

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



August 6, 1998

ALL COUNTY INFORMATION NOTICE I-44-98

TO: ALL COUNTY WELFARE DIRECTOR S
ALL CalWORKS PROGRAM SPECIALIST S

REASON FOR THIS TRANSMITTAL

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

SUBJECT: PAOLI V. ANDERSON IMPLEMENTATION MATERIALS

REFERENCE: ALL COUNTY LETTER NOS. 97-59, 97-63, 98-18 AND 98-55

The purpose of this All County Information Notice is to transmit the remaining implementation materials for th Paoli v. Anderson court case. Attached to this letter are:

Claim form (Temp 2159)

Poster (Temp 2158A MULTILINGUAL)

Notices of Action to approve a claim, to approve a claim with interest, to deny a claim, and to request additional information

Reporting document (GEN 1172)

Interest Rate Multiplier Chart

A claim form in English and a separate form in Spanish were provided with ACL 98-55. The Paoli court order requires that CDSS make the claim form available in English, Spanish, Cambodian, Chinese, Russian and Vietnamese. The attached claim form includes all of these languages on a single form for your convenience. You may use the claim forms previously provided or the attached claim form, and both are to be accepted from claimants.

The attached poster (Temp 2158A MULTILINGUAL) must be prominently displayed during the claims period from August 15, 1998 through November 30, 1998. The attached reporting document (GEN 1172) must be submitted no later than March 10, 1999.

Use the attached interest rate multiplier chart to calculate any interest due on corrective underpayments. Interest is to be paid only to claimants who are **not** receiving CalWORKs cash aid at the time any corrective underpayment is made. To use the multiplier chart, match the retroactive month to the payment month to determine the multiplier percentage. Then, multiply the amount of the corrective underpayment for the retroactive month by the multiplier percentage on the chart to get the amount of interest for that retroactive month. Do the same interest calculation for each month of retroactive eligibility.

As previously noted in ACL 98-18, the Paoli court order covers overpayments for lump sum periods of ineligibility after October 1996, including those caused by aid paid pending and by failure to report a lump sum. Counties are to follow the instructions in ACL 98-55 to recompute benefits for a previous period of ineligibility after October 1996.

The Paoli court order requires that the dollar amount of the corrective underpayments made and the interest paid be reported. Detailed instructions on this reporting will follow shortly in a County Fiscal Letter.

Pursuant to MPP 63-502.2(j), for purposes of determining eligibility for food stamp benefits, these retroactive payments are excluded as income, but counted as a resource in the month received. If you have any questions regarding food stamp benefits, please contact Mr. Ernie Villalobos at (916) 657-1680.

If you have any questions about the Paoli court case, please call Mr. Vincent Toolan at (916) 654-1808.

Sincerely,
Original Document Signed By
Maria Hernandez for Charr Lee Metsker on 8/6/98
CHARR LEE METSKER, Chief
Employment and Eligibility Branch

Attachments

c: CWDA
CSAC

PAOLI V. ANDERSON LUMP SUM COURT CASE CLAIM FORM

Provide all the information you can. If you don't have all the information, fill in what you can.

NAME			SOCIAL SECURITY NUMBER — —	
ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER (IF ANY)		CASE NUMBER IF KNOWN		DATE OF BIRTH
LUMP SUM AMOUNT \$	DATE YOU RECEIVED THE LUMP SUM	DATES OF PERIOD OF INELIGIBILITY	COUNTY WHERE YOU WERE LIVING WHEN YOU RECEIVED THE LUMP SUM	

Complete as much as you can and return this claim form to:

Interest will be paid only to claimants who are not receiving CalWORKs cash aid when the underpayment is issued.

CLAIM FORMS MUST BE SUBMITTED BY NOVEMBER 30, 1998.

TEMP 2159 (8/98)

FORMULARIO DE RECLAMACION PARA EL CASO PAOLI VS. ANDERSON – PAGOS GLOBALES

Dé toda la información que pueda. Si no tiene toda la información, complete lo que pueda.

