STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

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

June 2, 1994

ALL-COUNTY LETTER NO. 94-44

TO: ALL COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

SUBJECT: REVISED SAWS 1, APPLICATION FOR CASH AID, FOOD STAMPS, AND MEDI-CAL; AND REVISED NOTICES OF ACTION

REFERENCE: ALL COUNTY LETTER (ACL) NO. 94-28; ALL COUNTY WELFARE DIRECTORS LETTER (ACWDL) NO. 93-78; MEDICAL ELIGIBILITY MANUAL (MEM) LETTER NO. 122

HANDBOOK: THIS LETTER CONTAINS INFORMATION UPDATING THE AFDC NOTICE OF ACTION HANDBOOK

The purpose of this letter is to transmit copies of a revised SAWS 1 (4/94), Application for Cash Aid, Food Stamps, and Medi-Cal; and revised Notice of Action (NOA) forms for the NA 200 (4/94), NA 290 (4/94), NA 960X (4/94), and NA 960Y (4/94). This letter also provides information about the changes to, and implementation instructions for, these forms including new Medi-Cal messages for all Aid to Families with Dependent Children (AFDC) NA Notice of Action forms.

SAWS 1 (ATTACHMENT 1)

This attachment provides a description of the changes to the form and implementation instructions. Changes include language simplification; reorganization of text and reformatting of form structure; and the addition of information about the California Alternative Assistance Program (CAAP), Medi-Cal Presumptive Eligiblity for Pregnant Women (PE), Medi-Cal Only cases, and Food Stamp Rules.

REVISED NOTICES OF ACTION (ATTACHMENT 2)

This attachment provides copies of, and instructions for the revised NA 200, NA 290, NA 960X, and NA 960Y forms. The NA 200 and NA 290 are AFDC NOAs. The NA 960X and NA 960Y are NOAs used by the AFDC, Food Stamp, CAAP and Supplemental Child Care (SCC) Programs. Each of these NOAs includes new or revised Medi-Cal messages.

STOCK

- o Counties have the option of depleting prior stock of the SAWS 1 (9/90). State produced stock for the prior 9/90 English and Spanish versions of the SAWS 1 is depleted. Any county that uses the 9/90 version until it is depleated must provide the CAAP 100 (an informing document named the California Alternative Assistance Program (CAAP) Information) to AFDC eligible applicants/recipients at intake/redetermination. For those counties using the 4/94 version it is recommended that a copy of the CAAP 100 be provided to any working applicant or recipient who requests information about CAAP benefits. The CAAP 100 provides additional information not included on the SAWS 1. Please disregard prior instructions in ACL 94-28 that indicated that the CAAP 100 would be obsolete when CAAP informing was integrated onto the SAWS 1.

- o California Department of Social Services (CDSS) will limit its initial order for stock of the SAWS 1 (4/94) to approximately a six-month supply of state produced forms. CDSS recommends that counties also restrict the amount of their initial order of state or locally reproduced stock of the SAWS 1 (4/94). Possible regulation changes in the Food Stamp expedited service referral process may necessitate a revision of the SAWS 1 in the next six to twelve months. If such a revision is necessary, counties may not be able to deplete existing stock (of either the 9/90 or 4/94 versions of the SAWS 1). CDSS plans to release an All-County Information Notice in September 1994 that will provide the current status of any plans to revise this form.

- o See Attachment 2 for information about the use of current on-hand stock of the NA forms.

- o State produced supplies of the 4/94 revisions of the SAWS 1, the SAWS 1 (SP), and the NA forms are expected to be available by July 29, 1994.

TRANSLATIONS

Copies of the Asian language versions (Chinese, Lao, Cambodian, and Vietnamese) of the SAWS 1 (4/94) and the NOAs will be forwarded to the County Forms Coordinators by the Language Services Bureau when the translations are available.

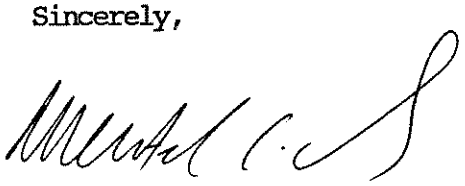
CONTACTS

If you have any questions or need further information, please contact the following staff regarding the specific areas below:

- o Camera-Ready copies of the English and/or Spanish versions of the SAWS 1 and/or NOAs: the Forms Management Unit at (916) 657-1907 or CALNET 437-1907;

- Asian translations of SAWS and/or NOAs: Shirley Lu at (916) 654-1277 or CALNET at 464-1277.
- SAWS 1 or this letter: Elizabeth Allred (916) 657-3350 or CALNET at 437-3350.
- NOAs: John Honeycutt at (916) 654-1077 or CALNET at 464-1077.
- CAAP 100: Debbie Fox at (916) 654-0708 or CALNET at 464-0708.

Sincerely,



MICHAEL C. GENEST
Deputy Director
Welfare Programs Division

Attachments

c: CWDA
Frank Martucci, Department of Health Services

ATTACHMENT 1

SAWS 1 (4/94), APPLICATION FOR CASH AID, FOOD STAMPS, AND MEDI-CAL

This attachment provides a description of the major changes, implementation issues, and copies of the English and Spanish versions of the SAWS 1 (4/94).

The SAWS 1 has been substantively and technically revised. This attachment provides an outline of the major changes, not a detailed line-by-line description of the changes to the SAWS 1. The attachment, when necessary, also provides implementation instructions.

SAWS 1 FORM AND COVERSHEET

- Changes include the revision of existing language to simplify or clarify text. Some text has been shifted from one section to another to improve understanding of discussed or requested information.

- The term "Medical Assistance" was replaced by "Full Medi-Cal," "Restricted Medi-Cal" or "Full or Restricted Medi-Cal" as appropriate to the context of the narrative.

COVERSHEET, PAGE 1

- Narrative has been added for the California Alternative Assistance Program (CAAP), a new program mandated by SB 35, Chapter 69, Statutes of 1993.

- Narrative has been added for "Medi-Cal Presumptive Eligibility for Pregnant Women," a new program mandated by AB 501, Chapter 1127, Statutes of 1992. Information about PE was transmitted by Department of Health Services' transmittals, ACWDL NO. 93-78 and MEM Letter No. 122.

COVERSHEET, PAGE 2

- The Definitions section was reorganized. Definitions were added for CAAP, Medi-Cal, PE, and Authorized Representative. Definitions were revised for Restricted Medi-Cal and You, Anyone, Everyone.

- Information in the Other Things You Should Know section regarding Intentional Program Violations and repayment of overpayments/overissuances, has been reorganized, language simplified, and updated to reflect regulatory changes in the Food Stamp and Medi-Cal Programs.

- Narrative about Food Stamp Rules has been added to parallel information on the DFA 285-A1, Application for Food Stamps.

SAWS 1

- Narrative in the applicant instructions section was revised to incorporate required informing for Medi-Cal Only (MCO) cases. The referred document, "Citizenship/Immigration Status Information for Applicants and Beneficiaries of Medi-Cal," is the MC 009/MC 19. This information notice should be given to all applicants for MCO **BEFORE** he/she is given any form that asks for Social Security Number, birthplace, citizenship or immigration status.

