ERRATA

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IMPLEMENTATION OF GRANT STRUCTURE AND AID PAYMENT PROVISIONS - CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) PROGRAM

REFERENCE: ALL COUNTY LETTER (ACL) 97-59
DATED OCTOBER 14, 1997

This Errata transmits corrected copies of the following items that were previously sent with ACL 97-59. In the budget calculation, the wording "+ Non-Assistance Unit Members" was inadvertently omitted on the Special Needs line. Also, for the 185% test the wording "Assistance Unit + Non-Assistance Unit Members" was inserted and subsequently identified as not necessary.

M40-171C (1/98)	Application Processing: Basic Approval
M44-113G1 (1/98)	Income: Change in Income
M44-133Q (1/98)	Income: Minor Parent Income
NA 200 (1/98)	Multipurpose: Include Budget
NA 210 (1/98)	Discontinue, Suspend: Financial Eligibility
NA 211 (1/98)	Deny, Discontinue, Suspend: 185%
NA 271 (1/98)	Continuation Page - Family Income Computations: Cash Aid
NA 300 (1/98)	Continuation Page - Recipient Financial Eligibility/185% Tests

The following NOA message had incorrect language under the Region 2 Insert. The last sentence should read: "The Maximum Aid and Basic Need Standard in this county are lower than the county you were living in before."

M44-315B (1/98)	Aid Payment Levels: Inserts to Intercounty Transfer (ICT) Approvals between Regions

Since the NA forms will not have the footer and revision date changed, attached are the prior versions stamped "SAMPLE" with a line in the left margin to indicate the area affected. The NOA messages will state below the instructions, "This message replaces ... dated 01-01-98 released in ACL 97-59.

We apologize for any inconvenience this may have caused.

State of California
Department of Social Services

Noa Msg Doc No.: M40-171C
Action : Approve
Issue: Application Processing
Title: Basic Approval

Auto ID No.:
Source :
Issued by :
Reg Cite : 40-171.2, 40-129, 44-315
44-317

Use Form No. : NA 290
Original Date : 02-01-97
Revision Date : 01-01-98

MESSAGE:

The County has approved your cash aid and Medi-Cal. The cash aid payment for your first month of aid is $_____.

Your first day of cash aid is _____. Your first day of Medi-Cal is the first day of the month you applied for aid.

[ ] The cash aid payment for your first month of aid is only for a <u>part</u> of a month. It is for the time from your first day of cash aid, show above, through the end of the month. If nothing changes, next month's cash aid will be for a <u>full</u> month.

[ ] You asked for an Immediate Need payment. Your immediate need is being met with a payment of your first month's cash aid within the immediate need time limit of 1 working day.

Your cash aid is figured on this page.

INSTRUCTIONS: Use for approvals and restorations FOR CASES WHICH INCLUDE MINOR PARENTS. Check the applicable box(es). When you check the immediate need box, you will not need to send a separate notice to the applicant denying the immediate need request.

Print message on NA 290 with special budget in right column. Budget includes language to accommodate the comparison of MAP for the minor parent's child(ren).

For cases with income (AU + Non-AU members), use NA 271 (1/98) as a second page. Also, include the applicable regulation cites.

This message replaces M40-171C dated 01-01-98 released in ACL 97-59.

file: pkian/MSERIES/app.40171c

Section A. Countable Income, Month of _____

Total Business Income $_____
Business Expenses:
a. 40% Standard..... -_____
OR
b. Actual ..... -_____
Net Earnings from Self-Employment..... =_____

Total Disability-Based Unearned Income of
(Assistance Unit+ Non-Assistance Unit Members) $_____
$225 Disregard..... -_____
Nonexempt Unearned Disability-Based Income =_____
OR
Unused Amount of $225 Disregard..... = _____

Total Earned Income..... $_____
Net Earnings from Self-Employment (from above) +_____
Subtotal..... =_____
Unused Amount of $225 Disregard (from above) -_____
Subtotal..... =_____
Earned Income Disregard 50%..... -_____
Subtotal..... =_____
Nonexempt Unearned Disability-Based Income
(from above)..... +_____
Other Nonexempt Income of (Assistance Unit
+ Non-Assistance Unit Members)..... +_____
_____ +_____
Net Countable Income..... =_____

