINATION OF THE 100-HOUR RULE

This provision requires the elimination of the 100-hour work limit for AFDC-U recipient cases. This means that AFDC-U principal earner recipients may work over

100 hours in a month and still remain eligible to AFDC-U. However, the 100-hour limit will continue to apply to AFDC-U applicant cases as a means of establishing unemployed parent deprivation.

ATTACHMENTS

We are providing the following attachments to allow counties sufficient lead-time to plan for implementation and training of staff.

NOTE: If voters approve the Government Accountability and Taxpayers Protection Act (GATPA) in the November 3, 1992 election, Attachments I through VI will not be implemented. We would then provide you with new instructions and material as soon as possible.

GENERAL MASS INFORMING NOTICE - TEMP BC 1 (Attachment I)

The language on this notice is intended to serve the same purpose for the 1.3 percent reduction as it did for the 4.5 percent reduction. The 1.3 percent rollback notice should be used to give advance warning to mitigate the impact on the Cash Aid population. We recommend that you utilize this notice to alert Cash Aid recipients of the MAP rollback, to enable them to both plan ahead and to address their questions to the State. The notice has the State's special toll free number. In addition, information about the RFG and the elimination of the 100-Hour rule has been included.

AFDC PAYMENT STANDARD TABLE (Attachment II)

Attachment II is the AFDC Payment Standard Table containing the 1.3 percent reduction.

MAP CHART FOR OTHER STATES AND U.S. TERRITORIES (Attachment III)

This chart, used in conjunction with the RFG Rule, provides the MAP amounts for the other states and U.S. Territories.

NOTE: The amounts will be updated semi-annually effective each April 1st and October 1st. This is a change from the draft regulations transmitted in ACIN I-49-92, which stated that the amounts would be updated on an annual basis.

AFDC NOAS (Attachment IV)

Attachment IV contains seven reproducible copies of AFDC NOA forms and two NOA message documents with implementing instructions for the Budget changes.

AFDC FORMS (Attachment V)

Attachment V contains the forms BC JA 2 SUP (11/92), Supplemental Statement of Facts - Cash Aid, Relocation Family Grant (RFG) and the BC CA 30 (11/92) (Budget Change), Budget Worksheet. The BC JA 2 SUP provides information about the RFG and collects the necessary information to determine if the RFG applies. This supplemental form is to be used in conjunction with the JA 2, the CA 8 and the CA 8A. The BC CA 30 Budget Worksheet will implement the RFG provisions. Counties may locally reproduce stock of the CA 30, BC JA 2 SUP and the NA 200. If you need

camera ready copies of these forms, please call the Forms Management Bureau at (916) 657-1984.

Counties will need to locally reproduce 6-8 weeks of stock of the BC JA 2 SUP. State produced stock of a revised JA 2 will go to print on November 4, 1992 with stock expected to be shipped to the counties in December 1992.

Counties that order state reproduced stock of the JA 2 are asked to submit a GEN 727 B, County Forms Order, to the Department of Social Services Warehouse, with the Form Name and Number as follows: "WRDP/BC JA 2 (11/92)." Please limit your GEN 727 B request to the WRDP/BC JA 2 only and submit your order by November 25, 1992. Also, please limit your initial stock amount to a three month supply of the WRDP/BC JA 2. After you receive your initial order, you can submit a new GEN 727 (B) for an additional three month supply of forms.

TRANSLATIONS (Attachment VI)

Attachment VI contains reproducible copies of the Spanish language mass informing notice, the BC JA 2 SUP, and the seven NOA forms. Camera ready copies of these documents in Spanish, Vietnamese, Lao, Cambodian and Chinese will be forwarded under separate cover by the Language Services Bureau.

FOOD STAMPS

Adjustments to Food Stamp benefits made as a result of the reduction in Cash Aid levels shall be handled as a mass change as specified in M.S. 63-504.392. The general mass informing notice (Attachment I) contains the Food Stamp information necessary to inform recipients of the changes. An individual Notice of Increased Benefits (DFA 377.4) is not required.

CONTACTS

If you have any questions or need further information regarding the Budget changes, please contact the following staff of the AFDC Policy Implementation Bureau at (916) 654-2137 or CALNET 464-2137: **MAP Reduction/Relocation Family Grant:** Jane Laciste; **100 Hour Rule/Relocation MAP Chart:** Yvonne Lee; **NOAS:** John Honeycutt; **Forms/Notices:** Elizabeth Allred. For **Food Stamp Program** questions, please contact Suzanne McNamee at (916) 657-3815. For questions related to **translations**, please contact Armand Herra at (916) 654-1286.

Sincerely,

MICHAEL C. GENEST
Deputy Director
Welfare Programs Division

ATTACHMENTS

ATTACHMENT I

IMPORTANT NOTICE FOR CASH AID RECIPIENTS

PLEASE READ

A CHANGE IN STATE LAW

As of December 1, 1992, State law changes the rules for cash aid. The new rules lower the maximum amount of cash aid a family can get, limit the amount of cash aid for applicants who have not lived in California for the last 12 months, and remove the limit on the number of hours a recipient can work and still be eligible for cash aid.

MAXIMUM AID PAYMENT (MAP) CHANGE

State law lowers the Maximum Aid Payment that a family can get by 1.3 percent. See the table to the right to find out the most your cash aid may change. This change will take effect December 1, 1992. If we are not able to lower your December cash aid right away, you will be overpaid and will have to pay this money back. You will get another notice if you are overpaid.

You need to plan for this change. If cash aid is your only income, you will have less money to meet your family's needs. But if you go to work, even part-time, or have other income you can keep more money to meet your family's needs.

TO GET MORE INFORMATION

Please call toll free: 1-800-925-8960

or

TTD for hearing impaired: 1-800-952-8349

FOOD STAMP CHANGE

Most families will get more Food Stamps when their cash aid goes down.

CASH AID MAP TABLE

PERSONS ON AID	OLD MAP	NEW MAP	DECREASE
1	$ 311	$ 307	$ 4
2	511	504	7
3	633	624	9
4	753	743	10
5	859	847	12
6	965	952	13
7	1,059	1,045	14
8	1,155	1,139	16
9	1,247	1,230	17
10 or more	1,340	1,322	18

RELOCATION FAMILY GRANT

The Relocation Family Grant applies to **applicants** who have not lived in California for the last 12 months. The Relocation Family Grant limits the amount of cash aid a family can get to the lesser of:

- the MAP from the State where they last lived; or
- the cash aid figured for California.

The Relocation Family Grant can apply for up to 12 months.

ELIMINATION OF THE 100-HOUR RULE

The change in State law allows a recipient to work more hours. There is no longer a limit on the number of hours a recipient can work and still be eligible for cash aid. There is only a limit on the amount of income you can earn and still remain eligible.

ATTACHMENT II

Estimates Branch
September 02, 1992

AFDC PAYMENT STANDARDS
EFFECTIVE DECEMBER 1, 1992

ASSISTANCE UNIT SIZE	MAXIMUM AID PAYMENT	MBSAC	185% OF MBSAC	IN-KIND INCOME				80% OF MAP
				HOUSING	UTILITIES	FOOD	CLOTHING	
1	307	345	638	155	33	87	27	245 x
2	504	567	1,048 x	209	38	184	50	403
3	624	703	1,300 x	228	41	235	76	499
4	743	834	1,542 x	239	42	290	101	594
5	847	952	1,761	239	42	350	128	677 x
6	952	1,070	1,979 x	239	42	406	151	761
7	1,045	1,175	2,173 x	239	42	453	180	836
8	1,139	1,281	2,369 x	239	42	496	202	911
9	1,230	1,388	2,567 x	239	42	544	230	984
10	1,322	1,508	2,789 x	239	42	589	252	1,057 x
More than 10	1,322	Add $14 for each additional person						
Reference	44-315.311	44-315.311	44-207.113	44-115.311----------				44-402.1 44-211.531

x - Rounded down to the next lower whole dollar in accordance with 45 CFR Ch. II Sec. 233.20(a)(2)(iv).