- Technical changes to the form include narrative changes, reformatting and renumbering of items. Formatting that divided the form into Sections A and B was deleted. Former Items 2-5 and 8-12 were reformatted to eliminate the two column question format.

- New question 8 revised former question 2 to allow the applicant to specify an application for either Full or Restricted Medi-Cal.

- New question 9 revised former question 3 to now read "Has anyone ever asked for or gotten aid or benefits, including Medi-Cal or Medicaid?"

- New question 13 revised former question 6 to specify an immediate medical need (for Medi-Cal) and to now include prior AFDC Immediate Need question 12g.

- Narrative and YES/NO checkboxes were added to Item 12 (the pregnancy question): "If YES, did she get a Presumptive Eligibility Card?"

- If a presumptively eligible woman applies for Cash Aid or Medi-Cal, submit a transaction to MEDS to record the pending application. After the PE input has been made, annotate the transaction in the County Use Only section to the right of Item 12.

- The county is not required to provide a listing of PE providers to applicants. If the applicant asks the worker where PE services may be obtained, the applicant should be told to discuss PE with her own provider.

- The narrative for completion of the Immediate Need/Expedited Service was language and format simplified.

COUNTY USE ONLY

- Portions of this section were reformatted to conserve space.

- Deleted in the "Type of Application, CA" was the narrative and check box for ECA [(Entrant Cash Assistance).

- Additions to this section include: narrative and checkboxes for "Pickle Screening," which is placed to the right of item 9, and "E.S. questions not completed," which is placed in the "FS E.S." section.

COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR FULL OR RESTRICTED MEDI-CAL

To apply for Cash Aid, Food Stamps, and/or Medi-Cal, complete Items 1-13 on the attached application, and sign the Certification Section (Item 19). Give the form to the welfare office.

Before you can get Cash Aid, Food Stamps, or Full or Restricted Medi-Cal; or emergency assistance, such as: AFDC Immediate Need, AFDC Homeless Assistance, or Food Stamp Expedited Service, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

To get AFDC Immediate Need and/or AFDC Homeless Assistance, you must appear to be eligible for AFDC. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your Social Security Number(s), trying to get income available to you, and agreeing to cooperate with the district attorney about child and spousal support.

AFDC IMMEDIATE NEED

If you have an emergency, you may be able to get up to $200 while we work on your application. You will need to tell us about your emergency and you will need to show that you don't have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

AFDC HOMELESS ASSISTANCE

If you are homeless, tell the county if you want to apply for homeless assistance.

CALIFORNIA ALTERNATIVE ASSISTANCE PROGRAM (CAAP)

If you are working AND eligible for Cash Aid, you can apply for the California Alternative Assistance Program (CAAP). If you choose to be in CAAP, you will get child care payments and Medi-Cal benefits, but not cash aid. You may also be able to get Food Stamps. Tell the county if you want to apply for CAAP.

APPLICANTS FOR FOOD STAMPS: All you have to do the day you apply is give us your name and address, tell us you want Food Stamps (Item 8) and sign the application (Item 19). Before we can tell if you are eligible, you must give us facts on this application. You should be told if you are eligible within 30 days after you apply.

Food Stamps — Date of Eligibility

If you are eligible for Food Stamps, we will figure your benefits from the date you apply. You can apply for Food Stamps the first day you contact the welfare department.

FOOD STAMP EXPEDITED SERVICE

You may have the right to get Food Stamps within three days. Your household must be eligible for the Food Stamp program

AND HAVE

- no place to live or have temporary housing,

OR

- rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions **(see the other side of the page for definitions of income and liquid resources),**

OR

- no more than $100 liquid resources and less than $150 income for the month before deductions,

OR

- no more than $100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get Food Stamps within three days, **complete Items 1 - 17 on the attached application**; give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

MEDI-CAL - MEDICAL EMERGENCY/PREGNANCY

If you have a medical emergency or are pregnant AND want Medi-Cal as soon as possible, complete Items 1-14. You must also give all the facts we ask for during your eligibility interview and complete all eligibility requirements.

MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer Presumptive Eligibility. If you apply for AFDC or Medi-Cal by the end of the month after the month you get a Presumptive Eligibility card, your Medi-Cal will continue until aid is approved or denied. If you are getting Presumptive Eligibility, check "YES" in both parts of Item 12 and tell the county.

TURN PAGE OVER FOR MORE INFORMATION

WHAT WE MEAN WHEN WE SAY:

- **California Alternative Assistance Program (CAAP):** child care payments and Medi-Cal, but not cash aid.
- **Cash Aid:** AFDC (Aid to Families with Dependent Children) and Refugee Cash Assistance.
- **Food Stamps:** benefits for low income households to help buy food.
- **Food Stamp Expedited Service:** Food Stamps within 3 days.
- **Medi-Cal:** medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** temporary Medi-Cal coverage from certain doctors or clinics for many prenatal care services.
- **Restricted Medi-Cal:** emergency and pregnancy related care only. If you are eligible for Restricted Medi-Cal, you don't have to give your Social Security Number, place of birth, citizen/alien status, or alien registration number. To see if you are eligible for Full or Restricted Medi-Cal, read "Citizenship/Immigration Status Information for Applicants and Beneficiaries of Medi-Cal."
- **Authorized Representative:** a person picked by an applicant or recipient for Food Stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** a responsible member of the Food Stamp household.
- **Income:** money received or expected, such as:
  - earnings, welfare, child support, Supplemental Security Income (SSI) or Social Security, pension or retirement payments;
  - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
  - strike funds; payments from roomers and boarders; school grants and loans;
  - cash gifts, cash winnings, any other cash payments.
- **Liquid resources:** other money, such as:
  - cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
  - trust deeds, notes receivable, stocks or bonds, etc.
- **Utilities:** gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** any and all persons who live in your home.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for Cash Aid and Food Stamps at the same time and have one interview for both.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **PERJURY** means that you lie on purpose about the facts you give us. Perjury is a crime. The law says you must sign a penalty of perjury statement on most forms to get and to keep getting Cash Aid, Food Stamps, and Medi-Cal.

  This means that if on purpose you give wrong facts or fail to report all facts or situations that affect eligibility and aid payments, you may be fined up to $10,000 for Cash Aid and $250,000 for Food Stamps and/or sent to jail/prison for 5 years for Cash Aid and 20 years for Food Stamps. And Cash Aid and Food Stamps can be stopped for six months, twelve months, or forever.
- If you get too much Cash Aid, Food Stamps, or Medi-Cal, and it's your fault, you will have to pay it back and if you are getting aid/benefits, your benefits may be lowered or stopped. If you get too much Cash Aid and Food Stamps, even if it's the county's fault, you may have to pay it back and if you are getting aid/benefits, your benefits may be lowered or stopped.
- **SOCIAL SECURITY NUMBER** -You must give us the Social Security Number (SSN) for each applicant for Cash Aid, Food Stamps and/or Full Medi-Cal. If you refuse to give us either an SSN or proof of application for an SSN, you won't be able to get aid or benefits, **unless you are applying for Restricted Medi-Cal.**

  We computer match SSNs against records from tax, welfare, employment, the Social Security Administration and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you aren't getting aid in more than one case, or in another county or state.