Section B. Your Cash Aid, Month of _____

1.Maximum Aid,____Persons (Assistance Unit
+ Non-Assistance Unit Members)..... $_____
2.Special Needs(Assistance Unit + Non-
Assistance Unit Members)..... +_____
3.Net Countable Income from Section A.... -_____
4.Subtotal..... =_____

5.Maximum Aid,____Persons(Assistance Unit only)
(Excluding Sanctioned Persons)..... $_____
6.Special Needs (Assistance Unit only)... +_____
7.Maximum Aid Subtotal..... =_____
8.**Full Month Aid Subtotal**.....
(Lowest Amount on Line 4 or 7)..... =_____

9. Maximum Aid for Minor parent's
____ eligible child(ren)..... $_____
10. Special Needs..... +_____
11. Minor parent's child(ren) Subtotal... =_____
12. **Full Month Aid Subtotal**
(Greater Amount on Line 8 or 11)..... =_____
13. Line 12 Prorated for Part of Month... =_____
14. Adjustments: 25% Child Support Sanction -_____
Overpayment..... -_____
14a. Other Sanctions..... -_____
14b. Bonus..... +_____
15. **Monthly Cash Aid Amount**
(Line 12 or 13 Adjusted)..... =_____

State of California
Department of Social Services

Noa Msg Doc No.: M44-113G1
Action : Change
Issue: Income
Title: Change in Income

Auto ID No.:
Source :
Issued by :
Reg Cite : 44-100, 89-201.6

Use Form No. : NA 290
Original Date : 02-01-97
Revision Date : 01-01-98

MESSAGE:

As of _____, the County is changing your monthly cash aid from $_____ to $_____.

Here's why:

Your family income has changed. When your income changes, your cash aid amount also changes.

Your new cash aid amount is figured on this page.

INSTRUCTIONS: Use to change the grant amount FOR CASES WHICH INCLUDE MINOR PARENTS when an assistnace unit (AU) reports a change in income.

Print message on NA 290 with special budget in right column. Budget includes language to accommodate the comparison of MAP for the minor parent's child(ren).

This message replaces M44-113G1 dated 01-01-98 released in ACL 97-59.

file: pkian/MSERIES/inc.44113g1

Section A. Countable Income, Month of _____

Total Business Income $_____
Business Expenses:
a. 40% Standard..... -_____
OR
b. Actual ..... -_____
Net Earnings from Self-Employment..... =_____

Total Disability-Based Unearned Income of
(Assistance Unit+ Non-Assistance Unit Members) $_____
$225 Disregard..... -_____
Nonexempt Unearned Disability-Based Income =_____
OR
Unused Amount of $225 Disregard..... = _____

Total Earned Income..... $_____
Net Earnings from Self-Employment (from above) +_____
Subtotal..... =_____
Unused Amount of $225 Disregard (from above) -_____
Subtotal..... =_____
Earned Income Disregard 50%..... -_____
Subtotal..... =_____
Nonexempt Unearned Disability-Based Income
(from above)..... +_____
Other Nonexempt Income of (Assistance Unit
+ Non-Assistance Unit Members)..... +_____
_____ +_____
Net Countable Income..... =_____

Section B. Your Cash Aid, Month of _____

1.Maximum Aid,____Persons (Assistance Unit
+ Non-Assistance Unit Members)..... $_____
2.Special Needs(Assistance Unit + Non-
Assistance Unit Members)..... +_____
3.Net Countable Income from Section A.... -_____
4.Subtotal..... =_____

5.Maximum Aid,____Persons(Assistance Unit only)
(Excluding Sanctioned Persons)..... $_____
6.Special Needs (Assistance Unit only)... +_____
7.Maximum Aid Subtotal..... =_____
8.**Full Month Aid Subtotal**.....
(Lowest Amount on Line 4 or 7)..... =_____