ATTACHMENT III

RELOCATION FAMILY GRANT

Issued: October 1992

Maximum Aid Payments for All Other States and U.S. Territories

STATE	Assistance Unit Size															
	1 CHILD	1 ADULT	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Alabama	$100	$100	$123	$149	$168	$194	$219	$250	$280	$311	$342	$373	$404	$435	$466	$497
Alaska	326	515	821	923	1025	1127	1229	1331	1433	1535	1637	1739	1841	1943	2045	2147
Arizona	198	198	266	334	401	469	537	605	673	740	808	875	942	1009	1076	1143
Arkansas	81	81	162	204	247	286	331	373	415	457	457	457	457	457	457	457
Colorado	99	214	280	356	432	512	590	652	715	779	840	902	959	1016	1072	1129
Connecticut	356	356	473	581	683	781	884	997	1102	1193	1304	1359	1489	1527	1643	1744
Delaware	201	201	270	338	407	475	544	612	681	750	819	888	957	1026	1095	1164
Dist. of Columbia	258	258	321	409	499	575	676	776	858	943	1025	1081	1162	1215	1281	1329
Florida	180	180	241	303	364	426	487	549	610	671	733	795	857	919	981	1043
Georgia	155	155	235	280	330	378	410	444	470	496	530	568	568	568	568	568
Guam	420	420	537	673	776	874	985	1141	1251	1351	1449	1550	1651	1752	1853	1954
Hawaii	407	407	550	693	835	978	1121	1263	1406	1549	1691	1834	1977	2120	2262	2405
Idaho	208	208	254	315	357	399	433	479	522	566	609	652	695	739	782	825
Illinois	102	212	268	367	414	485	545	574	604	635	669	705	741	781	822	866
Indiana	139	139	229	288	346	405	463	522	580	639	697	756	814	873	931	990
Iowa	183	183	361	426	495	548	610	670	731	791	865	952	1039	1126	1213	1300
Kanasa	239	239	321	396	462	521	580	639	701	760	819	878	937	996	1055	1114
Kentucky	162	162	196	228	285	333	376	419	419	419	419	419	419	419	419	419
Louisiana	71	71	136	190	234	276	315	352	390	426	462	501	540	580	620	662
Maine	127	214	337	453	569	685	801	917	1033	1149	1265	1381	1497	1613	1729	1845
Maryland	167	167	294	377	454	526	579	651	715	773	834	895	954	1013	1073	1134
Massachusetts	392	392	486	579	668	760	854	946	1037	1128	1220	1315	1410	1506	1600	1695
Michigan	96	276	371	459	563	659	792	868	944	1020	1096	1172	1248	1324	1400	1476
Minnesota	250	250	437	532	621	697	773	850	916	980	1035	1089	1142	1195	1248	1301
Mississippi	60	60	96	120	144	168	192	216	240	264	288	312	336	360	384	408
Missouri	135	135	234	292	341	387	430	473	514	554	594	635	675	715	755	796
Montana	86	238	322	405	488	571	654	738	822	861	899	933	967	997	1025	1052

* For AU sizes greater than 15, contact the DSS policy analyst.

** Updated semi-annually effective April 1st and October 1st of each year.

RELOCATION FAMILY GRANT

Maximum Aid Payments for All Other States and U.S. Territories

Issued October 1992

STATE	Assistance Unit Size															
	1 CHILD	1 ADULT	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Nebraska	$222	$222	$293	$364	$435	$506	$577	$648	$719	$790	$861	$932	$1003	$1074	$1145	$1216
Nevada	230	230	289	348	407	466	525	584	643	702	761	819	878	937	996	1055
New Hampshire	145	388	451	516	575	631	707	766	854	902	975	1056	1124	1187	1250	1313
New Jersey	162	162	322	424	488	552	616	680	744	808	872	936	1000	1064	1128	1192
New Mexico	192	192	258	324	389	455	520	586	652	717	783	849	914	979	1044	1109
New York	352	352	468	577	687	800	884	1010	1101	1173	1246	1318	1391	1463	1536	1608
North Carolina	181	181	236	272	297	324	349	373	386	406	430	448	473	496	521	546
North Dakota	108	217	326	401	491	558	616	656	698	740	782	824	866	908	950	992
Ohio	199	199	274	334	413	483	538	601	667	733	800	864	930	996	1061	1127
Oklahoma	95	211	264	341	423	495	565	639	701	762	762	762	762	762	762	762
Oregon	209	310	395	460	565	660	755	840	925	985	1090	1195	1300	1405	1510	1615
Pennsylvania	205	205	316	403	497	589	670	753	836	919	1002	1085	1168	1251	1334	1417
Puerto Rico	132	132	156	180	204	228	252	276	300	324	348	372	396	420	444	468
Rhode Island	327	327	449	554	632	710	800	880	970	1042	1132	1212	1293	1375	1461	1542
South Carolina	124	124	167	210	252	295	337	380	423	465	508	550	593	635	678	720
South Dakota	284	284	357	404	450	497	543	589	635	681	728	774	820	866	912	958
Tennessee	95	95	142	185	226	264	305	345	386	425	467	508	549	589	630	670
Texas	63	75	158	184	221	246	284	308	351	377	420	446	488	514	557	583
Utah	233	233	323	402	470	536	589	618	648	677	705	735	764	793	822	851
Vermont	465	465	567	673	755	845	902	1001	1084	1163	1242	1321	1399	1478	1557	1636
Virgin Islands	120	120	180	240	300	360	420	480	540	600	660	720	780	840	900	960
Virginia	157	157	231	291	347	410	435	435	435	435	435	435	435	435	435	435
Washington	339	339	428	531	624	719	817	943	1044	1044	1044	1044	1044	1044	1044	1044
West Virginia	145	145	201	249	312	360	413	461	477	477	477	477	477	477	477	477
Wisconsin	249	249	440	518	618	709	766	830	879	921	943	963	983	1003	1023	1043
Wyoming	195	195	320	360	390	450	510	575	640	700	765	777	789	801	813	825

* For AU sizes greater than 15, contact the DSS policy analyst.

** Updated semi-annually effective April 1st and October 1st of each year.

ATTACHMENT IV

NOTICES OF ACTION

This attachment includes all new or revised English language Notices of Action (NOAs) needed for implementation of this package. A revised NA 274 Continuation Page - Overpayment Computations, reflecting the new Relocation Family Grant computation, will be issued at a later date.

Clients must receive timely and adequate notice of all changes to their aid caused by the change in law.

LIST OF ATTACHED NOAS, AND INSTRUCTIONS FOR UPDATING THE AFDC NOA HANDBOOK

Handbook Section 5 - NA FORMS AND FORM INSTRUCTIONS

- Insert revised NA form and instructions; remove obsolete versions:
  - NA 200 (11/92) CHANGE
  - Instructions for NA 200 (11/92)

Handbook Section 6 - NOA MESSAGE DOCUMENTS

- Insert new message documents:
  - M89-402A - RFG Approval
  - M89-402S - Stop RFG Rules

Handbook Section 7 - NOA MESSAGE FORMS

- Use of this section is at county option. Insert new message forms if you are using this section. These forms are provided for county convenience.
  - MF89-402A RFG APPROVAL
  - MF89-402S CHANGE, STOP RFG

Not filed in Handbook:

- The use of these NOAs is temporary:
  - RBK 11t - CHANGE
  - RBK 12t - CHANGE MIDMONTH
  - RBK 13.1t - CHANGE INC. O/P
  - RBK 13.2t - CHANGE INC. O/P - Continuation Page for RBK 13.1t

GENERAL PLAN FOR USE OF ATTACHED NOAS

- The generic Monthly Cash Aid Amount computation, reflected in the right hand column of the NA 200 (and of the other attached NOAs as well), has been revised to include the computation of the Relocation Family Grant, Lines 8, 12, 13, and 14. In addition, it has been revised to provide a clearer presentation of the information that it contains.

- The series of 4 RBK (for RollBacK) forms is for temporary use in transitioning to the new MAP levels.

- The new M89-402A message is for ongoing use in approving aid using the Relocation Family Grant rules.

- The new M89-402S message is for ongoing use in transitioning a family from the RFG rules to a regular California grant.

REVISED GENERIC "MONTHLY CASH AID AMOUNT" COMPUTATION (NA 200)

The computation secton of the NA 200 is "generic" in the sense that a large variety of NOA messages have been designated for placement on the "blank" NA 200 form. Thus, counties should take note that all NOA forms or formats that they have developed, based on the NA 200, are affected by this revision, and must be changed accordingly.

The only change to the way that the Monthly Cash Aid Amount is actually computed is the inclusion of the Relocation Family Grant, reflected in Lines 8, 12, 13, and 14. All other changes to the computation section are changes in the way the information is presented; they are not changes in the way aid is figured.

The main changes to the computation section are described below:

- Changes to Section A

  - The "$30 Disregard" line has been removed as unnecessary and to save space.

  - The "$30 and 1/3 Disregard" line that remains is unchanged, but it will now be used to show EITHER the $30 Disregard or the $30 and 1/3 Disregard, as appropriate.