FOOD STAMP RULES

For Food Stamp cases, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household or another household member saying that you can apply for the household, pick up their Food Stamps, and/or use the Food Stamps to buy food for the household.

COMPLAINTS OR STATE HEARINGS

If you have a complaint, first contact the county. If you and the county can't agree, you may call or write to:

Public Inquiry and Response
744 P Street, M.S. 16-23
Sacramento, CA 95814
Phone 1 - (800) 952 - 5253
or
for the hearing impaired
TDD 1 - (800) 952-8349

If you think any action taken by the county is wrong, you can ask for a State Hearing by writing to your local county welfare office or by calling one of the phone numbers listed above. You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing.

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL (SAWS 1)

Before completing this application, read the Coversheet. If you are applying for Medi-Cal Only read the information notice, "Citizenship/Immigration Status Information for Applicants and Beneficiaries of Medi-Cal," before completing Item 2 (the Social Security Number). If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)

2. SOCIAL SECURITY NUMBER (SSN) (Applicants for restricted Medi-Cal benefits don't need to give an SSN.) - -

3. MAIDEN OR OTHER NAME (IF ANY)

4. HOME ADDRESS: NUMBER STREET
CITY ZIP CODE

5. MAILING ADDRESS (IF DIFFERENT)
CITY ZIP CODE

6. TELEPHONE NUMBER(S): HOME WORK MESSAGE

7. Is your home address permanent? ☐ YES ☐ NO ☐ NO HOME
If not permanent, please explain:

8. Is anyone applying for: Cash Aid ☐ YES ☐ NO Full Medi-Cal ☐ YES ☐ NO
Food Stamps ☐ YES ☐ NO Restricted Medi-Cal ☐ YES ☐ NO
Any Other Program(s) ☐ YES ☐ NO If YES, explain:

9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/Medicaid? ☐ YES ☐ NO
If YES, explain:
Name(s) used, where (county, state, country), when, type(s) of aid or benefit:

10. The law says we must record your ethnic group and language. This won't affect your eligibility.
a. Ethnic Group ☐ White ☐ Hispanic ☐ Black ☐ Filipino ☐ Guamanian
☐ Asian Indian ☐ Alaskan Native ☐ American Indian
☐ Laotian ☐ Cambodian ☐ Japanese ☐ Korean ☐ Chinese ☐ Samoan
☐ Vietnamese ☐ Hawaiian ☐ Other Asian or Pacific Islander (Specify):

b. Language ☐ English ☐ Cantonese ☐ Lao ☐ Tagalog ☐ American Sign
☐ Spanish ☐ Cambodian ☐ Vietnamese ☐ Russian ☐ Other (Specify):_____

11. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO

12. Is anyone pregnant? ☐ YES ☐ NO If YES, did she get a Presumptive Eligibility card? ☐ YES ☐ NO

13. Does anyone have a personal emergency? If YES, check (✔) type: ☐ YES ☐ NO
☐ Immediate Medical Need ☐ Pregnancy ☐ Child Abuse ☐ Spousal Abuse
☐ Elder Abuse ☐ Other emergency which threatens health or safety: Explain:

IF YOU NEED: AN AFDC IMMEDIATE NEED PAYMENT.....FILL IN ITEMS 14 - 18.
FOOD STAMP EXPEDITED SERVICE.....FILL IN ITEMS 14 - 17.
MEDI-CAL OR ARE PREGNANT AND HAVE AN IMMEDIATE MEDICAL NEED.....FILL IN ITEM 14.

14. How much liquid resources does everyone, including children, have?
☐ Cash, uncashed checks or money orders $_____
☐ Checking/savings or credit union account(s) $_____
☐ Trust deeds, notes receivable, stocks or bonds $_____
☐ Other (explain) $_____

15. How much income did everyone, including children, get or will they get this month?

Date	Amount	Date	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____

16. How much is your rent or mortgage this month?
$ _____

17. How much are your utilities that are not included in your rent this month? _____

18. • Do you have an eviction notice or notice to pay or quit?..... ☐ YES ☐ NO
• Have your utilities been shut off or do you have a shut-off notice?..... ☐ YES ☐ NO
• Will your food run out in 3 days or less?..... ☐ YES ☐ NO
• Do you need essential clothing, such as diapers or clothing needed for cold weather?..... ☐ YES ☐ NO
• Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?..... ☐ YES ☐ NO

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.
- **I declare under penalty of perjury under the laws of the United States of America and the State of California that information I have given on this form is true, correct, and complete.**

19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE — DATE SIGNED

SIGNATURE OF WITNESS TO MARK OR INTERPRETER — DATE SIGNED

COUNTY USE ONLY

COUNTY OF APPLICATION

CO OF RESIDENCE (IF DIFF)

DATE RECEIVED

TYPE OF APPLICATION:
CA: ☐ AFDC ☐ RCA
FS: ☐ Initial ☐ Recert ☐ Rest
MC: ☐ Full ☐ Restricted

Homeless:
FS: ☐ YES ☐ NO
AFDC: ☐ YES ☐ NO ☐ CA 42

☐ Pickle Screening

Ethnic Group:

Primary Language:

☐ Presumptive Eligibility input

☐ **Referral Date:**

AFDC IN
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete
(_____)
(Initials)

FS E.S.
☐ E.S. questions not completed
☐ Screened for E.S.
Date_____
(_____)
(Initials)

FS Referral for:
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of SAWS 1 coversheet given to applicant

CASE NAME

CASE NUMBER

HOJA DE INFORMACION ADJUNTA A LA SOLICITUD PARA ASISTENCIA MONETARIA, ESTAMPILLAS PARA COMIDA Y/O MEDI-CAL RESTRINGIDA

Para solicitar Asistencia Monetaria, Estampillas para Comida, y/o Medi-Cal, complete las secciones del 1 al 13 en la solicitud que se adjunta, y firme la sección de certificación (Sección 19). Dé la forma al departamento de bienestar.

Antes de poder recibir Asistencia Monetaria, Estampillas para Comida o Medi-Cal Completa o Restringida; o asistencia de emergencia, como: AFDC para Necesidad Inmediata, Asistencia de AFDC para las Personas sin Hogar, o Servicio Urgente de Estampillas para Comida, usted tiene que darnos toda la información y/o contestar las preguntas en la entrevista para determinar si usted reúne los requisitos. Utilizamos la información que usted nos da para determinar su derecho a recibir beneficios.

Para recibir AFDC para Necesidad Inmediata y/o Asistencia de AFDC para las Personas sin Hogar, tiene que parecer que reúne los requisitos para recibir AFDC. Llene la forma que se adjunta y denos la información que le pidamos. Es posible que usted tenga que cumplir con algunas reglas, como darnos su(s) número(s) del Seguro Social, tratar de obtener ingresos que estén a la disposición de usted, y acceder a cooperar con el Fiscal del Distrito con respecto al mantenimiento de hijos y de esposa(o).