9. Maximum Aid for Minor parent's
___ eligible child(ren)..... $_____
10. Special Needs..... +_____
11. Minor parent's child(ren) Subtotal... =_____
12. **Full Month Aid Subtotal**
(Greater Amount on Line 8 or 11)..... =_____
13. Line 12 Prorated for Part of Month... =_____
14. Adjustments: 25% Child Support Sanction -_____
Overpayment..... -_____
14a. Other Sanctions..... -_____
14b. Bonus..... +_____
15. **Monthly Cash Aid Amount**
(Line 12 or 13 Adjusted)..... =_____

State of California
Department of Social Services

Noa Msg Doc No.: M44-133Q
Action : Change
Issue: Income
Title: Minor Parent Income

Auto ID No.:
Source :
Issued by :
Reg Cite : 89-201.5

Use Form No. : NA 290
Original Date : 02-01-97
Revision Date : 01-01-98

MESSAGE:

As of _____, the County is changing your monthly cash aid from $_____ to $_____.

Here's why:

Your parent's income has changed.

When you are pregnant or a parent and under age 18 living with your parent, some of your parent's income is counted to figure your cash aid. When their income changes, your income also changes.

We figured how much of your parent's income we used on the next page.

Your new cash aid amount is figured on this page.

INSTRUCTIONS: Use to change the grant amount in minor parent cases when a change in the family's income (AU + Non-AU) causes the minor parent's income to change.

Print message on NA 290 with special budget in right column. Budget includes language to accommodate the comparison of MAP for the minor parent's child(ren).

This message replaces M44-133Q dated 01-01-98 released in ACL 97-59.

file: pkian/MSERIES/ mp.44133q

Section A. Countable Income, Month of _____

Total Business Income $_____
Business Expenses:
a. 40% Standard..... -_____
OR
b. Actual ..... -_____
Net Earnings from Self-Employment..... =_____

Total Disability-Based Unearned Income of
(Assistance Unit+ Non-Assistance Unit Members) $_____
$225 Disregard..... -_____
Nonexempt Unearned Disability-Based Income =_____
OR
Unused Amount of $225 Disregard..... = _____

Total Earned Income..... $_____
Net Earnings from Self-Employment (from above) +_____
Subtotal..... =_____
Unused Amount of $225 Disregard (from above) -_____
Subtotal..... =_____
Earned Income Disregard 50%..... -_____
Subtotal..... =_____
Nonexempt Unearned Disability-Based Income
(from above)..... +_____
Other Nonexempt Income of (Assistance Unit
+ Non-Assistance Unit Members)..... +_____
_____ +_____
Net Countable Income..... =_____

Section B. Your Cash Aid, Month of _____

1.Maximum Aid,____Persons (Assistance Unit
+ Non-Assistance Unit Members)..... $_____
2.Special Needs(Assistance Unit + Non-
Assistance Unit Members)..... +_____
3.Net Countable Income from Section A.... -_____
4.Subtotal..... =_____

5.Maximum Aid,____Persons(Assistance Unit only)
(Excluding Sanctioned Persons)..... $_____
6.Special Needs (Assistance Unit only)... +_____
7.Maximum Aid Subtotal..... =_____
8.**Full Month Aid Subtotal**.....
(Lowest Amount on Line 4 or 7)..... =_____

9. Maximum Aid for Minor parent's
___ eligible child(ren)..... $_____
10. Special Needs..... +_____
11. Minor parent's child(ren) Subtotal... =_____
12. **Full Month Aid Subtotal**
(Greater Amount on Line 8 or 11)..... =_____
13. Line 12 Prorated for Part of Month... =_____
14. Adjustments: 25% Child Support Sanction -_____
Overpayment..... -_____
14a. Other Sanctions..... -_____
14b. Bonus..... +_____
15. **Monthly Cash Aid Amount**
(Line 12 or 13 Adjusted)..... =_____

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 Business Income ..... $ _____
Business Expenses:
a. 40% Standard ..... - _____
OR
b. Actual ..... - _____
Net Earnings from Self-Employment ..... = _____

Total Disability-Based Unearned Income of
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
$225 Disregard ..... - _____
Nonexempt Unearned Disability-Based Income ..... = _____
OR
Unused Amount of $225 Disregard ..... = _____