NOMBRE			NUMERO DEL SEGURO SOCIAL — —	
DIRECCION		CIUDAD	ESTADO	ZONA POSTAL
Nº DE TELEFONO (SI ES QUE TIENE TELEFONO)		NUMERO DEL CASO SI ES QUE LO SABE		FECHA DE NACIMIENTO
CANTIDAD DEL PAGO GLOBAL \$	FECHA EN QUE RECIBIO EL PAGO GLOBAL	FECHAS DEL PERIODO EN QUE NO FUE ELEGIBLE	CONDADO DONDE VIVIA CUANDO RECIBIO EL PAGO GLOBAL	

Conteste todas las preguntas que pueda y devuelva este formulario de reclamación a:

Sólo se le pagará interés a los reclamantes que no estén recibiendo asistencia monetaria de CalWORKs* cuando se emita el ajuste por el pago insuficiente.

LOS FORMULARIOS DE RECLAMACION SE TIENEN QUE ENTREGAR A MAS TARDAR EL 30 DE NOVIEMBRE DE 1998.

*Programa de California de Oportunidades de Trabajo y Responsabilidad hacia los Niños

TEMP 2159 (SP) (8/98)

PAOLI 對 ANDERSON 一次總付款法庭案件申領表格
請提供所有你能提供的資料。假如你沒有所有的資料，請填寫你能夠填寫的。

姓名			社會保險號碼 — —	
地址		市	州	郵遞區號
電話號碼 (假如有的話)		案件號碼, 假如知道的話		出生日期
一次總付款金額 \$	你收到一次總付款的日期	合格期的日期	在你收到一次總付款時你所居住的郡	

請盡可能多地填寫並且把這份申領表格寄回至：

利息將只付給頒發不足付款時不領取加州工作機會和向孩子負責任計劃 (CalWORKs) 現金補助的請求人。

申領表格必須在 **1998年十一月30日** 以前呈交。

TEMP 2159 (CH) (8/98)

សំណើវិធានការណែនាំសេវាសង្គមចំពោះប្រាក់ចំណូលទាបដ៏ PAOLI ប្រឆាំងនឹង ANDERSON
សូមផ្តល់ព័ត៌មានទាំងអស់តាមតែលទ្ធភាពរបស់លោកអ្នក ។ បើសិនជាលោកអ្នកមិនមានព័ត៌មានទាំងអស់ទេ សូមបំពេញតាមតែលោកអ្នកអាចធ្វើបាន ។

Form with fields: ឈ្មោះ, លេខសន្តិច័យសង្គ្រោះ, កាលបរិច្ឆេទ, ក្រុង, រដ្ឋ, លេខហ្សែបកូដ, លេខទូរស័ព្ទ(បើសិនជាមាន), លេខសំណុំរឿងបើសិនជាបានដឹង, កាលបរិច្ឆេទកើត, ចំនួនប្រាក់ចំណូលទាបដ៏, កាលបរិច្ឆេទដែលលោកអ្នកបានទទួលប្រាក់ចំណូលទាបដ៏, កាលបរិច្ឆេទនៃកំឡុងពេលដែលមិនមានសិទ្ធិទទួល, ខណ្ឌដែលលោកអ្នកបានរស់នៅ នៅពេលដែលលោកអ្នកបានទទួលប្រាក់ចំណូលទាបដ៏

សូមបំពេញសំណើនេះទៅតាមលទ្ធភាពរបស់លោកអ្នក ហើយនិងផ្ញើសំណើទាមទារនេះទៅ :

គេនឹងបង់ការប្រាក់ទៅឱ្យអ្នកតាមការណែនាំដែលមិនទទួលបានប្រាក់ជំនួយនៃកម្មវិធីជួយឱ្យធ្វើការនិងទទួលខុសត្រូវចំពោះកូននៃរដ្ឋកាលីហ្វ័រនីញ៉ា (California Work Opportunity and Responsibility to Kids ឬ CalWORKs) នៅពេលដែលគេបង់ប្រាក់ដែលមិនបានផ្តល់ឱ្យគ្រប់ចំនួនធម្មតា ។

ពាក្យទាមទារត្រូវតែដាក់ស្នើមកដោយមិនឱ្យយឺតជាងថ្ងៃទី៣០ ខែវិច្ឆិកា ឆ្នាំ១៩៩៨ ។

TEMP 2159 (CB) (8/98)

АНКЕТА ТРЕБОВАНИЯ ВЫПЛАТЫ ДЕНЕЖНОЙ ПОМОЩИ ИЗ-ЗА РЕШЕНИЯ СУДА ПАОЛИ ПРОТИВ АНДЕРСОН
Предоставьте всю информацию, которую Вы можете. Если у Вас нет всей информации, заполните, что можете.