PAGO DE AFDC POR NECESIDAD INMEDIATA

Si tiene una emergencia, es posible que pueda recibir hasta $200 dólares mientras tramitamos su solicitud. Es necesario que usted nos describa su emergencia y demostrar que no tiene los ingresos ni el dinero para cubrir estas emergencias:

- Falta de hogar o de alimentos
- Aviso de desocupación de la vivienda
- No tener servicios públicos o municipales o haber recibido aviso de que cortarán esos servicios
- Falta de ropas esenciales
- Necesidades esenciales de transporte que no se han satisfecho
- Otras clases de emergencias que son importantes para la salud y seguridad

Si se niega su solicitud para un pago por necesidad inmediata, puede volver a pedirlo mientras tramitamos su solicitud. Dígale al condado si algo cambia.

AFDC PARA LAS PERSONAS SIN HOGAR

Si usted no tiene hogar, dígale al condado si usted desea solicitar asistencia para personas sin hogar.

PROGRAMA DE ASISTENCIA ALTERNATIVA DE CALIFORNIA (CAAP)

Si usted está trabajando Y reúne los requisitos para recibir Asistencia Monetaria, puede solicitar los beneficios del Programa de Asistencia Alternativa de California (CAAP). Si usted elige estar en CAAP, usted recibirá pagos para el cuidado de niños y Medi-Cal, pero no de asistencia monetaria. Es posible que también pueda recibir Estampillas para Comida. Dígale al condado si usted desea solicitar beneficios de CAAP.

SOLICITANTES DE ESTAMPILLAS PARA COMIDA: Todo lo que tiene que hacer el día que presente su solicitud, es darnos su nombre y domicilio, decirnos que desea Estampillas para Comida (Sección 8) y firmar la solicitud (Sección 19). Antes de poder decirle si usted reúne los requisitos, tiene que darnos información en esta solicitud. Se le tiene que notificar si usted reúne los requisitos, en un plazo de 30 días después de presentar la solicitud.

Estampillas para Comida—Fecha en que Reúne los Requisitos

Si usted reúne los requisitos para recibir Estampillas para Comida, calcularemos sus beneficios a partir de la fecha en que usted presente la solicitud. Usted puede solicitar Estampillas para Comida el primer día en que se ponga en contacto con el departamento de bienestar.

SERVICIO URGENTE DE ESTAMPILLAS PARA COMIDA

Es posible que usted pueda recibir estampillas para comida en un plazo de tres días. Las personas que forman el hogar suyo tienen que reunir los requisitos para el programa de Estampillas para Comida, y

- no tener un lugar donde vivir ni vivienda temporal, o,
- tener renta (alquiler) o pago hipotecario y gastos de servicios públicos y municipales cuyo monto es más que sus recursos líquidos y los ingresos de este mes antes de las deducciones **(vea el reverso de esta hoja para ver lo que significan ingresos y recursos líquidos)**, o
- tener no más de $100 dólares en recursos líquidos y menos de $150 dólares en ingresos para el mes antes de las deducciones, o
- tener no más de $100 dólares en recursos líquidos y por lo menos un miembro de la familia que es trabajador del campo migratorio o de temporada.

Antes de poder recibir Estampillas para Comida en un plazo de tres días, **complete las secciones del 1 al 17 en la solicitud que se adjunta**; dénos toda la información que le pidamos durante su entrevista para determinar si usted reúne los requisitos; y dénos pruebas de su identidad.

MEDI-CAL PARA EMERGENCIAS MEDICAS/EMBARAZO

Si usted tiene una emergencia médica o está embarazada Y desea recibir Medi-Cal tan pronto como sea posible, complete las secciones del 1 al 14. También tiene que dar toda la información que le pidamos durante su entrevista para determinar si usted reúne los requisitos y debe cumplir con los requisitos para tener ese derecho.

DERECHO PRESUNTO PARA RECIBIR MEDI-CAL (PE) PARA LAS MUJERES EMBARAZADAS

Si usted está embarazada, es posible que usted reciba Medi-Cal temporal de ciertos proveedores médicos para muchos servicios de cuidado prenatal antes de solicitar Medi-Cal regular. Pregúnteles a su doctor o clínica si ofrecen "Presumptive Elegibility (PE)". Si usted presenta su solicitud para AFDC o Medi-Cal a más tardar el fin del mes después después del mes en que recibia una tarjeta de Derecho, Presunto, su Medi-Cal continuará hasta que se apruebe o niegue la asistencia. Si usted está recibiendo Derecho Presunto marque "SI" en ambas partes de la sección 12 y dígaselo al condado.

VEA LA PAGINA EN EL REVERSO PARA MAS INFORMACION

LO QUE SIGNIFICA CUANDO DECIMOS

- **Programa de Asistencia Alternativa de California (CAAP):** beneficios de cuidado de niños y Medi-Cal, pero no asistencia monetaria.
- **Asistencia Monetaria:** AFDC (Asistencia para Familias con Niños Necesitados) y Asistencia Monetaria para Refugiados.
- **Estampillas para Comida:** beneficios para los hogares que tienen bajos ingresos, para ayudarles a comprar alimentos.
- **Servicio Urgente de Estampillas para Comida:** Estampillas para Comida en 3 días.
- **Medi-Cal:** beneficios médicos necesarios para las personas que reúnen los requisitos
- **Derecho Presunto para Recibir Medi-Cal (PE):** cobertura temporal de Medi-Cal para ciertas clases de doctores o clínicas para varios servicios de cuidado prenatal.
- **Medi-Cal Restringido:** solamente cuidado de emergencia y el relacionado al embarazo. Si usted reúne los requisitos para recibir Medi-Cal Restringido, no tiene que dar su número del Seguro Social, lugar de nacimiento, ciudadanía/condición legal como extranjero, ni el número de registro como extranjero. Para cerciorarse si reúne los requisitos para recibir Medi-Cal Completo o Restringido, lea "Información sobre la Situación Migratoria/de Ciudadanía para las Personas que Solicitan y las que Reciben Beneficios de Medi-Cal".
- **Representante Autorizado:** alguien seleccionado por una persona que solicita beneficios de Estampillas para Comida y/o de Medi-Cal, o una que los recibe, que puede encargarse de algunos de sus asuntos.
- **Jefe de Familia:** una persona responsable que es miembro del hogar para fines del Programa de Estampillas para Comida.
- **Ingresos:** dinero que se ha recibido o se espera recibir como:
  - ingresos ganados, asistencia pública, mantenimiento de hijos, Ingresos Complementarios de Seguridad (SSI) o del Seguro Social, pensión o pagos de jubilación;
  - Beneficios del Seguro contra Desempleo (UIB), Seguro del Estado contra Incapacidad (SDI), Beneficios para Veteranos (VA), u otros pagos por incapacidad;
  - fondos de huelga, pagos procedentes de huéspedes e inquilinos; préstamos y subvenciones a estudiantes;
  - regalos y premios en efectivo, y otros pagos en efectivo.
- **Recursos en efectivo:** otro dinero como:
  - dinero a la mano, cheques sin cambiar, dinero en cuentas de cheques, cuentas de ahorros; o certificados de ahorro;
  - escrituras en fideicomiso (trust), cuentas que le deben, acciones o bonos, etc.
- **Servicios Públicos y Municipales:** gas, electricidad, combustible para calefacción, teléfono (tarifa básica), instalación de los servicios, recolección de basura, agua, drenaje, etc.
- **Usted, Cualquiera, Todos:** cualquier persona, y todas las personas que vivan en el hogar de usted.