Total Earned Income ..... $ _____
Net Earnings from Self-Employment (from above) ..... + _____
Subtotal ..... = _____
Unused Amount of $225 Disregard (from above) ..... - _____
Subtotal ..... = _____
Earned Income Disregard 50% ..... - _____
Subtotal ..... = _____
Nonexempt Unearned Disability-Based Income
(from above). ..... + _____
Other Nonexempt Income of (Assistance Unit + Non-Assistance Unit Members)_____ + _____
_____ + _____

Net Countable Income ..... = _____

Section B. Your Cash Aid, Month of _____

1. Maximum Aid _____ Persons
(Assistance Unit + Non-Assistance Unit Members) .. $ _____
2. Special Needs (Assistance Unit + Non-Assistant Unit Members) ..... + _____
3. Net Countable Income from Section A ..... - _____
4. Subtotal ..... = _____
5. Maximum Aid _____ Persons (Assistance Unit only)
(Excluding Sanctioned Persons) ..... $ _____
6. Special Needs (Assistance Unit only) ..... + _____
7. Maximum Aid Subtotal ..... = _____
8. **Full Month Aid Subtotal**
(Lowest Amount on Line 4 or 7 ..... = _____
9. Line 8 Prorated for Part of Month ..... = _____
10. Adjustments: 25% Child Support Sanction ..... - _____
Overpayment ..... - _____
Other Sanctions ..... - _____
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

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

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.

SAMPLE

Monthly Cash Aid Amount

Section A. Countable Income, Month of _____

Total Business Income ..... $ _____
Business Expenses:
a. 40% Standard ..... - _____
OR
b. Actual ..... - _____
Net Earnings from Self-Employment ..... = _____

Total Disability-Based Unearned Income of
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
$225 Disregard ..... - _____
Nonexempt Unearned Disability-Based Income ..... = _____
OR
Unused Amount of $225 Disregard ..... = _____

Total Earned Income ..... $ _____
Net Earnings from Self-Employment (from above) ..... + _____
Subtotal ..... = _____
Unused Amount of $225 Disregard (from above) ..... - _____
Subtotal ..... = _____
Earned Income Disregard 50% ..... - _____
Subtotal ..... = _____
Nonexempt Unearned Disability-Based Income
(from above)..... + _____
Other Nonexempt Income of (Assistance Unit + Non-Assistance Unit Members)_____ + _____
_____ + _____

Net Countable Income ..... = _____

Section B. Your Cash Aid, Month of _____

1. Maximum Aid _____ Persons
(Assistance Unit + Non-Assistance Unit Members) .. $ _____
2. Special Needs (Assistance Unit only) ..... + _____
3. Net Countable Income from Section A ..... - _____
4. Subtotal ..... = _____
5. Maximum Aid _____ Persons (Assistance Unit only)
(Excluding Sanctioned Persons) ..... $ _____
6. Special Needs (Assistance Unit only) ..... + _____
7. Maximum Aid Subtotal ..... = _____
8. **Full Month Aid Subtotal**
(Lowest Amount on Line 4 or 7 ..... = _____
9. Line 8 Prorated for Part of Month ..... = _____
10. Adjustments: 25% Child Support Sanction ..... - _____
Overpayment ..... - _____
Other Sanctions ..... - _____
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

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

**DISCONTINUE, SUSPEND-
FINANCIAL ELIGIBILITY**

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:

Net Countable Income

Total Business Income ..... $ _____
Business Expenses:
a. 40% Standard ..... - _____
OR
b. Actual ..... - _____
Net Earnings from Self-Employment ..... = _____

Total Disability-Based Unearned Income of
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
$225 Disregard ..... - _____
Nonexempt Unearned Disability-Based Income ..... = _____
OR
Unused Amount of $225 Disregard ..... = _____

Total Earned Income ..... $ _____
Net Earnings from Self-Employment (from above) ..... + _____
Subtotal ..... = _____
Unused Amount of $225 Disregard (from above) ..... - _____
Subtotal ..... = _____
Earned Income Disregard 50% ..... - _____
Subtotal ..... = _____

Nonexempt Unearned Disability-Based Income
(from above)..... + _____
Other Nonexempt Income of (Assistance Unit + Non-
Assistance Unit Members)_____ + _____
_____ + _____

Child Support collected by the County, Except for
Maximum Family Grant child (for financial
eligibility only) ..... + _____

(A) Net Countable Income ..... = _____

Maximum Aid Payment
Maximum Aid for _____ Persons
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
Special Needs (Assistance Unit + Non-Assistance
Unit Members) ..... + _____

(B) Maximum Aid Payment ..... = _____

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

**DISCONTINUE, SUSPEND-
FINANCIAL ELIGIBILITY**

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.