  - One of the 3 lines used to show Other Countable Income has been removed to save space.

- Changes to Section B

  - Former Line 3 "Subtotal" has been removed as unnecessary and to save space.

  - "Subtotal A" has been renamed "Basic Need Subtotal" to provide a more meaningful name.

  - "Subtotal B" has been renamed "Maximum Aid Subtotal" to provide a more meaningful name.

  - "Cash Aid Amount" has been renamed "Full Month Aid Subtotal" to provide a name that shows that the figure is for a full month in contrast to the new line below.

  - New Line 9, "Line 8 Prorated for Part of Month," fills a gap in the computation, where there was no place to show a partial month proration, when applicable.

  - "Overpayment Adjustment" has been renamed "Adjustment to Collect Overpayment" to show that the adjustment is a collection.

  - Lines 12, 13, and 14 have been added to show components of the new Relocation Family Grant computation.

A NOA containing this generic computation must be used when providing notice to Relocation Family Grant cases. For all other uses, counties may continue using the 7/91 version of the NA 200 (and other NOAs using the same version of the computation) until current stock is exhausted.

USING THE RBK SERIES OF NOAS TO TRANSITION TO THE NEW MAP LEVELS

The RBK Series of NOAs included in this package and the procedures for their use are very similar to the RBK Series of NOAs and procedures sent to counties on September 4, 1992 as Attachment III to All-County Letter No. 92-78. This letter provided instructions for implementation of the 4.5 percent MAP rollback. Most of the following instructions, except for dates and form numbers, are taken verbatim from that Attachment.

Time Frames

The RBK NOAs are based on December 1 as the effective date of the 1.3 percent MAP reduction. Each of these alternative NOAs covers a different set of circumstances, depending on how soon the county can mail the NOA. If you have sufficient lead time before November 20, you must use the first NOA, RBK-11t, and mail it on or before that date. If you cannot meet that date, but can mail the change NOA by December 4, use the second NOA, RBK-12t, and mail it on or before December 4. If you cannot mail a NOA by that date, use the third NOA, RBK-13.1t with continuation page RBK-13.2t, and mail them as soon after December 4 as possible:

- RBK-11t - Change. If used, must be mailed by November 20. This is a simple NOA providing timely and adequate notice of the December 1 change.

- RBK-12t - Change Midmonth. If used, must be mailed during the period, November 21 thru December 4. Changes monthly aid as of December 1 and changes midmonth warrant to avoid an overpayment.

- RBK-13.1t and RBK-13.2t - Change Inc. O/P (2 pages). If used, is to be mailed as soon after December 4 as possible. Changes monthly aid as of January 1 and deals with December overpayment. This NOA is provided for those situations in which it is not possible to notify the client earlier.

These NOAs are designed for situations where the rollback is the only action. The three Page 1 NOAs are each to be used with the standard NA BACK 6. For cases in which you have other actions to combine with the rollback action, combine them on the appropriate NA form according to standard procedure.

Special DSS Phone Lines for Client Inquiries and Appeals on the Rollback

We have installed special phone lines to provide information to clients who want to know more about the State law change. Appeal requests on the rollback will also be accepted on these lines. Information about these phones is included on the enclosed NOAs.

All NOAs that you prepare for rollback must include these phone numbers.

Special Treatment of Rollback-Only State Hearing Requests

We will provide special handling of mailed requests for a State hearing for cases in which the ONLY reason for the change in aid is the rollback.

Special mailing instructions are included immediately below the standard "State Hearing" section on the right hand side of each attached RBK Series NOA:

> **If you want a hearing, send your request to:**
> State Dept. of Social Services
> Administrative Adjudications Div.
> 744 P St., M.S. 19-98
> Sacramento, CA 95814
> **rather than to the address on the back.**
> **This will allow quicker handling of your appeal.**

(Los Angeles County will substitute in the address, "M.S. 19-99" for "M.S. 19-98.)

When preparing County NOA forms for rollback, include this language ONLY on forms intended for rollback-only use. When you prepare NOA forms for mixed use, rollback plus some other action, do NOT include this special message.

Instructions for Completing Attached Rollback NOAs

All NOAs:

- Fill in the "from" and "to" $ amounts.
- Fill in Sections A and B with applicable months and amounts.

RBK-11t - Change:

- This is the preferred alternative.
- For mailing by November 20, when you can still give timely notice of the rollback effective December 1.

RBK-12t - Change Midmonth:

- This is the first backup alternative.
- For mailing during period of November 21 thru December 4, when you can still give timely notice of a change to the Mid-December warrant.

RBK-13.1t and RBK-13.2t - Change Inc. O/P

- This is the second backup alternative. This timing results in an overpayment for December and a great deal of extra work. Avoid it if you can.
- For mailing after December 4, while you can still give timely notice of the rollback for January 1.

- Page 1 - Fill in amount overpaid for December.
- Page 1, Section B, Line 10 - Include the amount of the overpayment adjustment, if any, being collected from the January grant.

- Page 2 - This page must be sent with Page 1.
- Page 2 - Check the appropriate box(s) about collection of the overpayment.

- Additional Continuation Pages:

  - NA 274C (7/91) - OVERPAYMENT COMPUTATIONS - Fill in and attach to show the computation of the overpayment.

  - NA 275 (7/91) - OVERPAYMENT ADJUSTMENT COMPUTATION - If grant adjusting for the overpayment in January, fill in and attach to show the amount of overpayment that can be collected in January.

- Complete the page numbers on each page.

Summary for RBK NOAS

Three reproducible Page 1 RBK NOAs and a Continuation Page NOA are attached. Use the Page 1 NOAs with the NA BACK 6. The Page 1 NOAs contain a special State Hearing address and special phone numbers. The attached NOAs can be used as-is for rollback-only notification.

All rollback NOAs must be timely and adequate.

The NOAs are designed for use during the time frames specified above.

When you prepare your own NOA forms for rollback:

- Start with a standard NA form, most likely, the NA 200.
- For NOAs to be used exclusively for rollback, include the special State Hearing address.
- For rollback NOAs that include one or more additional messages, do NOT include the special address.
- Include the special telephone numbers on ALL rollback NOAs.

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

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

(ADDRESSEE)

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

Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

Total Earned Income	$	
Work Expense Disregard	-	
$30 and 1/3 Disregard	-	
Dependent Care Disregard	-	
Other Countable Income -- Sources:		
_____	+	
_____	+	
Court Ordered Support You Paid	-	
Net Countable Income	=	

Section B. Your Cash Aid, Month of _____

1. Basic Need, _____ Persons	$	
2. Special Needs	+	
3. Net Countable Income from Section A	-	
4. Basic Need Subtotal	=	
5. Maximum Aid, _____ Persons	$	
6. Special Needs	+	
7. Maximum Aid Subtotal	=	
8. **Full Month Aid Subtotal** (Lowest Amount on Line 4, 7, or 14)	=	
9. Line 8 Prorated for Part of Month	=	
10. Adjustment to Collect Overpayment	-	
11. **Monthly Cash Aid Amount** (Line 8 or 9 less Line 10)	=	
12. Former State MAP, _____ Persons	$	
13. Special Needs (California)	+	
14. Former State Subtotal	=	

Rules: These rules apply; you may review them at your welfare office. MPP

INSTRUCTIONS

NA 200 (11/92) CHANGE

This is a multipurpose generic "blank" Notice of Action form, typically used for change messages. It is blank in the left column and shows the computation of the monthly cash aid amount in the right column. It can be used whenever such a general form is needed, subject to the rules for completing Notice of Action forms contained in the AFDC NOTICE OF ACTION HANDBOOK.

The form must be backed with the current NA Back.

LEFT COLUMN

- Enter the message to the client. This typically will come from one or more NOA message documents contained in the AFDC NOTICE OF ACTION HANDBOOK.

- Under "Rules," you will typically enter the MPP regulation citations shown near the top of the appropriate NOA message document(s).

RIGHT COLUMN

- Fill in all applicable blanks.

    - Lines 12 thru 14 - These lines are exclusively for Relocation Family Grant situations. Fill in only when Relocation Family Grant rules are applicable.

file: na200ibc
date: 10-2-92

State of California
Department of Social Ser ces

Manual Msg. No.: 89-402A
Action : Approve
Issue: Application
Title: RFG Approval

Auto ID No. :
Flow Chart No. :
Source : 1992 State Budget
Rules: MPP 40-173.1, 44-315.4 and .5, 44-317, 89-402.4

Form No. : NA 200
Effective Date : 12/01/92
Revision Date :

MESSAGE:

As of _____, the County has approved your cash aid and cash based Medi-Cal. Your first day of cash aid is _____.