OTRAS COSAS QUE DEBE SABER:

- Puede solicitar asistencia monetaria y estampillas para comida al mismo tiempo, y tener una sola entrevista para ambas cosas.
- Tiene el derecho a llenar esta forma usted mismo(a) o pedir que le ayuden a llenarla.
- PERJURIO significa que usted miente a propósito con respecto a la información que usted nos dé. El perjurio es un delito mayor. La ley establece que usted tiene que firmar una declaración de sanción por perjurio en la mayoría de las formas para recibir o seguir recibiendo asistencia monetaria, estampillas para comida y Medi-Cal.

  Esto significa que si a propósito usted da información errónea o no reporta todos los datos o situaciones que afectan su derecho a recibir beneficios y sus pagos de asistencia, se le puede multar hasta por la cantidad de $10,000 dólares para casos de asistencia pública y $250,000 dólares para casos de estampillas para comida y/o se le puede encarcelar hasta por cinco años para casos de AFDC y hasta 20 para casos de estampillas para comida. Además se le pueden parar la asistencia monetaria y las estampillas para comida durante seis meses, doce meses, o para siempre.
- Si usted recibe asistencia monetaria, estampillas para comida o Medi-Cal de más y es culpa suya, tendrá que reembolsarlos y si está recibiendo ayuda/beneficios, posiblemente se reduzcan o paren. Si usted recibe asistencia monetaria y estampillas para comida de más, aun cuando sea culpa del condado, es posible que usted tenga que reembolsarlos, y si está recibiendo ayuda/beneficios, es posible que se reduzcan o paren.
- NUMERO DEL SEGURO -Usted tiene que darnos el número del Seguro Social para cada solicitante de asistencia monetaria, estampillas para comida y/o Medi-Cal completo. Si usted se rehusa a darnos ya sea el número del Seguro Social o pruebas de que se ha solicitado ese número, usted no podrá recibir asistencia o beneficios, **a menos que esté solicitando Medi-Cal restringido.**

  Comparamos con computadoras los números del Seguro Social con expedientes de oficinas de impuestos, bienestar, empleo, la Administración del Seguro Social y otras dependencias para asegurarnos que usted esté reportando todos sus ingresos y recursos. Tal vez verifiquemos las diferencias con patrones, bancos, y/u otros. También comparamos esos números del Seguro Social para asegurarnos que usted no esté recibiendo aistencia en más de un caso de asistencia , o en otro condado o estado.

REGLAS PARA ESTAMPILLAS PARA COMIDA

Para casos de estampillas para comida, puede llenar y firmar la solicitud, bajo pena de perjurio, un adulto miembro del hogar o un representante autorizado. Si usted no es un miembro adulto del hogar, tiene que tener una nota firmada por el jefe de la familia u otro miembro del hogar indicando que usted puede presentar una solicitud a nombre del hogar, recoger sus estampillas para comida, y/o usarlas para comprar alimentos para los miembros del hogar.

QUEJAS O AUDIENCIAS CON EL ESTADO

Si usted tiene una queja, comuníquese con el condado. Si el condado no puede solucionar el asunto, puede llamar o escribir a:

Public Inquiry and Response
744 P Street, M.S. 16-23
Sacramento, CA 95814
Teléfono 1 - (800) 952 - 5253

ó

para los sordos
TDD 1 - (800) 952-8349

Si cree que cualquier acción tomada por el condado está equivocada, puede pedir una audiencia con el estado escribiendo a su departamento de bienestar del condado local, o llamando a los números mencionados arriba. Tiene que pedir una audiencia en un plazo de 90 días contados a partir de la fecha de la acción, y explicar por qué la quiere.

SOLICITUD PARA ASISTENCIA MONETARIA, ESTAMPILLAS PARA COMIDA Y/O MEDI-CAL (SAWS 1)

Antes de completar esta solicitud, lea la hoja de información. Si usted está solicitando Medi-Cal Solamente, por favor lea el aviso informativo "Información sobre la Situación Migratoria/como Ciudadano, para Solicitantes y Beneficiarios de Medi-Cal" antes de completar el inciso 2, (Número del Seguro Social). Si necesita más espacio para contestar, escriba en el reverso de esta hoja.

1. NOMBRE DEL SOLICITANTE (NOMBRE, NOMBRE QUE USA EN MEDIO, APELLIDO)

2. No. DEL SEGURO SOCIAL (Los solicitantes de Medi-Cal restringido no necesitan dar un número del Seguro Social) - - -

3. NOMBRE DE SOLTERA U OTRO NOMBRE (SI LO HAY)

4. DIRECCION DEL HOGAR: NUMERO CALLE
CIUDAD ZONA POSTAL

5. DIRECCION POSTAL (SI ES DIFERENTE)
CIUDAD ZONA POSTAL

6. NUMERO DE TELEFONO(S): EN EL HOGAR EN EL TRABAJO PARA MENSAJES

7. ¿Es permanente la dirección de su hogar? ☐ SI ☐ NO ☐ NO TENGO HOGAR
Si no es permanente, por favor explique:

8. ¿Está alguien solicitando: Asistencia monetaria ☐ SI ☐ NO Medi-Cal completo ☐ SI ☐ NO
Estampillas para comida ☐ SI ☐ NO Medi-Cal restringido ☐ SI ☐ NO
Cualquier otro programa(s) ☐ SI ☐ NO Si es así, explique:

9. ¿Ha solicitado alguien, o recibido asistencia o beneficios, incluyendo Medi-Cal/Medicaid? ☐ SI ☐ NO
Si es así, explique:
Nombre(s) que ha usado, dónde (condado, estado, país), cuándo, clase(s) de asistencia o beneficios:

10. La ley establece que tenemos que anotar su grupo étnico e idioma. Esto no afectará su derecho a recibir beneficios.
a. Grupo étnico ☐ Blanco ☐ Hispano ☐ Negro ☐ Filipino ☐ Guameño
☐ Hindú ☐ Nativo de Alaska ☐ Indio de los E.U.
☐ Laosiano ☐ Camboyano ☐ Japonés ☐ Coreano ☐ Chino ☐ Samoano
☐ Vietnamita ☐ Hawaiano ☐ Otro asiático o isleño del Pacífico (Especifique):

b. IDIOMA ☐ Inglés ☐ Cantonés ☐ Laosiano ☐ Tagalo ☐ Idioma de señas
☐ Español ☐ Camboyano ☐ Vietnamita ☐ Ruso ☐ Otro (Especifique):_____

11. ¿Es alguien trabajador migratorio o de temporada? ☐ SI ☐ NO

12. ¿Está alguien embarazada? ☐ SI ☐ NO Si es así, ¿recibió ella una tarjeta de elegibilidad presunta? ☐ SI ☐ NO

13. ¿Tiene alguien alguna emergencia personal? Si es así, marque la (✔) clase: ☐ SI ☐ NO
☐ Necesidad médica inmediata ☐ Embarazo ☐ Abuso de niños ☐ Abuso de esposa(o)
☐ Abuso de ancianos ☐ Otra emergencia que amenaza la salud o la seguridad: Explique:

SI USTED NECESITA: UN PAGO DE AFDC POR NECESIDAD INMEDIATA ..... CONTESTE DEL 14 AL 18.
SERVICIO URGENTE DE ESTAMPILLAS PARA COMIDA..... CONTESTE DEL 14 AL 17.
MEDI-CAL O ESTA EMBARAZADA Y TIENE UNA NECESIDAD MEDICA URGENTE CONTESTE EL 14.