Form with fields: ИМЯ, НОМЕР СОЦИАЛЬНОГО СТРАХОВАНИЯ, АДРЕС, ГОРОД, ШТАТ, ПОЧТОВЫЙ ИНДЕКС, НОМЕР ТЕЛЕФОНА (ЕСЛИ ЕСТЬ), НОМЕР ДЕЛА, ЕСЛИ ЗНАЕТЕ, ДАТА РОЖДЕНИЯ, ЕДИНОВРЕМЕННО ВЫПЛАЧЕННАЯ СУММА, ДАТА, КОГДА ВЫ ПОЛУЧИЛИ ЕДИНОВРЕМЕННО ВЫПЛАЧЕННУЮ СУММУ, ДАТЫ ПЕРИОДОВ, КОГДА ВЫ НЕ ИМЕЛИ ПРАВО НА ПОМОЩЬ, ОКРУГ, ГДЕ ВЫ ЖИЛИ, КОГДА ПОЛУЧИЛИ ЕДИНОВРЕМЕННО ВЫПЛАЧЕННУЮ СУММУ

Заполните все, что можете и верните эту анкету:

Проценты будут уплачены только требующим, которые не получают денежную помощь по программе CalWORKs* во время выплаты недоплаченной суммы.
* - Программа возможности трудоустройства и ответственности перед детьми в Калифорнии.

АНКЕТЫ ТРЕБОВАНИЙ ДОЛЖНЫ БЫТЬ СДАНЫ ДО 30 НОЯБРЯ 1998 ГОДА.

TEMP 2159 (RS) (8/98)

MẪU ĐƠN XIN TRUY LÃNH TRỢ CẤP THEO TÌNH THẦN VỤ PAOLI KIẾN ANDERSON VÌ SỐ TIỀN NHẬN TRỌN MỘT LẦN
Xin quý vị kê khai thật đầy đủ các dữ kiện. Nếu quý vị không biết tất cả các dữ kiện, hãy điền những gì quý vị biết.

Form with fields: TÊN HỌ, SỐ AN SINH XÃ HỘI, ĐỊA CHỈ, THÀNH PHỐ, TIỂU BANG, SỐ KHU VỰC BƯU ĐIỆN, SỐ ĐIỆN THOẠI (NẾU CÓ), SỐ HỒ SƠ NẾU BIẾT, NGÀY SINH, SỐ TIỀN NHẬN TRỌN MỘT LẦN, NGÀY LÃNH SỐ TIỀN NHẬN TRỌN MỘT LẦN, CÁC NGÀY CỦA KHOẢNG THỜI GIAN KHÔNG HỘI ĐÚ ĐIỀU KIỆN, TÊN HAT NƠI QUÝ VỊ ĐÃ SINH SỐNG KHI QUÝ VỊ LÃNH SỐ TIỀN NHẬN TRỌN MỘT LẦN

Xin cố gắng điền thật đầy đủ và gửi hoàn mẫu đơn xin truy lãnh này cho:

Tiền lời sẽ chỉ được trả cho những người xin truy lãnh trợ cấp nào không có hưởng trợ cấp tiền mặt của chương trình CalWORKs (chương trình của California tạo cơ hội về việc làm và trách nhiệm đối với con em) vào lúc cấp trả phần cấp thiếu.

CÁC ĐƠN XIN TRUY LÃNH PHẢI ĐƯỢC NỘP VÀO HAY TRƯỚC NGÀY 30 THÁNG 11 NĂM 1998.

TEMP 2159 (VN) (8/98)

WELFARE MAY OWE YOU MONEY

Did you get cash from a lawsuit settlement, a worker's comp award, an inheritance or some other source?