SAMPLE

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:

Net Countable Income

Total Business Income ..... $ _____
Business Expenses:
a. 40% Standard ..... - _____
OR
b. Actual ..... - _____
Net Earnings from Self-Employment ..... = _____

Total Disability-Based Unearned Income of
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
$225 Disregard ..... - _____
Nonexempt Unearned Disability-Based Income ..... = _____
OR
Unused Amount of $225 Disregard ..... = _____

Total Earned Income ..... $ _____
Net Earnings from Self-Employment (from above) ..... + _____
Subtotal ..... = _____
Unused Amount of $225 Disregard (from above) ..... - _____
Subtotal ..... = _____
Earned Income Disregard 50% ..... - _____
Subtotal ..... = _____

Nonexempt Unearned Disability-Based Income
(from above)..... + _____
Other Nonexempt Income of (Assistance Unit + Non-
Assistance Unit Members)_____ + _____
_____ + _____

Child Support collected by the County, Except for
Maximum Family Grant child (for financial
eligibility only) ..... + _____

(A) Net Countable Income ..... = _____

Maximum Aid Payment
Maximum Aid for _____ Persons
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
Special Needs (Assistance Unit only) ..... + _____

(B) Maximum Aid Payment ..... = _____

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

DENY, DISCONTINUE, SUSPEND - 185%TEST

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.

Family Gross Income in _____ (MONTH)

_____	$ _____
_____	+ _____
_____	+ _____
_____	+ _____
Total Gross Income	= _____

Family Needs in _____ (MONTH)

Basic Need for _____ Persons	$ _____
Special Needs	+ _____
Total Needs	= _____
	x 1.85
185% of Needs	= _____

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

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

DENY, DISCONTINUE, SUSPEND - 185%TEST

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.

SAMPLE

Family Gross Income in _____ (MONTH)
(Assistance Unit + Non-Assistance Unit Members)

_____	$ _____
_____	+ _____
_____	+ _____
_____	+ _____
Total Gross Income	= _____

Family Needs in _____ (MONTH)

Basic Need for _____ Persons (Assistance Unit + Non-Assistance Unit Members)	$ _____
Special Needs (Assistance Unit only)	+ _____
Total Needs	= _____
	x 1.85
185% of Needs	= _____

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

NOTICE OF ACTION
(Continued)

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date _____
Case Name _____
Number _____

FAMILY'S INCOME

Monthly Cash Aid Amount

Section A. Countable Income, Month of ..... _____

Total Business Income ..... $ _____
Business Expenses:
a. 40% Standard ..... - _____
OR
b. Actual ..... - _____
Net Earnings from Self-Employment ..... = _____

Total Disability-Based Unearned Income of
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
$225 Disregard ..... - _____
Nonexempt Unearned Disability-Based Income ..... = _____
OR
Unused Amount of $225 Disregard ..... = _____

Total Earned Income ..... $ _____
Net Earnings from Self-Employment (from above) ..... + _____
Subtotal ..... = _____
Unused Amount of $225 Disregard (from above) ..... - _____
Subtotal ..... = _____
Earned Income Disregard 50% ..... - _____
Subtotal ..... = _____
Nonexempt Unearned Disability-Based Income (from above) + _____
Other Nonexempt Income of (Assistance Unit +
Non-Assistance Unit Members)_____ + _____
_____ + _____
Net Countable Income ..... = _____

Section B. Your Cash Aid, Month of ..... _____

1. Maximum Aid_____Persons
(Assistance Unit + Non-Assistance Unit Members) .... $ _____
2. Special Needs (Assistance Unit + Non-Assistance
Unit Members) ..... + _____
3. Net Countable Income from Section A ..... -
4. Subtotal ..... = [ ]