Your first Monthly Cash Aid Amount is $_____. It is figured from your Full Month Aid Subtotal.

Your cash aid is figured using the rules for a Relocation Family Grant, and your Full Month Aid Subtotal is the lowest of the following subtotals in Section B:

Basic Need Subtotal
Maximum Aid Subtotal (California)
Former State Subtotal

Your Former State Subtotal is based on the Maximum Aid Payment (MAP) of _____. This MAP will be used to figure your grant for no more than __ month(s). You will get another notice before aid changes.

Here's why you get the Relocation Family Grant:

No one in your assistance unit lived in California for 12 months in a row just before you applied for cash aid.

INSTRUCTIONS: Use to approve aid figured using the rules for a Relocation Family Grant.

- Fill in all blanks.
  - Fourth blank - Fill in name of former state.

file: m89402abc

State of California
Department of Social Services

Manual Msg. No.: 89-402S
Action : Change
Issue: Restriction
Title: Stop RFG Rules
Form No. : NA 200
Effective Date : 12/01/92
Revision Date :

Auto ID No. :
Flow Chart No. :
Source: 1992 State Budget
Regulation Cite: MPP 89-402.4

MESSAGE:

As of _____, the County is changing:

[ ] Your monthly cash aid from $_____ to $_____ .

[ ] The way your monthly cash aid is figured, but there is no change to the amount of your aid.

Your aid is no longer figured using rules for a Relocation Family Grant.

Here's why:

At least 1 person in your assistance unit has now lived in California for 12 months in a row.

INSTRUCTIONS: Use at the end of the Relocation Family Grant period to inform the client that the period has ended.

- Check applicable box.
- Fill in all blanks.

file: l.m.docs/m89402sbc
date: 9/29/92

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

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

(ADDRESSEE)

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

As of _____, the County has approved your cash aid and cash based Medi-Cal. Your first day of cash aid is _____.

Your first Monthly Cash Aid Amount is $ _____. It is figured from your Full Month Aid Subtotal.

Your cash aid is figured using the rules for a Relocation Family Grant, and your Full Month Aid Subtotal is the lowest of the following subtotals in Section B:

Basic Need Subtotal
Maximum Aid Subtotal (California)
Former State Subtotal

Your Former State Subtotal is based on the Maximum Aid Payment (MAP) of _____. This MAP will be used to figure your grant for no more than _____ month(s). You will get another notice before aid changes.

Here's why you get the Relocation Family Grant:

No one in your assistance unit lived in California for 12 months in a row just before you applied for cash aid.

Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

Total Earned Income	$	
Work Expense Disregard	-	
$30 and 1/3 Disregard	-	
Dependent Care Disregard	-	
Other Countable Income -- Sources:		
_____	+	
_____	+	
Court Ordered Support You Paid	-	
Net Countable Income	=	

Section B. Your Cash Aid, Month of _____

1. Basic Need, _____ Persons	$	
2. Special Needs	+	
3. Net Countable Income from Section A	-	
4. Basic Need Subtotal	=	
5. Maximum Aid, _____ Persons	$	
6. Special Needs	+	
7. Maximum Aid Subtotal	=	
8. **Full Month Aid Subtotal** (Lowest Amount on Line 4, 7, or 14)	=	
9. Line 8 Prorated for Part of Month	=	
10. Adjustment to Collect Overpayment	-	
11. **Monthly Cash Aid Amount** (Line 8 or 9 less Line 10)	=	
12. Former State MAP, _____ Persons	$	
13. Special Needs (California)	+	
14. Former State Subtotal	=	

Rules: These rules apply; you may review them at your welfare office. MPP 40-173.1, 44-315.4 and .5, 44-317, 89-402.4.

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

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

(ADDRESSEE)

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

As of _____, the County is changing:

☐ Your monthly cash aid from $_____ to $ _____.

☐ The way your monthly cash aid is figured, but there is no change to the amount of your aid.

Your aid is no longer figured using rules for a Relocation Family Grant.

Here's why:

At least 1 person in your assistance unit has now lived in California for 12 months in a row.

Rules: These rules apply; you may review them at your welfare office. MPP 89-402.4

(Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

Total Earned Income	$	
Work Expense Disregard	-	
$30 and 1/3 Disregard	-	
Dependent Care Disregard	-	
Other Countable Income -- Sources:		
_____	+	
_____	+	
Court Ordered Support You Paid	-	
Net Countable Income	=	

Section B. Your Cash Aid, Month of _____

1. Basic Need, _____ Persons	$	
2. Special Needs	+	
3. Net Countable Income from Section A	-	
4. Basic Need Subtotal	=	
5. Maximum Aid, _____ Persons	$	
6. Special Needs	+	
7. Maximum Aid Subtotal	=	
8. **Full Month Aid Subtotal** (Lowest Amount on Line 4, 7, or 14)	=	
9. Line 8 Prorated for Part of Month	=	
10. Adjustment to Collect Overpayment	-	
11. **Monthly Cash Aid Amount** (Line 8 or 9 less Line 10)	=	
12. Former State MAP, _____ Persons	$	
13. Special Needs (California)	+	
14. Former State Subtotal	=	

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

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

(ADDRESSEE)

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

If you want a hearing, send your request to:
State Dept. of Social Services
Administrative Adjudications Div.
744 P St., M,.S. 19-98
Sacramento, CA 95814
rather than to the address on the back. This will allow quicker handling of your appeal.

As of December 1, 1992, the County is changing your cash aid from $ _____ to $ _____ .

Here's why:

As of December 1, 1992, a change in State law will lower the Maximum Aid Payment (MAP) that you can get by 1.3 percent.

Your new cash aid amount is figured on this notice.

If you want to know more about this State law change, or want to ask for a State Hearing only on the law change, the fastest way is to call toll-free:

1-800 925-8960

TDD for hearing impaired:

1-800 952-8349

Rules: These rules apply; you may review them at your welfare office. MPP 44-315; W & I Code Section 11450

Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

Total Earned Income	$	
Work Expense Disregard	-	
$30 and 1/3 Disregard	-	
Dependent Care Disregard	-	
Other Countable Income -- Sources:		
_____	+	
_____	+	
Court Ordered Support You Paid	-	
Net Countable Income	=	

Section B. Your Cash Aid, Month of _____

1. Basic Need, _____ Persons	$	
2. Special Needs	+	
3. Net Countable Income from Section A	-	
4. Basic Need Subtotal	=	
5. Maximum Aid, _____ Persons	$	
6. Special Needs	+	
7. Maximum Aid Subtotal	=	
8. **Full Month Aid Subtotal** (Lowest Amount on Line 4, 7, or 14)	=	
9. Line 8 Prorated for Part of Month	=	
10. Adjustment to Collect Overpayment	-	
11. **Monthly Cash Aid Amount** (Line 8 or 9 less Line 10)	=	
12. Former State MAP, _____ Persons	$	
13. Special Needs (California)	+	
14. Former State Subtotal	=	

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

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

(ADDRESSEE)

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

If you want a hearing, send your request to:
State Dept. of Social Services
Administrative Adjudications Div.
744 P St., M.S. 19-98
Sacramento, CA 95814
rather than to the address on the back. This will allow quicker handling of your appeal.

As of December 1, 1992, a change in State law lowers the Maximum Aid Payment (MAP) that you can get by 1.3 percent. Because of this law change, your monthly cash aid is being figured on the new lower MAP, starting on that date.

Therefore, as of December 1, 1992, the County is changing your cash aid from $ _____ to $ _____ .

This does not change your first December cash aid check, but your December midmonth check will be lower, so you won't be overpaid. If we waited until January, you would be overpaid and would have to pay money back.

This is how your December midmonth check is figured:

> Your new monthly cash aid amount (shown above), LESS the amount of your first December aid check, EQUALS the amount of your midmonth check.

Your new cash aid amount is figured on this notice.

