

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



January 29, 1996

ALL-COUNTY INFORMATION NOTICE NO. I-05-96

TO: ALL COUNTY WELFARE DIRECTORS
ALL IAR AGENCY PROGRAM CONTACTS
ALL IAR AGENCY FISCAL CONTACTS

<u>REASON FOR THIS TRANSMITTAL</u>	
<input type="checkbox"/>	State Law Change
<input checked="" type="checkbox"/>	Federal Law or Regulation Change
<input type="checkbox"/>	Court Order or Settlement Agreement
<input type="checkbox"/>	Clarification Requested by One or More Counties
<input type="checkbox"/>	Initiated by CDSS

SUBJECT: TRANSMITTAL OF NEW SSP 17 FORM FOR SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP) DRUG ADDICTS AND ALCOHOLICS (DA&A)

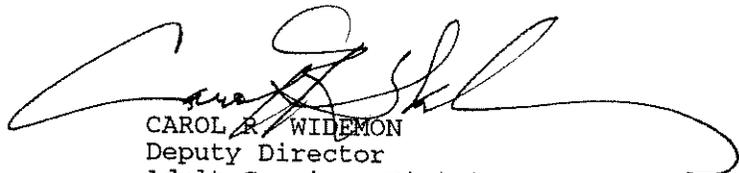
The purpose of this letter is to inform you of the new form "Notice of Action and Right to Request a State Hearing on Interim Assistance for DA&A Recipients" (Form SSP 17(DA&A)). This Interim Assistance Reimbursement (IAR) Program form must be used for all SSI/SSP recipients whose drug addiction or alcoholism is material to their disability. The development of this form was necessitated by a change in the way the Social Security Administration (SSA) processes the repayment of interim assistance provided to these recipients (see ACL 95-05). The regular Form SSP 17 is to be used for all other SSI/SSP recipients.

The SSP 17(DA&A) differs from the regular SSP 17 by informing the recipient of the IAR amount owed to the IAR agency. Additionally, it informs the recipient that SSA will forward any balance to his or her representative payee.

This form is now available from the California Department of Social Services' (CDSS) Warehouse in pads of 100. Please address supply requests as follows:

CDSS Warehouse
P.O.Box 22429
Sacramento, CA 95822
Phone: (916) 322-6250

A copy of the new form is attached for your information. Please direct any questions regarding this form to Ms. Terrie Marks, SSI/SSP Unit, at (916) 229-4041.


CAROL R. WIDEMON
Deputy Director
Adult Services Division

Attachment

**NOTICE OF ACTION AND
RIGHT TO REQUEST A STATE HEARING
ON INTERIM ASSISTANCE FOR DA&A RECIPIENTS**

<div style="border: 1px solid black; width: 40px; height: 40px; margin: 10px;"></div>	State No.: County No.: Worker No.: District: Date: Case Name: Interpreter Needed: <u> </u> <u> </u> <div style="text-align: center; font-size: small;">Language Dialect</div>
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This office was notified of your initial SSI/SSP payment in the amount of \$ _____, for the period _____ through _____. As per your agreement, we billed the Social Security Administration (SSA) in the amount of \$ _____ to repay the Interim Assistance you received for that same period while SSA completed your application for Supplemental Security Income payments. This leaves a balance owed you of \$ _____ for this period. The balance will be forwarded to your representative payee by SSA.

SSI/SSP PAYMENT

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

INTERIM ASSISTANCE PAYMENT

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

COMMENTS:

The law and/or regulations governing this action are:

Department of Social Services Eligibility Assistance Standards Manual Section (EAS) 46-337
 Public Law 103-296, Section 201(b)
 42 U.S. Code, Section 1383(g)
 20 CFR 416.1910

If you have any questions please contact me.

COUNTY/STATE REPRESENTATIVE	AGENCY	
TELEPHONE	DATE:	