5. Maximum Aid_____Persons (Assistance Unit only)
(Excluding Sanctioned Persons) ..... $ _____
6. Special Needs (Assistance Unit only) ..... +
7. Maximum Aid Subtotal ..... = [ ]
8. **Full Month Aid Subtotal**
(Lowest Amount on Line 4 or 7) ..... = _____
9. Line 8 Prorated for Part of Month ..... = _____
10. Adjustments: 25% Child Support Sanction ..... - _____
Overpayment ..... - _____
Other Sanctions ..... - _____
Bonus ..... + _____
11. **Monthly Cash Aid Amount**
(Line 8 or 9 Adjusted) ..... = _____

Rules: These rules apply; you may review them at your welfare office: MPP 44-133; 44-315

NOTICE OF ACTION
(Continued)

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date _____
Case Name _____
Number _____

FAMILY'S INCOME

Monthly Cash Aid Amount

Section A. Countable Income, Month of ..... _____

Total Business Income ..... $ _____
Business Expenses:
a. 40% Standard ..... - _____
OR
b. Actual ..... - _____
Net Earnings from Self-Employment ..... = _____

Total Disability-Based Unearned Income of
(Assistance Unit + Non-Assistance Unit Members) ..... $ _____
$225 Disregard ..... - _____
Nonexempt Unearned Disability-Based Income ..... = _____
OR
Unused Amount of $225 Disregard ..... = _____

Total Earned Income ..... $ _____
Net Earnings from Self-Employment (from above) ..... + _____
Subtotal ..... = _____
Unused Amount of $225 Disregard (from above) ..... - _____
Subtotal ..... = _____
Earned Income Disregard 50% ..... - _____
Subtotal ..... = _____
Nonexempt Unearned Disability-Based Income (from above) + _____
Other Nonexempt Income of (Assistance Unit +
Non-Assistance Unit Members)_____ + _____
_____ + _____
Net Countable Income ..... = _____

Section B. Your Cash Aid, Month of ..... _____

1. Maximum Aid_____Persons
(Assistance Unit + Non-Assistance Unit Members) .... $ _____
2. Special Needs (Assistance Unit only) ..... + _____
3. Net Countable Income from Section A ..... -
4. Subtotal ..... = [ ]

5. Maximum Aid_____Persons (Assistance Unit only)
(Excluding Sanctioned Persons) ..... $ _____
6. Special Needs (Assistance Unit only) ..... +
7. Maximum Aid Subtotal ..... = [ ]
8. **Full Month Aid Subtotal**
(Lowest Amount on Line 4 or 7) ..... = _____
9. Line 8 Prorated for Part of Month ..... = _____
10. Adjustments: 25% Child Support Sanction ..... - _____
Overpayment ..... - _____
Other Sanctions ..... - _____
Bonus ..... + _____
11. **Monthly Cash Aid Amount**
(Line 8 or 9 Adjusted) ..... = _____

Rules: These rules apply; you may review them at your welfare office: MPP 44-133

SAMPLE

NOTICE OF ACTION
(Continued)

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

RECIPIENT - FINANCIAL ELIGIBILITY/185% TESTS

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

☐ You are ineligible because your **Total Gross Income** is more than **185% of Needs.**

Family Gross Income

_____	$	_____
_____	+	_____
_____	+	_____
Total Gross Income	=	_____
Family Needs		
Basic Need, ____ Persons	$	_____
Special Needs	+	_____
Total Needs	=	_____
	x	1.85
185% of Needs	=	_____

☐ You are ineligible because your **Total Net Countable Income** is more than your **Maximum Aid Payment.**