If you want to know more about this State law change, or want to ask for a State Hearing only on the law change, the fastest way is to call toll-free:

1-800 925-8960

TDD for hearing impaired:

1-800 952-8349

Rules: These rules apply; you may review them at your welfare office. MPP 44-315; W & I Code Section 11450

Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

Total Earned Income	$ _____
Work Expense Disregard	- _____
$30 and 1/3 Disregard	- _____
Dependent Care Disregard	- _____
Other Countable Income -- Sources:	
_____	+ _____
_____	+ _____
Court Ordered Support You Paid	- _____
Net Countable Income	= _____

Section B. Your Cash Aid, Month of _____

1. Basic Need, _____ Persons	$ _____
2. Special Needs	+ _____
3. Net Countable Income from Section A	-
4. Basic Need Subtotal	= [ ]
5. Maximum Aid, _____ Persons	$ _____
6. Special Needs	+
7. Maximum Aid Subtotal	= [ ]
8. **Full Month Aid Subtotal** (Lowest Amount on Line 4, 7, or 14)	= _____
9. Line 8 Prorated for Part of Month	= _____
10. Adjustment to Collect Overpayment	- _____
11. **Monthly Cash Aid Amount** (Line 8 or 9 less Line 10)	= _____
12. Former State MAP, _____ Persons	$ _____
13. Special Needs (California)	+
14. Former State Subtotal	= [ ]

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

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

(ADDRESSEE)

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

If you want a hearing, send your request to:
State Dept. of Social Services
Administrative Adjudications Div.
744 P St., M,.S. 19-98
Sacramento, CA 95814
rather than to the address on the back. This will allow quicker handling of your appeal.

As of January 1, 1993 the County is changing your cash aid from $_____ to $_____ .You are being overpaid $ _____ for December.

Here's why:

As of December 1, 1992, a change in State law lowered the monthly Maximum Aid Payment (MAP) that you can get by 1.3 percent. This change to your cash aid is required by law.

Your new cash aid amount is figured on this notice.

If you want to know more about this State law change, or want to ask for a State Hearing only on the law change, the fastest way is to call toll-free:

1-800 925-8960

TDD for hearing impaired:

1-800 952-8349

Rules: These rules apply; you may review them at your welfare office: MPP 44-315; W & I Code Section 11450

Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

Total Earned Income	$	
Work Expense Disregard	-	
$30 and 1/3 Disregard	-	
Dependent Care Disregard	-	
Other Countable Income -- Sources:		
_____	+	
_____	+	
Court Ordered Support You Paid	-	
Net Countable Income	=	

Section B. Your Cash Aid, Month of _____

1. Basic Need, _____ Persons	$	
2. Special Needs	+	
3. Net Countable Income from Section A	-	
4. Basic Need Subtotal	=	
5. Maximum Aid, _____ Persons	$	
6. Special Needs	+	
7. Maximum Aid Subtotal	=	
8. **Full Month Aid Subtotal** (Lowest Amount on Line 4, 7, or 14)	=	
9. Line 8 Prorated for Part of Month	=	
10. Adjustment to Collect Overpayment	-	
11. **Monthly Cash Aid Amount** (Line 8 or 9 less Line 10)	=	
12. Former State MAP, _____ Persons	$	
13. Special Needs (California)	+	
14. Former State Subtotal	=	

NOTICE OF ACTION
(Continued)

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date _____
Case Name _____
Number _____

YOUR OVERPAYMENT

Because, in December we are not able to make the change required by the State law, you are being overpaid in December.

When there is an overpayment, monthly aid is lowered until the amount owed is paid back. We take less money out of your monthly aid payment when an overpayment is caused by a County mistake. We have decided that your overpayment was caused by the County.

The next page shows how we figured the amount of your overpayment.

☐ We will collect this overpayment at a later date. You will get another notice before we start to collect.

☐ Collection of this overpayment begins in January. See a following page to see how we figured how much will be taken from your monthly aid payment.

  ☐ Your whole overpayment is being collected in January. If there is no other change, your aid will go up in February. You will get another notice before your aid goes up.

If you go off cash aid before your overpayment is paid back, the County can take action to collect.

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

WARNING: If you think this overpayment is wrong, this is your last chance to ask for a hearing. The back of Page 1 tells how. If you stay on aid, the County can collect an AFDC overpayment by lowering your monthly grant. It can lower your food stamps to collect an overissuance unless it was the County's fault. If you go off aid before the overpayment or overissuance is paid back, the County may take what you owe out of your State income tax refund.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of page 1 tells how.

SUPPLEMENTAL STATEMENT OF FACTS — CASH AID RELOCATION FAMILY GRANT

ATTACHMENT V

State law limits the amount of cash aid a family can get to either the Maximum Aid Payment amount from the State where they last lived or the cash aid figured for California, whichever is less. This law applies to families who have not lived in California for the last 12 months in a row. This limit on cash aid can apply up to 12 months.

There are cash aid penalties for giving wrong or incomplete facts, or for failing to report facts or situations which may affect an applicant's/recipient's eligibility or benefits.

COUNTY USE ONLY

Case Name: _____

Case Number: _____

Worker: _____

RELOCATION

State Code: _____

RFG Level: _____

RFG Months: _____

NAME OF PERSON APPLYING OR CARETAKER RELATIVE OF CHILD(REN) FOR WHOM AID IS WANTED. | SOCIAL SECURITY NUMBER — —

HAS ANYONE IN THE FAMILY LIVED IN CALIFORNIA FOR THE LAST 12 MONTHS IN A ROW? ☐ YES ☐ NO

Complete section below for each person for whom you are applying. (If additional space is needed use the backside of this form.)

WHO	LAST OUT-OF-STATE RESIDENCE (CITY, STATE)	DATE ARRIVED IN CALIFORNIA

CERTIFICATION

I certify that I have been informed of the Relocation Family Grant information as stated above.

I understand that all facts included in this form are subject to investigation and review by County, State and Federal personnel, and if I give wrong facts my cash aid may be denied or stopped.

I declare under penalty of perjury, under the laws of the United States and the State of California that the information contained in this statement of facts is true, correct and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, OR AUTHORIZED REPRESENTATIVE)	DATE
SIGNATURE (OTHER PARENT LIVING IN THE HOME)	DATE
WITNESS, IF YOU SIGNED WITH AN "X"	DATE

COUNTY CERTIFICATION

I certify that I have informed the applicant/recipient or caretaker relative of the Relocation Family Grant as stated above.

ELIGIBILITY WORKER SIGNATURE	EW NUMBER	DATE

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC BUDGET WORKSHEET

CASE NAME:

CASE NUMBER:

WORKER NUMBER:

Payment Month_____ ASSISTANCE UNIT	Recipients	Check (✓) Federal	
ADULTS			
CHILDREN			
TOTAL			
A. Minimum Basic Standard of Adequate Care (MBSAC)/Rate for _____ Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. Net Nonexempt Income (Enter Item (B) 14 from Reverse)	–		
3. Potential Grant	$ =		
B. Maximum Aid Payment (MAP)/Rate for_____Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. MAP plus Special Needs	$		
C. Former State MAP for_____Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. Former State MAP plus Special Needs	$		
D. Aid Payment (Lesser of A3, B2 or C2)	$		
Proration figure Date:	X		
E. Prorated Aid Payment	$ =		
F. Homeless Assistance	+		
G. Overpayment Adjustment	–		
H. Adjusted Aid Payment	$ =		

Payment Month_____ ASSISTANCE UNIT	Recipients	Check (✓) Federal	
ADULTS			
CHILDREN			
TOTAL			
A. Minimum Basic Standard of Adequate Care (MBSAC)/Rate for _____ Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. Net Nonexempt Income (Enter Item B 14 from Reverse)	–		
3. Potential Grant	$ =		
B. Maximum Aid Payment (MAP)/Rate for_____Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. MAP plus Special Needs	$		
C. Former State MAP for_____Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. Former State MAP plus Special Needs	$		
D. Aid Payment (Lesser of A3, B2 or C2)	$		
Proration figure Date:	X		
E. Prorated Aid Payment	$ =		
F. Homeless Assistance	+		
G. Overpayment Adjustment	–		
H. Adjusted Aid Payment	$ =		

Payment Month_____ ASSISTANCE UNIT	Recipients	Check (✓) Federal	
ADULTS			
CHILDREN			
TOTAL			
A. Minimum Basic Standard of Adequate Care (MBSAC)/Rate for _____ Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. Net Nonexempt Income (Enter Item B 14 from Reverse)	–		
3. Potential Grant	$ =		
B. Maximum Aid Payment (MAP)/Rate for_____Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. MAP plus Special Needs	$		
C. Former State MAP for_____Persons	$		
1. Special Needs (Other than Homeless Assistance)	+		
2. Former State MAP plus Special Needs	$		
D. Aid Payment (Lesser of A3, B2 or C2)	$		
Proration figure Date:	X		
E. Prorated Aid Payment	$ =		
F. Homeless Assistance	+		
G. Overpayment Adjustment	–		
H. Adjusted Aid Payment	$ =		

