STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 324-4184

January 23, 1991

ALL COUNTY LETTER NO. 91-03

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: SPECIAL CIRCUMSTANCES ALLOWANCE PROGRAM

This letter is to provide direction to county welfare departments when the Special Circumstances Allowance (SCA) benefit funds allocation is depleted.

Although funds for the program may be depleted, state statutes at Welfare and Institutions Code Section 12550 continue to mandate the SCA Program. Therefore, counties must continue to accept applications for benefits. The applicant shall be provided a Notice of Intended Action (SSP 4B) denying benefits due to the unavailability of funds. The Notice of Action allows the applicant the opportunity to request a fair hearing. It is not necessary to further establish an applicant's eligibility when allocated benefit funds have been depleted. Attached is a sample SSP 4B which provides language for Section "B" Other. Also, at the bottom of the form, add the following laws which require the action taken: Chapter 467, Statutes of 1990; and Welfare and Institutions Code Section 12601.

Applications should be kept on file and retained according to current records retention requirements (MPP 23-355).

If you should have questions regarding the administrative allocation, please contact the County Administrative Expense Control Bureau at (916) 322-5802. Questions regarding program or the benefit allocation should be directed to the Adult Program Management Bureau at (916) 324-4184.

ROBERT A. HOREL
Deputy Director

Attachment

cc: CWDA

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

NOTICE OF INTENDED ACTION AND RIGHT TO REQUEST A STATE HEARING ON YOUR APPLICATION FOR A SPECIAL CIRCUMSTANCES ALLOWANCE

COUNTY STAMP

SAMPLE

DATE: _____

CASE NAME: _____

SSN NO.: _____

CASE NO.: _____

COUNTY NO.: _____

DISTRICT: _____

WORKER NO.: _____

YOUR APPLICATION FOR A SPECIAL CIRCUMSTANCES ALLOWANCE HAS BEEN:

☐ **APPROVED** *SEE SECTION "A" BELOW* ☐ **DENIED** *SEE SECTION "B" BELOW*

SECTION "A" APPROVAL FOR SPECIAL CIRCUMSTANCES ALLOWANCE

YOU HAVE BEEN APPROVED FOR THE FOLLOWING SPECIAL CIRCUMSTANCES ALLOWANCE ITEMS:

_____

_____

YOU WILL BE REQUIRED TO USE THE FOLLOWING RESOURCES TO PAY PART OF THIS COST:

RESOURCE: _____ AMOUNT: $ _____

$ _____

TOTAL LIQUID RESOURCES $ _____

YOUR SHARE OF TOTAL RESOURCES $ _____

MINUS EXEMPT RESOURCES ($)

RESOURCES YOU MUST USE TO PAY PART OF COST $ _____

TOTAL ESTIMATED COST $ _____

YOUR SHARE OF ESTIMATED COST $ _____

MINUS RESOURCES YOU MUST USE ($)

REMAINING ESTIMATED COST $ _____

ESTIMATED MAXIMUM ALLOWANCE $ _____

THE FINAL AMOUNT PAID MAY BE LESS THAN THIS IF THE ACTUAL COST IS LESS THAN ESTIMATED

AFTER YOU HAVE RECEIVED THESE SERVICES OR ITEMS, PLEASE BRING OR MAIL THIS FORM IMMEDIATELY, TOGETHER WITH ALL OF THE BILLS, CONTRACTS, ETC., TO THIS OFFICE SO THAT PAYMENT CAN BE MADE. PAYMENT MAY BE MADE TO YOU OR TO THE SUPPLIER.

SECTION "B" REASONS FOR DENIAL

YOUR APPLICATION FOR A SPECIAL CIRCUMSTANCES ALLOWANCE HAS BEEN DENIED BECAUSE:

☐ YOU HAVE LIQUID RESOURCES IN THE AMOUNT OF $_____. SINCE THIS AMOUNT IS MORE THAN YOUR SHARE OF THE ESTIMATED COST OF THE SPECIAL CIRCUMSTANCES ITEM, YOU ARE NOT ELIGIBLE FOR AN ALLOWANCE.

☒ OTHER: The funding under the FY 1990/91 Budget Act for this program is no longer available.

THIS ACTION IS REQUIRED BY THE FOLLOWING LAWS AND/OR REGULATIONS:
STATE DEPARTMENT OF SOCIAL SERVICES, MANUAL OF POLICIES AND PROCEDURES, SECTION 46–425; Chapter 467, Statutes of 1990; and Welfare and Institutions Code Section 12601.
PLEASE CONTACT ME IF YOU HAVE ANY QUESTIONS ON THIS MATTER.

ELIGIBILITY WORKER	TELEPHONE

IF YOU BELIEVE THIS ACTION IS WRONG, YOU MAY ASK FOR A STATE HEARING (SEE REVERSE)

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

TDD (800) 952-8349* For Deaf Only

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response. If you arrange for a representative before the hearing, your respresentative will be sent duplicate copies of information related to the hearing. The bottom portion of this form, Statement of Authorization, may be used to appoint a representative, or you may prepare a separate written statement authorizing someone to act on your behalf. You may also call our toll-free number to provide this information.

Request for a State Hearing

NAME _____ PHONE NUMBER ( )

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

I am requesting a state hearing because of an action by the welfare department of _____ county regarding the receipt of a special circumstances allowance. The reasons for my request are as follows: _____

I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

LANGUAGE _____ DIALECT _____

SIGNATURE _____ DATE _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department and the U.S. Department of Health and Human Services. Authority: W&IC 10950.

STATEMENT OF AUTHORIZATION

The following person has agreed to help me with my hearing: _____ NAME OF AUTHORIZED REPRESENTATIVE

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ PHONE NUMBER _____

I authorize your office to release any or all information concerning my hearing to him/her.

SIGNED: _____ APPLICANT OR RECIPIENT

SIGNED: _____ AUTHORIZED REPRESENTATIVE

SAMPLE

SSP 4 (Back)