- The AFDC lump sum rule has ended. Under the Paoli lawsuit, if you were ineligible for cash aid any time after October 1996 because you got a lump sum (from a lawsuit settlement, worker's compensation award, inheritance or other source), welfare might owe you back cash aid, even if you got the lump sum before October 1996. You might also be eligible for back benefits if you had an overpayment caused by ineligibility for cash aid any time after October 1996 because of a lump sum.
- To claim back benefits, you must submit a simple claim form giving your name and whatever information you have about the lump sum. You can get a claim form at the welfare office or by calling toll-free 1-800-952-5253.

ALL CLAIM FORMS FOR BACK CASH AID MUST BE TURNED IN BY NOVEMBER 30, 1998.

ES POSIBLE QUE LA ASISTENCIA PUBLICA (*WELFARE*) LE DEBA DINERO

¿Recibió usted dinero proveniente del arreglo de una demanda, una compensación por lesiones de trabajo, una herencia o de alguna otra fuente?

- Se terminó la regla de AFDC (Asistencia para Familias con Niños Necesitados) en relación a las cantidades globales (*lump sum*). De acuerdo a la demanda conocida en inglés como “*Paoli lawsuit*”, si usted no era elegible para recibir asistencia monetaria en cualquier momento después de octubre de 1996 debido a que usted recibió una cantidad global (proveniente del arreglo de una demanda, una compensación por lesiones de trabajo, una herencia o de alguna otra fuente), es posible que la asistencia pública le deba asistencia monetaria retroactiva, aun si usted recibió la cantidad global antes de octubre de 1996. Es posible que también sea elegible para recibir beneficios retroactivos si es que, debido a una cantidad global, usted recibió un pago excesivo el cual sucedió debido a su inelegibilidad para recibir asistencia monetaria después de octubre de 1996.
- Para solicitar beneficios retroactivos, usted tiene que presentar un reclamo simple en el cual dé su nombre y cualquier información que tenga acerca de la cantidad global. Usted puede obtener un formulario de reclamo en la oficina de bienestar público o puede obtenerlo llamando al número de teléfono gratuito 1-800-952-5253.

TODOS LOS RECLAMOS PARA ASISTENCIA MONETARIA RETROACTIVA SE TIENEN QUE ENTREGAR A MAS TARDAR EL 30 DE NOVIEMBRE DE 1998.

- 假如你不瞭解此通知的內容，請和你的工作人員聯絡。
- បើសិនជាលោកអ្នកមិនយល់សេចក្តីប្រកាសនេះទេ សូមជួបទាក់ទងជាមួយអ្នកកាន់សំណុំរឿងរបស់លោកអ្នក ។
- Если Вы не понимаете смысл этого извещения, пожалуйста, обратитесь к Вашему работнику.
- Nếu quý vị không hiểu nội dung thông báo này, xin liên lạc với nhân viên phụ trách hồ sơ của quý vị.

POST FROM AUGUST 15, 1998 THROUGH NOVEMBER 30, 1998.

COURT CASE STATISTICAL REPORT

SEND ONE COPY TO:

California Department of Social Services
 Data Operations Branch, Reports Unit, MS 19-81
 P.O. Box 944243
 Sacramento, CA 94244-2430
 (916) 322-9819