BUDGET RECOMPUTATION

I. Aid Payment Previously Authorized	$
J. Correct Aid Payment	$
K. Overpayment (If I larger than J)	$
L. Underpayment (If J larger than I)	$
EW INITIAL AND DATE	AUTHORIZATION DATE

I. Aid Payment Previously Authorized	$
J. Correct Aid Payment	$
K. Overpayment (If I larger than J)	$
L. Underpayment (If J larger than I)	$
EW INITIAL AND DATE	AUTHORIZATION DATE

I. Aid Payment Previously Authorized	$
J. Correct Aid Payment	$
K. Overpayment (If I larger than J)	$
L. Underpayment (If J larger than I)	$
EW INITIAL AND DATE	AUTHORIZATION DATE

INCOME COMPUTATION

(A) 185% INCOME TEST	Budget Month _____ for Payment Month _____	Budget Month _____ for Payment Month _____	Budget Month _____ for Payment Month _____
1. 185% of MBSAC plus Special Needs for _____ Persons	=		
2. Gross Income (B3 plus B11 plus excluded persons gross income. Include child support collected by the county.)	=		
3. Gross Income Eligible (A1 exceeds A2)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

(B) NET INCOME COMPUTATION		Budget Month _____ for Payment Month _____			Budget Month _____ for Payment Month _____			Budget Month _____ for Payment Month _____		
		Person 1	Person 2	Person 3	Person 1	Person 2	Person 3	Person 1	Person 2	Person 3
1. Gross Earned Income	$									
2. Net Income from Self-Employment Earnings *(If applicable, calculate below)*	+									
3. Total Earned Income	=									
4. Standard Work Expense Disregard	–									
5. Disregard $30 (if applicable)	–									
6. Subtotal	=									
7. Disregard 1/3 of Subtotal in 6 above (if applicable)	–									
8. Subtotal	=									
9. Dependent Care Expense Disregard a) Full Time - Child(ren) over 2 years ____	–									
b) Full Time - Child(ren) under 2 years ____	–									
c) Part Time - Child(ren) over 2 years ____	–									
d) Part Time - Child(ren) under 2 years ____	–									
e) Incapacitated Individual	–									
10. Subtotal	=									
11. Other Countable Income: *(Specify)*	+									
	+									
	+									
12. Court Ordered Child/Spousal Support Paid	–									
13. Net Nonexempt Income	$ =									
14. Total Net Nonexempt Income *(Enter in A 2 on Side 1)*			$ =			$ =			$ =	

(C) EARNINGS FROM SELF-EMPLOYMENT				
1. Gross Earnings from Self-Employment	$			
2. Business Expenses: *(Specify)*	–			
	–			
	–			
	–			
3. Net Business Income (C1 minus C2. Enter in B2 above)	$ =			

ATTACHMENT VI

SPANISH TRANSLATIONS

- GENERAL MASS INFORMING NOTICE TEMP BC 1
- BC JA 2 SUP (11/92)
- NA 200 (11/92) CHANGE
- MF89-402A RFG APPROVAL
- MF89-402S CHANGE, STOP RFG
- AFDC NOA RBK 11t - CHANGE
- AFDC NOA RBK 12t - CHANGE MIDMONTH
- AFDC NOA RBK 13.1t - CHANGE INC. O/P
- AFDC NOA RBK 13.2t - CHANGE INC. O/P - Continuation Page for RBK 13.1t.

AVISO IMPORTANTE PARA LAS PERSONAS QUE RECIBEN ASISTENCIA MONETARIA

FAVOR DE LEER

CAMBIO EN LA LEY ESTATAL

A partir del 1 de diciembre de 1992, la ley estatal cambia las reglas para la asistencia monetaria. Las nuevas reglas reducen la cantidad máxima de asistencia monetaria que una familia puede recibir, limita la cantidad de asistencia monetaria a los solicitantes que no han vivido en California los últimos 12 meses, y elimina el límite en el número de horas que una persona que recibe asistencia puede trabajar y todavía reunir los requisitos para recibir asistencia.

CAMBIO EN EL PAGO MAXIMO DE ASISTENCIA (MAP)

La ley estatal reduce en un 1.3 por ciento el Pago Máximo de Asistencia que una familia puede recibir. Vea la tabla a la derecha para enterarse lo más que pudiera cambiar su asistencia monetaria. Este cambio entra en vigor el 1 de diciembre de 1992. Si no podemos reducir su asistencia monetaria correspondiente a diciembre inmediatamente, usted recibirá un pago excesivo y tendrá que reembolsar este dinero. Si recibe un pago excesivo, recibirá otra notificación.

Necesita hacer planes con respecto a este cambio. Si la asistencia monetaria es su única fuente de ingresos, usted tendrá menos dinero para satisfacer las necesidades de su familia. Pero si usted trabaja, aunque sea parte del tiempo, o tiene otros ingresos, puede quedarse con más dinero para satisfacer las necesidades de su familia.

PARA MAS INFORMACION

Por favor llame gratuitamente al: 1-800-925-8960

o

Para los sordos, TTD: 1-800-952-8349

CAMBIO EN LAS ESTAMPILLAS PARA COMIDA

La mayoría de las familias recibirán más estampillas para comida cuando su asistencia monetaria baje.

PAGO MENSUAL PARA NUEVA COLOCACION DE UNA FAMILIA

El Pago Mensual para Nueva Colocación de una Familia es pertinente a los **solicitantes** que no han vivido en California durante los últimos 12 meses. El Pago Mensual para Nueva Colocación de una Familia limita la cantidad de asistencia monetaria que una familia puede recibir, a lo que sea menor entre:

- el MAP del estado donde vivían anteriormente, o
- la asistencia monetaria calculada para California.

El Pago Mensual para Nueva Colocación de una Familia puede durar hasta 12 meses.

TABLA DEL MAP DE ASISTENCIA MONETARIA

PERSONAS QUE RECIBEN ASISTENCIA	MAP ANTIGUO	MAP NUEVO	REDUCCION
1	$ 311	$ 307	$ 4
2	511	504	7
3	633	624	9
4	753	743	10
5	859	847	12
6	965	952	13
7	1,059	1,045	14
8	1,155	1,139	16
9	1,247	1,230	17
10 o más	1,340	1,322	18

ELIMINACION DE LA REGLA DE LAS 100 HORAS

El cambio en la ley estatal permite a una persona que recibe beneficios trabajar más horas. Ya no hay un límite en el número de horas que una persona que reciba beneficios puede trabajar y todavía reunir los requisitos para recibir asistencia monetaria. Hay sólo un límite en la cantidad de ingresos que puede ganar y todavía seguir siendo elegible.

DECLARACION SUPLEMENTAL DE DATOS — ASISTENCIA MONETARIA PAGO MENSUAL PARA NUEVA COLOCACION DE UNA FAMILIA

SOLO PARA USO DEL CONDADO

Case Name: _____

Case Number: _____

Worker: _____

RELOCATION

State Code: _____

RFG Level: _____

RFG Months: _____

La ley estatal limita la cantidad de asistencia que una familia puede recibir, ya sea al Pago Máximo de Asistencia del estado donde vivieron últimamente o a la asistencia monetaria calculada para California, lo que sea menos. Esta ley aplica a familias que no han vivido en California durante los últimos 12 meses consecutivos. Este límite en la asistencia monetaria puede durar hasta 12 meses.

Existen sanciones de asistencia monetaria por dar datos erróneos o incompletos, o por no reportar datos o situaciones que pudieran afectar la elegibilidad de un solicitante/persona que recibe beneficios.

NOMBRE DE LA PERSONA QUE PRESENTA LA SOLICITUD O PARIENTE ENCARGADO DEL CUIDADO DE LOS NIÑOS PARA LOS QUE SE SOLICITA LA ASISTENCIA.	NUMERO DEL SEGURO SOCIAL ___ ___

¿HA VIVIDO EN CALIFORNIA ALGUN MIEMBRO DE LA FAMILIA MAS DE 12 MESES CONSECUTIVOS? ☐ SI ☐ NO

Complete la sección de abajo para cada persona para la que solicite beneficios. (Si necesita más espacio, use el reverso de esta forma.)

¿QUIEN?	ULTIMA RESIDENCIA FUERA DEL ESTADO (CIUDAD, ESTADO)	FECHA EN QUE LLEGO A CALIFORNIA

CERTIFICACION

Certifico que se me ha informado sobre el Pago Mensual para Nueva Colocación de una Familia antes mencionado.

Entiendo que todos los datos que se incluyen en esta forma están sujetos a investigación y revisión por personal del condado, del estado y federal, y que si doy datos erróneos es posible que se niegue o pare mi asistencia monetaria.