14. ¿Cuánto tiene cada uno en recursos líquidos, incluyendo a los niños?
☐ Efectivo, cheques sin cobrar o giros bancarios/postales $_____
☐ Cuentas de cheques/ahorros o en la unión de crédito $_____
☐ Escrituras en fideicomiso, pagarés que le deben, valores $_____
☐ Otro (explique) $_____

15. ¿Cuánto recibieron o recibirán todos en ingresos, incluyendo a los niños este mes?

Fecha	Cantidad	Fecha	Cantidad
_____	$_____	_____	$_____
_____	$_____	_____	$_____

16. ¿Cuánto es su alquiler o hipoteca este mes?
$ _____

17. ¿Cuánto es de los servicios que no están incluidos en su alquiler este mes? _____

18. • ¿Ha recibido un aviso de desocupación, o informándole que pague o se salga?..... ☐ SI ☐ NO
• ¿Le cortaron, o recibió aviso que le van a cortar sus servicios?..... ☐ SI ☐ NO
• ¿Se le acabará la comida en 3 días o menos?..... ☐ SI ☐ NO
• ¿Necesita ropas esenciales, incluyendo pañales o ropa necesaria para clima frío?..... ☐ SI ☐ NO
• ¿Necesita ayuda de transporte para obtener alimentos, ropa, cuidado médico u otros artículos de emergencia?..... ☐ SI ☐ NO

- Certifico que recibí una copia de la hoja de información. Entiendo y convengo que tengo que cumplir con las reglas de elegibilidad habiendo la posibilidad de que se me pida que cumpla con algunas de ellas antes que se me otorgue asistencia. Entiendo que es posible que se comprueben y verifiquen las declaraciones que he hecho en esta forma.
- **Declaro bajo pena de perjurio, en conformidad con las leyes de los Estados Unidos de América y del Estado de California que la información que he dado en esta forma es verdadera, correcta y completa.**

19. FIRMA (O MARCA) DEL SOLICITANTE O REPRESENTANTE AUTORIZADO — FECHA DE LA FIRMA

FIRMA DEL TESTIGO A LA MARCA O DEL INTERPRETE — FECHA DE LA FIRMA

SOLO PARA USO DEL CONDADO

COUNTY OF APPLICATION

CO OF RESIDENCE (IF DIFF)

DATE RECEIVED

TYPE OF APPLICATION:
CA: ☐ AFDC ☐ RCA
FS: ☐ Initial ☐ Recert ☐ Rest
MC: ☐ Full ☐ Restricted

Homeless:
FS: ☐ YES ☐ NO
AFDC: ☐ YES ☐ NO ☐ CA 42

☐ Pickle Screening

Ethnic Group:

Primary Language:

☐ Presumptive Eligibility input

☐ **Referral Date:**

AFDC IN
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete
(_____)
(Initials)

FS E.S.
☐ E.S. question not completed
☐ Screened for E.S.
Date_____
(_____)
(Initials)

FS Referral for:
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of SAWS 1 coversheet given to applicant

CASE NAME

CASE NUMBER

AFDC NOTICES OF ACTION

NOAS AND INSTRUCTIONS ATTACHED:

- NA 200 (4/94) MULTIPURPOSE - INCL BUDGET - Revised Form and Instructions
- NA 290 (4/94) MULTIPURPOSE - Revised Form and Instructions
- NA 960X (4/94) STOP AID; REPORT NOT RECEIVED - Revised Form and Instructions
- NA 960Y (4/94) STOP AID; REPORT INCOMPLETE - Revised Form and Instructions
- Spanish Versions of NA 200, NA 290, NA 960X, and NA 960Y

Information on the nature and use of each form is found in the instructions accompanying each form. See below for information about changes.

EFFECTIVE DATES

All of the forms are effective immediately, subject to availability.

FOR HOLDERS OF THE AFDC NOTICE OF ACTION HANDBOOK

File the English language NA forms and instructions in Section 5 of your AFDC NOA Handbook. Remove the earlier versions.

CHANGES/ADDITIONS TO MEDI-CAL MESSAGES ON NA SERIES FORMS

Two new Medi-Cal messages have been developed for incorporation on AFDC NA Forms. They replace other Medi-Cal messages presently incorporated on NA forms. The first version deals with the new plastic Benefits Identification Cards and is to be placed on all Page 1 NA forms that do NOT use the second version.

> **Medi-Cal: Keep your plastic Benefits Identification Card(s).**

The heading and message are to be set in bold type.

The second version is an extension of the first and provides important information for persons being discontinued from cash aid but not from Medi-Cal. When used, it replaces the first version.

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

The heading and the last sentence are to be set in bold type.

The appropriate Medi-Cal message is to be incorporated on Page 1 NA forms at the bottom of the left column, immediately above the "Rules" statement (as shown on the NA forms included in this attachment).

It is recognized that in some automated environments (including SAWS), the NOA stopping cash aid ALSO stops or changes Medi-Cal benefits. The second Medi-Cal message would NOT be used in this environment.

It is also recognized that in some few manual environments, this is also the case. Counties in this situation may use any appropriate method to eliminate the inappropriate (first) sentence of the second Medi-Cal message from the NA forms that it uses. This may include reprinting forms without that sentence and may include typing out or crossing out the sentence by the worker.

Medi-Cal Changes to State AFDC NA Forms Supplied in Quantity

Because the second version of the message is required only for discontinuance NA forms and for change NA forms that can be used to discontinue one or more persons, its use will be limited to the NA forms that can be used to do this. As it happens, ALL Page 1 NA forms presently supplied in quantity by the State can be used to discontinue one or more persons, and therefore, all will be changed to include this message. These forms are:

NA 200, 210, 211, 290, 960X, and 960Y

Revised versions of the NA 210 and 211, which are not included in this Attachment, will be issued at a later time.

Transition Period for the Medi-Cal Messages

During a transition period ending with actions effective after December 31, 1994, counties may implement the above Medi-Cal messages at any time they consider appropriate.

By that date, all AFDC NOAs issued by counties must include at least the first Medi-Cal message. Also, by that date, the second Medi-Cal message must be included on all AFDC NOAs that discontinue one or more persons.

IMPLEMENTATION INSTRUCTIONS FOR NA FORMS and DESCRIPTION OF CHANGES

*** NA 200 (4/94) MULTIPURPOSE - INCL BUDGET - Revised Form and Instructions ***

The revised NA 200 incorporates the following changes:

Left Column

- New Medi-Cal message is added just above the "Rules" message.

Right Column

- Section B is revised to provide a place for Cal-Learn bonus and penalty amounts in the cash aid computation:
  - Line 10a is added to show the amount of an adjustment for one or more Cal-Learn penalties.
  - Line 10b is added to show the amount of an adjustment for one or more Cal-Learn bonuses.
- Line 11 is modified to reflect these changes.
- Lines 12-14 for Relocation Family Grant information, which are currently not being used, are removed. Line 8 is modified to reflect this change.