Net Countable Income		
Total Business Income	$	_____
Business Expenses:		
a. 40% Standard	-	_____
OR		
b. Actual	-	_____
Net Earnings from Self-Employment	=	_____
Total Disability-Based Unearned Income of (Assistance Unit + Non-Assistance Unit Members)	$	_____
$225 Disregard	-	_____
Nonexempt Unearned Disability-Based Income	=	_____
OR		
Unused Amount of $225 Disregard	=	_____
Total Earned Income	$	_____
Net Earnings from Self-Employment (from above)	+	_____
Subtotal	=	_____
Unused Amount of $225 Disregard	-	_____
Subtotal	=	_____
Earned Income Disregard 50%	-	_____
Subtotal	=	_____
Nonexempt Unearned Disability-Based Income (from above)	+	_____
Other Nonexempt Income of (Assistance Unit + Non-Assistance Unit Members)_____	+	_____
_____	+	_____
Child Support collected by the County, Except for Maximum Family Grant child (for financial eligibility only)	+	_____
Total Net Countable Income	=	_____
Maximum Aid Payment		
Maximum Aid for_____Persons (Assistance Unit + Non-Assistance Unit Members)	$	_____
Special Needs (Assistance Unit + Non-Assistance Unit Members)	+	_____
Maximum Aid Payment	=	_____

Rules: These rules apply; you may review them at your welfare office: MPP 44-207.2, 44-207.3
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
(Continued)

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

RECIPIENT - FINANCIAL ELIGIBILITY/185% TESTS

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

☐ You are ineligible because your **Total Gross Income** is more than **185% of Needs.**

Family Gross Income
(Assistance Unit + Non-Assistance Unit Members)

_____	$	_____
_____	+	_____
_____	+	_____
Total Gross Income	=	_____
Family Needs		
Basic Need, ____ Persons (Assistance Unit + Non-Assistance Unit Members)	$	_____
Special Needs (Assistance Unit only)	+	_____
Total Needs	=	_____
	x	1.85
185% of Needs	=	_____

☐ You are ineligible because your **Total Net Countable Income** is more than your **Maximum Aid Payment.**

Net Countable Income		
Total Business Income	$	_____
Business Expenses:		
a. 40% Standard	-	_____
OR		
b. Actual	-	_____
Net Earnings from Self-Employment	=	_____
Total Disability-Based Unearned Income of (Assistance Unit + Non-Assistance Unit Members)	$	_____
$225 Disregard	-	_____
Nonexempt Unearned Disability-Based Income	=	_____
OR		
Unused Amount of $225 Disregard	=	_____
Total Earned Income	$	_____
Net Earnings from Self-Employment (from above)	+	_____
Subtotal	=	_____
Unused Amount of $225 Disregard	-	_____
Subtotal	=	_____
Earned Income Disregard 50%	-	_____
Subtotal	=	_____
Nonexempt Unearned Disability-Based Income (from above)	+	_____
Other Nonexempt Income of (Assistance Unit + Non-Assistance Unit Members)_____	+	_____
_____	+	_____
Child Support collected by the County, Except for Maximum Family Grant child (for financial eligibility only)	+	_____
Total Net Countable Income	=	_____
Maximum Aid Payment		
Maximum Aid for_____Persons (Assistance Unit + Non-Assistance Unit Members)	$	_____
Special Needs (Assistance Unit only)	+	_____
Maximum Aid Payment	=	_____

SAMPLE

Rules: These rules apply; you may review them at your welfare office: MPP 44-207.2, 44-207.3
State Hearing: If you think this action is wrong, you can ask for a hearing. The back of page 1 tells how.

State of California
Department of Social Services

Noa Msg Doc No.: M44-315B
Action : Approve
Issue: Aid Payment Levels
Title: ICT between Reg-1 and Reg-2
MAP Increase/Decrease

Auto ID No.:
Source :
Issued by :
Reg Cite : 44-315.311(a), 40-189

Use Form No. : NA 200
Original Date : 11-01-96
Revision Date : 01-01-98

MESSAGE:

REGION 1 INSERT

[ ] A change in State law lowered the Maximum Aid a total of 4.9 percent in the county where you are now living. The Maximum Aid in this county is higher than the county you were living in before.

REGION 2 INSERT

[ ] A change in State law lowered the Maximum Aid about 9.56 percent and the Basic Need Standard by 4.9 percent in the county where you are now living. The Maximum Aid and Basic Need Standard in this county are lower than the county you were living in before.

INSTRUCTIONS: Use as language to insert for intercounty transfers that are approved and ONLY when the case is coming from a different Region's county. This would be used by the receiving county.

This message replaces M44-315B dated 01-01-98 released in ACL 97-59.

file: pkian/MSERIES/ap.44315b