Declaro bajo pena de perjurio, en conformidad con las leyes de los Estados Unidos y del Estado de California, que la información que contiene esta declaración de datos es verdadera, correcta y completa.

FIRMA (PADRE/MADRE O PERSONA ENCARGADA DEL CUIDADO DE UN PARIENTE, O REPRESENTANTE AUTORIZADO)	FECHA
FIRMA (OTRO PADRE/MADRE QUE VIVE EN EL HOGAR)	FECHA
TESTIGO, SI FIRMO CON UNA "X"	FECHA

CERTIFICACION DEL CONDADO

I certify that I have informed the applicant/recipient or caretaker relative of the Relocation Family Grant as stated above.

ELIGIBILITY WORKER SIGNATURE	EW NUMBER	FECHA

NOTIFICACION DE AC ON

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador(a) : _____
Número : _____
Teléfono : _____
Dirección : _____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el estado. Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En el reverso de esta hoja se le explica cómo hacerlo. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

Cantidad de la asistencia monetaria mensual

Sección A. Ingresos contables en el mes de _____

Total de ingresos ganados	$	
Deducción por gastos de trabajo	-	
Deducción de $30 y 1/3	-	
Deducción por cuidado de personas a su cargo	-	
Otros ingresos contables (enumere las fuentes)		
_____	+	
_____	+	
Mantenimiento pagado ordenado por la corte	-	
Ingresos contables netos	=	

Sección B. Su asist. monetaria en el mes de _____

1. Necesidades básicas, _____ personas	$	
2. Necesidades especiales	+	
3. Ingresos contables netos de la Sección A	-	
4. Subtotal de necesidades básicas	=	
5. Asistencia máxima, _____ personas	$	
6. Necesidades especiales	+	
7. Subtotal de asistencia máxima	=	
8. **Subtotal de asist. del mes completo** (Cant. menor en el renglón 4, 7, o 14)	=	
9. Renglón 8 prorrateado para parte del mes	=	
10. Ajuste para cobrar el pago excesivo	-	
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 o 9 menos el renglón 10)	=	
12. MAP del estado anterior, _____ personas.	$	
13. Necesidades especiales (California)	+	
14. Subtotal del estado anterior	=	

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP

NOTIFICACION DE AC( )N

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador(a) : _____
Número : _____
Teléfono : _____
Dirección : _____
_____
_____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el estado. Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En el reverso de esta hoja se le explica cómo hacerlo. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

A partir del _____, el condado ha aprobado su asistencia monetaria y su Medi-Cal basado en asistencia monentaria. Su primer día de recibir asistencia monetaria es el _____.

Su primera cantidad de asistencia monetaria mensual es $ _____. Esta se calcula de su subtotal de asistencia del mes completo.

Su asistencia monetaria se calcula usando las reglas para un Pago Mensual para Nueva Colocación de una Familia, y su subtotal de asistencia del mes completo es el más bajo de los siguientes subtotales en la Sección B:

Subtotal de necesidades básicas
Subtotal de asistencia máxima (California)
Subtotal del estado anterior

Su subtotal del estado anterior se basa en el Págo Máximo de Asistencia (MAP) de _____.
Se usará este MAP para calcular su pago mensual para no más de _____ mes(es). Usted recibirá otra notificación antes que cambie la asistencia.

Esta es la razón por la cual usted recibirá el Pago Mensual para Nueva Colocación de una Familia:

Nadie en su unidad familiar para fines de la asistencia ha vivido en California durante 12 meses consecutivos inmediatamente antes que usted solicitara asistencia monetaria.

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP 40-173.1, 44-315.4 y .5, 44-317, 89-402.4.

Cantidad de la asistencia monetaria mensual

Sección A. Ingresos contables en el mes de _____

Total de ingresos ganados	$	
Deducción por gastos de trabajo	-	
Deducción de $30 y 1/3	-	
Deducción por cuidado de personas a su cargo	-	
Otros ingresos contables (enumere las fuentes)		
_____	+	
_____	+	
Mantenimiento pagado ordenado por la corte	-	
Ingresos contables netos	=	

Sección B. Su asist. monetaria en el mes de _____

1. Necesidades básicas, _____ personas	$	
2. Necesidades especiales	+	
3. Ingresos contables netos de la Sección A	-	
4. Subtotal de necesidades básicas	=	
5. Asistencia máxima, _____ personas	$	
6. Necesidades especiales	+	
7. Subtotal de asistencia máxima	=	
8. **Subtotal de asist. del mes completo** (Cant. menor en el renglón 4, 7, o 14)	=	
9. Renglón 8 prorrateado para parte del mes	=	
10. Ajuste para cobrar el pago excesivo	-	
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 o 9 menos el renglón 10)	=	
12. MAP del estado anterior, _____ personas.	$	
13. Necesidades especiales (California)	+	
14. Subtotal del estado anterior	=	

NOTIFICACION DE AC ION

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador(a) : _____
Número : _____
Teléfono : _____
Dirección : _____
_____
_____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el estado. Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En el reverso de esta hoja se le explica cómo hacerlo. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

A partir del _____, el condado cambiará:

☐ su asistencia monetaria cantidad mensual de
$ _____ a $ _____.

☐ la manera en que se calcula su asistencia monetaria mensual, pero no hay cambios en la cantidad de su asistencia.

Su asistencia ya no se calcula usando las reglas para un Pago Mensual para Nueva Colocación de una Familia.

La razón es la siguiente:

Por lo menos una persona en su unidad familiar para fines de la asistencia, ya ha vivido en California durante 12 meses consecutivos.

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP 89-402.4.

Cantidad de la asistencia monetaria mensual

Sección A. Ingresos contables en el mes de _____

Total de ingresos ganados	$	
Deducción por gastos de trabajo	-	
Deducción de $30 y 1/3	-	
Deducción por cuidado de personas a su cargo	-	
Otros ingresos contables (enumere las fuentes)		
_____	+	
_____	+	
Mantenimiento pagado ordenado por la corte	-	
Ingresos contables netos	=	

Sección B. Su asist. monetaria en el mes de _____

1. Necesidades básicas, _____ personas	$	
2. Necesidades especiales	+	
3. Ingresos contables netos de la Sección A	-	
4. Subtotal de necesidades básicas	=	
5. Asistencia máxima, _____ personas	$	
6. Necesidades especiales	+	
7. Subtotal de asistencia máxima	=	
8. **Subtotal de asist. del mes completo** (Cant. menor en el renglón 4, 7, o 14)	=	
9. Renglón 8 prorrateado para parte del mes	=	
10. Ajuste para cobrar el pago excesivo	-	
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 o 9 menos el renglón 10)	=	
12. MAP del estado anterior, _____ personas.	$	
13. Necesidades especiales (California)	+	
14. Subtotal del estado anterior	=	

NOTIFICACION DE AC ON

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador(a) : _____
Número : _____
Teléfono : _____
Dirección : _____
_____
_____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el estado. Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En el reverso de esta hoja se le explica cómo hacerlo. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

Si desea una audiencia, en vez de enviar su petición a la dirección en el reverso, envíela a:

State Department of Social Services
Administrative Adjudications Division
744 P Street, M.S. 19-98
Sacramento, CA 95814

Esto acelerará el trámite de su apelación.

A partir del 1 de diciembre de 1992, el condado cambiará su asistencia monetaria de $_____ a $_____.

La razón es la siguiente:

A partir del 1 de diciembre de 1992, un cambio en la ley estatal reducirá en un 1.3 por ciento, el pago máximo de asistencia (MAP) que usted puede recibir.

En esta notificación se calcula su nueva cantidad de asistencia monetaria.

Si usted desea saber más acerca de este cambio en la ley estatal, o desea pedir una audiencia con el estado sólamente con respecto al cambio en la ley, la manera más rápida es llamando gratuitamente al:

1-800-925-8960

TDD para los sordos:

1-800-952-8349

Cantidad de la asistencia monetaria mensual

Sección A. Ingresos contables en el mes de _____

Total de ingresos ganados		$ _____
Deducción por gastos de trabajo		- _____
Deducción de $30 y 1/3		- _____
Deducción por cuidado de personas a su cargo		- _____
Otros ingresos contables (enumere las fuentes)		
_____		+ _____
_____		+ _____
Mantenimiento pagado ordenado por la corte		- _____
Ingresos contables netos		= _____

Sección B. Su asist. monetaria en el mes de _____

1. Necesidades básicas, _____ personas		$ _____
2. Necesidades especiales		+ _____
3. Ingresos contables netos de la Sección A		-
4. Subtotal de necesidades básicas		=
5. Asistencia máxima, _____ personas		$ _____
6. Necesidades especiales		+
7. Subtotal de asistencia máxima		=
8. **Subtotal de asist. del mes completo** (Cant. menor en el renglón 4, 7, o 14)		= _____
9. Renglón 8 prorrateado para parte del mes		= _____
10. Ajuste para cobrar el pago excesivo		- _____
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 o 9 menos el renglón 10)		= _____
12. MAP del estado anterior, _____ personas.		$ _____
13. Necesidades especiales (California)		+
14. Subtotal del estado anterior		=

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP 44-315; sección 11450 del Código de Bienestar e Instituciones (W&IC).