Bottom of the Form

- The title is changed to more clearly reflect the nature of the form.

USING CURRENT SUPPLIES OF THE FORM

Because of the very large inventory of NA 200 forms and of derivative forms that have been designed using the NA 200 as the master form, counties may continue to use up supplies of the 11/92 version of the NA 200 and its derivatives except as follows:

- Do NOT use the 11/92 version or its derivatives:
  - For messages applying the Cal-Learn bonus and/or penalty because the budget computation on the 11/92 version does not provide a place for this information.
  - After December 31, 1994 for AFDC actions discontinuing one or more persons unless you add the appropriate Medi-Cal message, as explained in the Medi-Cal section above.

*** NA 290 (4/94) MULTIPURPOSE - Revised Form and Instructions ***

The revised NA 290 incorporates the following changes:

Left Column

- New Medi-Cal message replaces current message. Check box is removed.

Bottom of the Form

- A title is added.

It may be helpful to note that the NA 290 and the NA 200 are generically related. The NA 200 is simply an NA 290 to which has been added the budget computation.

USING CURRENT SUPPLIES OF THE FORM

Because of the very large inventory of NA 290 forms and derivative forms that have been designed using the NA 290 as the master form, counties may continue to use the 5/87 version of the NA 290 and its derivatives except as follows:

- Do NOT use the 5/87 version or its derivatives after December 31, 1994 for AFDC actions discontinuing one or more persons unless you replace the current Medi-Cal message with the appropriate Medi-Cal message, as explained in the Medi-Cal section above.

*** NA 960X (4/94) STOP AID; REPORT NOT RECEIVED - Revised Form and Instructions ***

The basic functions of the form remain unchanged: Stop aid because the monthly report has not been received, tell the client how to stop the action, and warn the client about the earned income disregards penalty and how to avoid it.

Within this context, the following changes have been made to clarify and expand coverage of the form:

Left Column

- The format is changed to conform to the "Turner" standards.

- A checkbox is added to stop payments under the California Alternative Assistance Program (CAAP).

- The "Cash Aid Penalty for Families with Earned Income" paragraph is rewritten for clarification and is moved from the left column to the right column.

  - A sentence is added that advises clients with earnings to see the penalty information in the next column.

- New Medi-Cal message replaces current message. Check box is removed.

- Rule citations for SCC and CAAP are added.

Right Column

- Penalty Information - Information about the EARNED INCOME DISREGARDS penalty for families who give the county earnings information after the 11th is rewritten for clarification and is moved from the left column.

  - Clients are informed that the penalty applies only if the discontinuance action is stopped.

  - The checkbox is removed from this section. Since the client has not yet reported, the county doesn't always know whether or not to check the box. The headline for the section is revised to identify to whom it applies.

  - CAAP payment and SCC information are added to the statement.

Bottom of the Form

- The title of the form is revised to clarify.

USING CURRENT SUPPLIES OF THE FORM

There are two current versions of the form. All counties have recevied copies of the 6/93 version; some counties have received copies of the newer 12/93 version that was revised to provide information about SCC payments.

Counties may use current supplies of both versions of the form until they are exhausted but not for actions effective after December 31, 1994, which is the deadline for using the new Medi-Cal language that appears on the 4/94 version included with this attachment. Current supplies, however, cannot be used under the following circumstances:

- They cannot be used when stopping CAAP payments because the older versions do not cover CAAP actions.

- The 6/93 version cannot be used for clients who are currently getting SCC payments because it does not tell the client about the possible loss of the SCC payment for late reporting of earnings.

*** NA 960Y (4/94) STOP AID; REPORT INCOMPLETE - Revised Form and Instructions ***

The basic functions of the form remain unchanged: Stop aid because the monthly report is incomplete, tell the client how to stop the action, and warn the client about the earned income disregards penalty and how to avoid it.

Within this context, the following changes have been made to clarify and expand coverage of the form:

Left Column

- The format is changed to conform to the "Turner" standards.
- A checkbox is added to stop payments under the California Alternative Assistance Program (CAAP).
- Information about stopping the action is rewritten to clarify.
- A sentence is added that advises clients with earnings to see the penalty information in the next column.
- New Medi-Cal message replaces current message. Check box is removed.
- Rule citations for SCC and CAAP are added.

Right Column

- The Food Stamps paragraph remains unchanged.
- The earned income disregards penalty information section developed for the NA 960X, described above, is included in this column, replacing the existing paragraph.

Bottom of the Form

- The title of the form is revised to clarify.

USING CURRENT SUPPLIES OF THE FORM

Counties may use current supplies of the 8/93 version of the form until they are exhausted but not for actions effective after December 31, 1994, which is the deadline for using the new Medi-Cal language on the 4/94 version included with this attachment. Current supplies cannot, however, be used under the following circumstances:

- They cannot be used when stopping CAAP payments because the older versions do not cover CAAP actions.
- They cannot be used for clients who have been getting SCC payments and who give the county earnings information after the 11th because the 8/93 version does not tell the client about possible loss of the SCC payment under this circumstance.

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** (Lower Amount on Line 4 or 7)	=	_____
9. Line 8 Prorated for Part of Month	=	_____
10. Adjustments: Collect Overpayment	-	_____
10a. Cal-Learn Penalty	-	_____
10b. Cal-Learn Bonus	+	_____
11. **Monthly Cash Aid Amount** (Line 8 or 9 Adjusted)	=	_____

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: MPP

NOTIFICACION DE ACCION

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 -- Fuentes:		
_____	+	_____
_____	+	_____
Mantenimiento que Ud. pagó 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, ó 7)	=	_____
9. Renglón 8 prorrateado para parte del mes	=	_____
10. Ajustes: Cobro de pago excesivo	-	_____
10a. Sanción de Cal-Learn	-	_____
10b. Bonificación de Cal-Learn	+	_____
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 ó 9 ajustado)	=	_____

Medi-Cal: Esta Notificación de Acción NO cambia o para sus beneficios de Medi-Cal. Conserve su(s) tarjeta(s) de identificación de beneficios de plástico.

Ordenamientos. Las siguientes reglas, las cuales puede revisar en su oficina de bienestar, son pertinentes: MPP

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.

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: MPP

NOTIFICACION DE ACCION

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(a).

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.

Medi-Cal: Esta Notificación de Acción NO cambia o para sus beneficios de Medi-Cal. Conserve su(s) tarjeta(s) de identificación de beneficios de plástico.

Ordenamientos. Las siguientes reglas, las cuales puede revisar en su oficina de bienestar, son pertinentes: MPP

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 stopping your:

- ☐ Cash Aid
- ☐ Food Stamps
- ☐ California Alternative Assistance Program (CAAP) Payment

Here's why:

As of the 11th of this month, the county has not received your monthly report (CA 7 or SAWS 7) due this month.

TO STOP THIS ACTION, the County must RECEIVE your COMPLETE report no later than the FIRST WORKING DAY OF NEXT MONTH.

If you give us your complete report, and if you have earnings, see the next column about a penalty that may apply.

Penalty - Applies Only to Cash Aid or CAAP Families Who Give Us Earnings Information After the 11th.

