

DEPARTMENT OF BENEFIT PAYMENTS
744 P Street, Sacramento, CA 95814



February 17, 1976

ALL-COUNTY LETTER NO. 76-29

TO: ALL COUNTY WELFARE DIRECTORS
WELFARE FISCAL SUPERVISORS
COUNTY AUDITORS
ADMINISTRATIVE SERVICES OFFICERS

SUBJECT: INDO-CHINESE REFUGEE ASSISTANCE CLAIMS
CUBAN REFUGEE CLAIMS
REPATRIATED AMERICAN CLAIMS

Form AA 412, Expenditure Statement for the Indo-Chinese Refugee Assistance Program (attached), has been revised for simplification and clarification. Only the Summary Form has been revised. The Aid Payroll (Contra Roll) remains unchanged. Revisions are as follows:

1. Line D, Number of Persons, has been eliminated as Line D, Number of Cases, accurately represents this figure.
2. The requirement for Number of Cases under Line E, Expenditures, has been entirely eliminated as the necessary statistical information is contained in Lines A through D.
3. Under Line E, Expenditures, the request for assistance costs information for Family Cases and for One-Person Cases has been transferred from Lines 1. a. and 1. b. to Lines 5, 6 and 7. This clarifies that the information required is the net assistance costs for the two different types of cases.

Please destroy all previous AA 412 forms when you receive a supply of the revised forms which will be sent to you under separate cover.

Indo-Chinese Refugee, Cuban Refugee, and Repatriated American payrolls may now be submitted on microfiche, as the audit function has been transferred to the Claims Audit and Control Bureau. Beginning with the month of February, please mail these claims to:

Department of Benefit Payments
Claims Audit and Control Bureau
744 P Street, M.S. 19-14
Sacramento, California 95814

If there are any questions, please contact Gen Whitfield or Vicki Smith
at 916/445-7046.

Sincerely,

Kyle S. McKinsey
GARY G. ADAMS *for* 
Deputy Director

cc: CWDA

Attachment

SUBMIT IN DUPLICATE TO:

DEPARTMENT OF BENEFIT PAYMENTS
 CLAIMS AUDIT AND CONTROL BUREAU
 744 P STREET, M.S. 19-14
 SACRAMENTO, CALIFORNIA 95814

**INDOCHINESE REFUGEE ASSISTANCE EXPENDITURE
 STATEMENT AND CLAIM FOR REIMBURSEMENT**

COUNTY
MONTH _____, 19____

	<u>NUMBER OF CASES</u>	<u>NUMBER OF PERSONS</u>
A. Cases receiving financial assistance for the first time	_____	_____
B. Cases discontinued during the month	_____	_____
C. Family cases receiving assistance during the month	_____	_____
D. One person cases receiving assistance during the month	_____	_____

	<u>AMOUNT</u>
E. Expenditures	
1. Assistance Costs	\$ _____
2. Less deductions from Expenditures:	
a. Abatements and repayments received during the month	(_____)
b. Warrants cancelled during the month	(_____)
3. Adjustments (show minus items in parentheses)	
Current FY	_____
Prior FY	_____
4. TOTAL	<u>\$ _____</u>
5. Net Assistance Costs for Family Cases	\$ _____
6. Net Assistance Costs for One Person Cases	\$ _____
7. Total Net Assistance Costs (balance to Line E.4.)	<u>\$ _____</u>

CERTIFICATION

This is to certify that the above information is correct to the best of my knowledge and belief; and that payment for these expenditures has not been received. Records and accounts in support of this claim are available for review and audit.

SIGNATURE OF AGENCY OFFICIAL	TITLE	DATE
_____	_____	_____, 19____