NOTIFICACION DE AC ON

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador(a) : _____
Número : _____
Teléfono : _____
Dirección : _____
_____
_____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el estado. Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En el reverso de esta hoja se le explica cómo hacerlo. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

Si desea una audiencia, en vez de enviar su petición a la dirección en el reverso, envíela a:

State Department of Social Services
Administrative Adjudications Division
744 P Street, M.S. 19-98
Sacramento, CA 95814

Esto acelerará el trámite de su apelación.

A partir del 1 de diciembre de 1992, un cambio en la ley estatal reduce en un 1.3 por ciento, el pago máximo de asistencia (MAP) que usted puede recibir. A causa de este cambio en la ley, se está calculando su asistencia monetaria mensual en conformidad con el nuevo MAP, el cual es más bajo, comenzando en esa fecha.

Por lo tanto, a partir del 1 de diciembre de 1992, el condado está cambiando su asistencia monetaria de $_____ a $_____.

Esto no cambia su primer cheque de asistencia monetaria para diciembre, pero su cheque para mediados del mes será menos, para que no vaya usted a recibir un pago excesivo. Si hubiéramos esperado hasta enero, usted recibiría un pago excesivo, y tendría que reembolsar el dinero.

Su cheque para mediados de diciembre se calcula de esta manera:

> Su nueva cantidad mensual de asistencia monetaria (se muestra arriba), MENOS la cantidad de su primer cheque de asistencia para el mes de diciembre, RESULTA en la cantidad de su cheque para mediados del mes.

En esta notificación se calcula su nueva cantidad de asistencia monetaria.

Si usted desea saber más acerca de este cambio en la ley estatal, o desea pedir una audiencia con el estado solamente con respecto al cambio en la ley, la manera más rápida es llamando gratuitamente al:

1-800-925-8960

TDD para los sordos:

1-800-952-8349

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP 44-315; sección 11450 del Código de Bienestar e Instituciones (W&IC).

Cantidad de la asistencia monetaria mensual

Sección A. Ingresos contables en el mes de _____

Total de ingresos ganados	$	
Deducción por gastos de trabajo	-	
Deducción de $30 y 1/3	-	
Deducción por cuidado de personas a su cargo	-	
Otros ingresos contables (enumere las fuentes)		
_____	+	
_____	+	
Mantenimiento pagado ordenado por la corte	-	
Ingresos contables netos	=	

Sección B. Su asist. monetaria en el mes de _____

1. Necesidades básicas, _____ personas	$	
2. Necesidades especiales	+	
3. Ingresos contables netos de la Sección A	-	
4. Subtotal de necesidades básicas	=	
5. Asistencia máxima, _____ personas	$	
6. Necesidades especiales	+	
7. Subtotal de asistencia máxima	=	
8. **Subtotal de asist. del mes completo** (Cant. menor en el renglón 4, 7, o 14)	=	
9. Renglón 8 prorrateado para parte del mes	=	
10. Ajuste para cobrar el pago excesivo	-	
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 o 9 menos el renglón 10)	=	
12. MAP del estado anterior, _____ personas.	$	
13. Necesidades especiales (California)	+	
14. Subtotal del estado anterior	=	

NOTIFICACION DE AC ON

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador(a) : _____
Número : _____
Teléfono : _____
Dirección : _____
_____
_____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el estado. Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En el reverso de esta hoja se le explica cómo hacerlo. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

Si desea una audiencia, en vez de enviar su petición a la dirección en el reverso, envíela a:

State Department of Social Services
Administrative Adjudications Division
744 P Street, M.S. 19-98
Sacramento, CA 95814

Esto acelerará el trámite de su apelación.

A partir del 1 de enero de 1993, el condado cambiará su asistencia monetaria de $_____ a $_____.
Se le están pagando $_____ en exceso en diciembre.

La razón es la siguiente:

A partir del 1 de diciembre de 1992, un cambio en la ley estatal redujo en un 1.3 por ciento, el Pago Máximo de Asistencia mensual (MAP) que usted puede recibir. La ley requiere este cambio en su asistencia monetaria.

En esta notificación se calcula su nueva cantidad de asistencia monetaria.

Si usted desea saber más acerca de este cambio en la ley estatal, o desea pedir una audiencia con el estado solamente con respecto al cambio en la ley, la manera más rápida es llamando gratuitamente al:

1-800-925-8960

TDD para los sordos:

1-800-952-8349

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP 44-315; sección 11450 del Código de Bienestar e Instituciones (W&IC).

Cantidad de la asistencia monetaria mensual

Sección A. Ingresos contables en el mes de _____

Total de ingresos ganados	$	
Deducción por gastos de trabajo	-	
Deducción de $30 y 1/3	-	
Deducción por cuidado de personas a su cargo	-	
Otros ingresos contables (enumere las fuentes)		
_____	+	
_____	+	
Mantenimiento pagado ordenado por la corte	-	
Ingresos contables netos	=	

Sección B. Su asist. monetaria en el mes de _____

1. Necesidades básicas, _____ personas	$	
2. Necesidades especiales	+	
3. Ingresos contables netos de la Sección A	-	
4. Subtotal de necesidades básicas	=	
5. Asistencia máxima, _____ personas	$	
6. Necesidades especiales	+	
7. Subtotal de asistencia máxima	=	
8. **Subtotal de asist. del mes completo** (Cant. menor en el renglón 4, 7, o 14)	=	
9. Renglón 8 prorrateado para parte del mes	=	
10. Ajuste para cobrar el pago excesivo	-	
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 o 9 menos el renglón 10)	=	
12. MAP del estado anterior, _____ personas.	$	
13. Necesidades especiales (California)	+	
14. Subtotal del estado anterior	=	

NOTIFICACION DE AC'ION
(Continuación)

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación: _____
Nombre del caso: _____
Número: _____

SU PAGO EXCESIVO

A causa de que en diciembre no podemos hacer el cambio requerido por la ley estatal, usted está recibiendo un pago excesivo en diciembre.

Cuando hay un pago excesivo, se reduce la asistencia mensual, hasta que se termine de reembolsar la cantidad que se debe. Cuando el pago excesivo es causado por un error del condado, tomamos menos dinero de su pago mensual de asistencia. Hemos decidido que el pago excesivo suyo fue causado por el condado.

La siguiente página muestra la manera en que calculamos la cantidad de su pago excesivo.

☐ Cobraremos este pago excesivo en una fecha posterior. Usted recibirá otra notificación antes que comencemos a cobrar.

☐ El cobro de este pago excesivo comienza en enero. Vea la siguiente página para ver la manera en que calculamos lo que tomaremos de su pago mensual de asistencia.

  ☐ Se cobrará todo su pago excesivo en enero. Si no hay otros cambios, su asistencia subirá en febrero. Usted recibirá otra notificación antes que su asistencia suba.

Si usted deja de recibir asistencia monetaria antes que reembolse su pago excesivo, el condado puede ejercitar una acción de cobranza.

Usted no tiene que utilizar beneficios del Seguro Social o de SSI que usted recibe, para reembolsar este pago excesivo.

ADVERTENCIA: Si cree que este pago excesivo está equivocado, esta es su última oportunidad de pedir una audiencia. En el reverso de la página 1, se le indica cómo hacerlo. Si sigue recibiendo asistencia, el condado puede cobrar un pago excesivo de AFDC reduciendo su pago mensual. Este puede reducir sus estampillas para comida para cobrar una emisión excesiva, a menos que sea error del condado. Si deja de recibir asistencia antes que se reembolse el pago excesivo o la emisión excesiva, el condado puede tomar lo que usted debe de su devolución de impuestos estatales sobre los ingresos.

Audiencia con el estado. Si cree que esta acción está equivocada, puede pedir una audiencia. En el reverso de la página 1 se le explica cómo hacerlo.