If this action is stopped (see the first column), the following penalty will apply when aid is figured:

Because we didn't get complete earnings information from you by the 11th of this month, next month's aid will be figured WITHOUT ANY EARNED INCOME DISREGARDS. This means that next month:

- Your cash aid may go down or stop.
- Your CAAP payments may stop.
- You won't get a Supplemental Child Care payment.

YOU CAN STOP THIS PENALTY if you had a GOOD REASON for reporting your EARNINGS after the 11th. Tell your worker the reason.

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 - Cash Aid: MPP 40-105.1, 40-181.22, 44-113.2; Food Stamps: 63-504.27, 63-504.3; SCC: 44-503.12; CAAP: 89-730.3, 89-730.4.

NOTIFICACION DE ACCION

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 de _____, el condado parará su:

- ☐ asistencia monetaria
- ☐ estampillas para comida
- ☐ pago del Programa de Asistencia Alternativa de California (CAAP)

La razón es la siguiente:

Para el 11 de este mes, el condado no había recibido su reporte mensual (CA 7 o SAWS 7) que se vencía este mes.

PARA PARAR ESTA ACCION, el condado tiene que RECIBIR su reporte COMPLETO a más tardar el PRIMER DIA LABORAL DEL PROXIMO MES.

Si usted nos da su reporte completo, y tiene ingresos ganados, vea la siguiente columna para ver las sanciones que posiblemente sean pertinentes.

Sanción - Es pertinente solamente para las familias que reciben asistencia monetaria o CAAP y que nos dan información sobre sus ingresos ganados después del día 11.

Si alguien para esta acción (vea la primera columna), se aplicará la siguiente sanción cuando se calcule la asistencia:

Como no recibimos la información completa sobre sus ingresos ganados para el 11 de este mes, la asistencia del siguiente mes se calculará SIN LAS DEDUCCIONES POR INGRESOS GANADOS. Esto significa que el próximo mes:

- es posible que posible que se reduzca o pare su asistencia monetaria.
- es posible que posible que paren sus pagos de CAAP.
- usted no recibirá un pago Suplemental de Cuidado de Niños.

USTED PUEDE PARAR ESTA SANCION si tuvo un MOTIVO JUSTIFICADO para reportar sus INGRESOS GANADOS después del día 11. Dígale a su trabajador(a) la razón.

Medi-Cal: Esta Notificación de Acción NO cambia ni para sus beneficios de Medi-Cal. **Conserve su(s) tarjeta(s) de plástico de identificación de beneficios.**

Ordenamientos. Las siguientes reglas, las cuales puede revisar en su oficina de bienestar, son pertinentes: Asistencia Monetaria: MPP 40-105.1, 40-181.22, 44-113.2; Estampillas para Comida: 63-504.27, 63-504.3; SCC: 44-503.12; CAAP: 89-730.3, 89-730.4.

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 stopping your:

- ☐ Cash Aid
- ☐ Food Stamps
- ☐ California Alternative Assistance Program (CAAP) Payment

Here's why:

The monthly report (CA 7 or SAWS 7) that we got from you this month is not complete.

TO STOP THIS ACTION, the County must RECEIVE your COMPLETE report by the FIRST WORKING DAY OF NEXT MONTH. You must send or bring in the following information:

- ☐ Complete the circled items on the enclosed report, and send or bring it to your worker.
- ☐ Send or bring to your worker the following:

If you give us this information, and if you have earnings, see the next column about a penalty that may apply.

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 - Cash Aid: MPP 40-105.1, 40-181.22, 40-181.24, 44-113.2; Food Stamps: 63-504.27, 63-504.3; SCC: 44-503.12; CAAP: 89-730.3, 89-730.4.

☐ **Food Stamps – Additional Information Needed**

In addition, you must give the county the following information so the amount of your food stamps can be figured. You must get this information to the county by the first working day of next month. If you were asked for proof of an expense and you do not give it, the expense will not be allowed. Also, if you do not give the County other information asked for, your food stamps may be decreased or stopped.

Penalty - Applies Only to Cash Aid Families Who Give Us Earnings Information After the 11th.

If this action is stopped (see the first column), the following penalty will apply when aid is figured:

Because we didn't get complete earnings information from you by the 11th of this month, next month's aid will be figured WITHOUT ANY EARNED INCOME DISREGARDS. This means that next month:

- Your cash aid may go down or stop.
- Your CAAP payments may stop.
- You won't get a Supplemental Child Care payment.

YOU CAN STOP THIS PENALTY if you had a GOOD REASON for reporting your EARNINGS after the 11th. Tell your worker the reason.

NOTIFICACION DE ACCION

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 de _____, el condado parará su:

- ☐ asistencia monetaria
- ☐ estampillas para comida
- ☐ pago del Programa de Asistencia Alternativa de California (CAAP)

La razón es la siguiente:

El reporte mensual (CA 7 o SAWS 7) que usted nos mandó este mes no está completo.

PARA PARAR ESTA ACCION, el condado tiene que RECIBIR su reporte COMPLETO a más tardar el PRIMER DIA LABORAL DEL PROXIMO MES. Tiene que enviar o traer la siguiente información:

☐ Complete las secciones marcadas con un círculo en el reporte que se adjunta, y envíeselo o lléveselo a su trabajador.

☐ Envíele o llévele a su trabajador(a) lo siguiente:

Si usted nos da esta información y tiene ingresos ganados, vea la siguiente columna para ver las sanciones que posiblemente sean pertinentes.

Medi-Cal: Esta Notificación de Acción NO cambia ni para sus beneficios de Medi-Cal. **Conserve su(s) tarjeta(s) de plástico de identificación de beneficios.**

Ordenamientos. Las siguientes reglas, las cuales puede revisar en su oficina de bienestar, son pertinentes: Asistencia Monetaria: MPP 40-105.1, 40-181.22, 40-181.24, 44-113.2; Estampillas para Comida: 63-504.27, 63-504.3; SCC: 44-503.12; CAAP: 89-730.3, 89-730.4.

☐ **Estampillas para Comida - Información adicional que se necesita**

Además, usted tiene que darle al condado la siguiente información para que se pueda calcular su cantidad de estampillas para comida. Tiene que hacerle llegar al condado esta información a más tardar el primer día laboral del próximo mes. Si se le pidieron pruebas de algún gasto y usted no las proporciona, no se permitirá el gasto. Además, si usted no le da al condado cualquier otra información que se le pida, es posible que se reduzcan o paren sus estampillas para comida

Sanción - Es pertinente solamente para las familias que reciben asistencia monetaria y que nos dan la información sobre sus ingresos ganados después del día 11.

Si alguien para esta acción (vea la primera columna), se aplicará la siguiente sanción cuando se calcule la asistencia:

Como no recibimos la información completa sobre sus ingresos ganados para el 11 de este mes, la asistencia del siguiente mes se calculará SIN LAS DEDUCCIONES POR INGRESOS GANADOS. Esto significa que el próximo mes:

- es posible que se reduzca o pare su asistencia monetaria.
- es posible que paren sus pagos de CAAP.
- usted no recibirá un pago Suplemental de Cuidado de Niños.

USTED PUEDE PARAR ESTA SANCION si tuvo un MOTIVO JUSTIFICADO para reportar sus INGRESOS GANADOS después del día 11. Dígale a su trabajador(a) la razón.