PAOLI V. ANDERSON

NAME OF COUNTY SUBMITTING REPORT	THIS REPORT IS DUE ON OR BEFORE: 3/10/99
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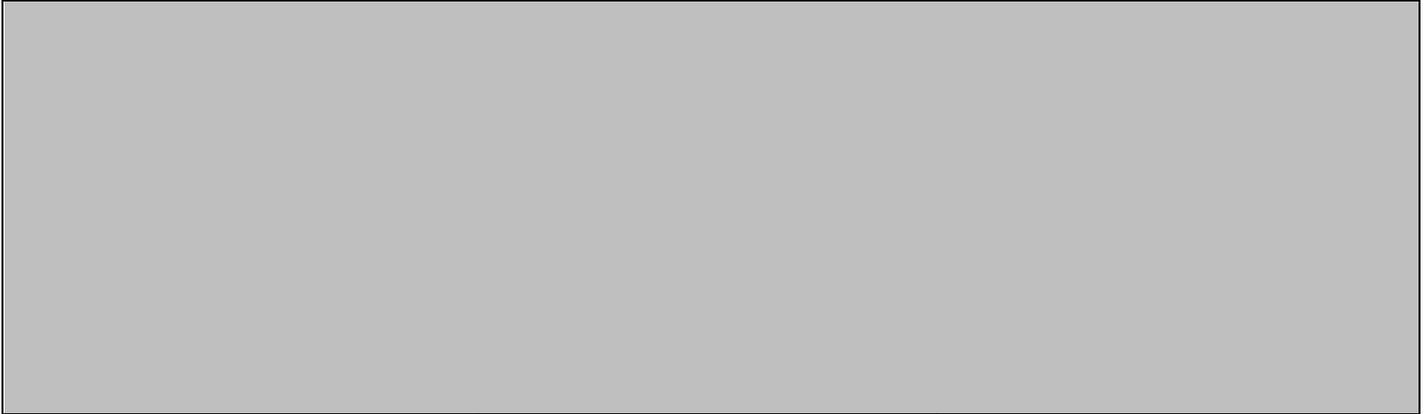
THIS REPORT IS:

ORIGINAL SUBMISSION
 REVISED SUBMISSION

REPORTING PERIOD: **8/15/98** TO **2/28/99**

1. Total number of claims for retroactive benefits, under Paoli v. Anderson, received from 8/15/98 through 11/30/98. (Must equal the total of items 2 and 3 below)	1
2. Total number of claims in item 1 (above) which were granted	2
3. Total number of claims in item 1 (above) which were denied. (Must equal the total of items 3A. and 3B. below)	3
A. Total number of claims denied for failure to submit necessary additional information	4
B. Total number of claims denied for other reasons	5

TO BE USED ONLY UPON INSTRUCTIONS FROM THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES



PERSON TO CONTACT REGARDING THIS REPORT	TELEPHONE NUMBER	DATE
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Interest Rate Multiplier Chart

PAYMENT MONTH

	8/98	9/98	10/98	11/98	12/98	1/99	2/99
11/96	.1225	.1283	.1341	.1349	.1458	.1518	.1574
12/96	.1166	.1225	.1283	.1341	.1349	.1458	.1518
1/97	.1108	.1166	.1225	.1283	.1341	.1349	.1458
2/97	.1049	.1108	.1166	.1225	.1283	.1341	.1349
3/97	.0992	.1049	.1108	.1166	.1225	.1283	.1341
4/97	.0933	.0992	.1049	.1108	.1166	.1225	.1283
5/97	.0875	.0933	.0992	.1049	.1108	.1166	.1225
6/97	.0817	.0875	.0933	.0992	.1049	.1108	.1166
7/97	.0758	.0817	.0875	.0933	.0992	.1049	.1108
8/97	.0699	.0758	.0817	.0875	.0933	.0992	.1049
9/97	.0641	.0699	.0758	.0817	.0875	.0933	.0992
10/97	.0583	.0641	.0699	.0758	.0817	.0875	.0933
11/97	.0525	.0583	.0641	.0699	.0758	.0817	.0875

RETROACTIVE MONTH

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 back cash aid of \$ _____.

HERE'S WHY:

A court says that we should have counted a lump sum you received like other kinds of income. You will not receive interest on the back cash aid because you are currently being aided.

Your back cash aid is figured on the next page.

- A check will be sent soon.
- A check is enclosed.

If you get Food Stamps we will count your back cash aid as a resource.

- You may get another notice from Food Stamps.

Rules: These rules apply. You may review them at your welfare office: Paoli v Anderson

YOUR HEARING RIGHTS

To Ask For a State Hearing

- You only have 90 days to ask for a hearing. The 90 days started the day after we gave or mailed you this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- Your CalWORKs Child Care benefits will **not** stay the same until your hearing.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

- Cash Aid Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child and/or Medical Support: The District Attorney's office will help you collect support even if you are not on cash aid. There is no cost for this help. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

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

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950).

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send or take this page to:

Your worker will get you a copy of this page if you ask. Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call: 1-800-952-8349.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my

- Cash Aid Food Stamps Medi-Cal Child Care
 Other (list) _____

Here's why: _____

- Check here and add a page if you need more space.
- I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

NAME _____

ADDRESS _____

- I need a free interpreter.
 My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My case number: _____

My signature: _____

Date: _____

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

(Continued)

Underpayment Amount Owed
(For Underpayments Occurring From 11/1/96 and before 1/1/98)

Notice Date : _____
Case Name : _____
Number : _____

Underpayment Month and Year:

(A) Family Gross Income	_____	_____	_____	_____	_____
_____	\$	_____	_____	_____	_____
_____	+	_____	_____	_____	_____
Total Gross Income (1)	=	=====	=====	=====	=====
Basic Need for _____ Persons	\$	_____	_____	_____	_____
Special Needs	+	_____	_____	_____	_____
Total Needs	=	=====	=====	=====	=====
	X	1.85	_____	_____	_____
185% of Needs (2)	=	=====	=====	=====	=====

If (1) is larger than (2) you were not eligible in that month, so no underpayment occurred.

(B) Net Countable Income					
Total Earned Income	\$	_____	_____	_____	_____
Work Expense Disregard	-	_____	_____	_____	_____
\$30 and 1/3 Disregard (Assistance Unit only)	-	_____	_____	_____	_____
Subtotal	=	=====	=====	=====	=====
Dependent Care Disregard (Assistance Unit only)	-	_____	_____	_____	_____
Other Countable Income (List Sources)	+	_____	_____	_____	_____
_____	+	_____	_____	_____	_____
Court Ordered Child/Spousal Support Paid for Persons Not Living in the Home	-	_____	_____	_____	_____
Support Paid to Other(s) Not Living in the Home Claimed as Federal Tax Dependent (Non-Assistance Unit Only)	-	_____	_____	_____	_____
Net Countable Income	=	=====	=====	=====	=====

(C) Correct Cash Aid Payment					
Basic Need Amount (# persons)	\$ ()	()	()	()	()
Special Needs	+	_____	_____	_____	_____
Net Countable Income	-	_____	_____	_____	_____
Subtotal A	=	=====	=====	=====	=====
Maximum Aid Payment (MAP)	\$	_____	_____	_____	_____
Special Needs	+	_____	_____	_____	_____
Subtotal B	=	=====	=====	=====	=====
Correct Cash Aid Amount (Lesser of Subtotal A or B)	\$	_____	_____	_____	_____

(D) Underpayment					
Correct Cash Aid Amount	\$	_____	_____	_____	_____
Cash Aid Paid to You	-	_____	_____	_____	_____
Underpayment	=	=====	=====	=====	=====

TOTAL UNDERPAYMENT (All Months) \$ _____

Rules: These rules apply; you may review them at your Welfare Office: PAOLI v. ANDERSON
State Hearing: If you think this action is wrong, you can ask for a hearing. The back of Page 1 tells how.

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

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Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

As of _____, the county has approved your back cash aid of \$_____, plus interest in the amount of \$_____, for a total amount of \$_____.

HERE'S WHY:

A court says that we should have counted a lump sum you received like other kinds of income.

Your back cash aid is figured on the next page.

- A check will be sent soon.
- A check is enclosed.

If you get Food Stamps we will count your back cash aid as a resource.

- You may get another notice from Food Stamps.

Rules: These rules apply. You may review them at your welfare office: Paoli v Anderson

YOUR HEARING RIGHTS

To Ask For a State Hearing

- You only have 90 days to ask for a hearing. The 90 days started the day after we gave or mailed you this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- Your CalWORKs Child Care benefits will **not** stay the same until your hearing.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

- Cash Aid Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child and/or Medical Support: The District Attorney's office will help you collect support even if you are not on cash aid. There is no cost for this help. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

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

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950).

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send or take this page to:

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HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my

- Cash Aid Food Stamps Medi-Cal Child Care
 Other (list) _____

Here's why: _____

- Check here and add a page if you need more space.
- I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

NAME _____

ADDRESS _____

I need a free interpreter.
My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My case number: _____

My signature: _____

Date: _____

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

(Continued)

Underpayment Amount Owed
(For Underpayments Occurring From 11/1/96 and before 1/1/98)

Notice Date : _____
Case Name : _____
Number : _____

Underpayment Month and Year: _____

(A) Family Gross Income

_____	\$	_____	_____	_____	_____	_____
_____	+	_____	_____	_____	_____	_____
Total Gross Income (1)	=	=====	=====	=====	=====	=====
Basic Need for _____ Persons	\$	_____	_____	_____	_____	_____
Special Needs	+	_____	_____	_____	_____	_____
Total Needs	=	_____	_____	_____	_____	_____
	X	1.85	_____	_____	_____	_____
185% of Needs (2)	=	=====	=====	=====	=====	=====

If (1) is larger than (2), you were not eligible in that month so no underpayment occurred.

(B) Net Countable Income

Total Earned Income	\$	_____	_____	_____	_____	_____
Work Expense Disregard	-	_____	_____	_____	_____	_____
\$30 and 1/3 Disregard (Assistance Unit only)	-	_____	_____	_____	_____	_____
Subtotal	=	=====	=====	=====	=====	=====
Dependent Care Disregard (Assistance Unit only)	-	_____	_____	_____	_____	_____
Other Countable Income (List Sources)	+	_____	_____	_____	_____	_____
_____	+	_____	_____	_____	_____	_____
Court Ordered Child/Spousal Support Paid for Persons Not Living in the Home	-	_____	_____	_____	_____	_____
Support Paid to Other(s) Not Living in the Home Claimed as Federal Tax Dependent (Non-Assistance Unit Only)	-	_____	_____	_____	_____	_____
Net Countable Income	=	=====	=====	=====	=====	=====

(C) Correct Cash Aid Payment

Basic Need Amount (# persons)	\$	()	()	()	()	()
Special Needs	+	_____	_____	_____	_____	_____
Net Countable Income	-	_____	_____	_____	_____	_____
Subtotal A	=	=====	=====	=====	=====	=====
Maximum Aid Payment (MAP)	\$	_____	_____	_____	_____	_____
Special Needs	+	_____	_____	_____	_____	_____
Subtotal B	=	=====	=====	=====	=====	=====
Correct Cash Aid Amount (Lesser of Subtotal A or B)	\$	_____	_____	_____	_____	_____

(D) Underpayment

Correct Cash Aid Amount	\$	_____	_____	_____	_____	_____
Cash Aid Paid to You	-	_____	_____	_____	_____	_____
Underpayment	=	=====	=====	=====	=====	=====
Interest Rate Multiplier	x	_____	_____	_____	_____	_____
Interest	=	=====	=====	=====	=====	=====

(E) Retroactive Benefits

Underpayment	Subtotal C	\$	_____	_____	_____	_____
Interest	Subtotal D	+	_____	_____	_____	_____
Total Retroactive Benefits	=	=====	=====	=====	=====	=====

Total Underpayment (Subtotal C-All Months) \$ _____
 Total Interest (Subtotal D-All Months) + _____
TOTAL RETROACTIVE BENEFITS (All Months) \$ _____

Rules: These rules apply; you may review them at your Welfare Office: PAOLI v. ANDERSON

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

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

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Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

We have denied your claim for back cash aid for the month(s) of _____ dated _____.

HERE'S WHY:

- You did not give us your claim by November 30, 1998.
- You did not return a completed claim form by _____.
- Your cash aid was not stopped, changed, or denied because you got a lump sum in this county.
- You did not send the information we requested by _____.
- You must file your request for back cash aid with the county where you applied for or got cash aid between November 1996 and November 1997.
- We have sent your claim to _____ county. You will get another notice from them.
- Your total countable property in the month(s) of _____, was more than the property limit of _____.
- Other:

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply. You may review them at your welfare office: Paoli v Anderson

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My name: _____

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Phone: _____

My case number: _____

My signature: _____

Date: _____

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DEPARTMENT OF SOCIAL SERVICES

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

(ADDRESSEE)

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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.

The county needs more facts on your PAOLI v ANDERSON claim dated _____.

- Fill in the circled parts of the attached claim form.
- You must send or bring the completed form back to us by _____.
- Other: _____

If we do not have it by this date, your claim will be denied and you will not get back cash aid.

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