NOTICE OF ACTION AND RIGHT TO REQUEST A STATE HEARING ON INTERIM ASSISTANCE

State No.:
County No.:
Worker No.:
District:
Date:
Case Name:
Interpreter Needed: _____ Language _____ Dialect

This office received on _____ a Supplemental Security Income/State Supplementary Program (SSI/SSP) payment for you in the amount of $ _____ , for the period _____ through _____. As per your agreement, we are sending you the balance of $_____ after deducting the amount of $_____ , to repay the amount of assistance you received from Interim Assistance for that same period while Social Security Administration (SSA) completed the work on your eligibility determination for SSI/SSP benefits.

SSI/SSP PAYMENT

If you disagree with the amount of the SSI/SSP payment of $_____, contact your local Social Security Office. The amount of the total SSI/SSP payment is subject to the SSA appeal process. A request for reconsideration must be filed within 60 days after the date the notice of the initial determination is received.

INTERIM ASSISTANCE PAYMENT

If you disagree with the amount of Interim Assistance withheld from your SSI/SSP payment or you contend that we did not send you the balance, if any, as shown above within the 10 working days, please contact the State Department of Social Services. This action is subject to the state fair hearing provision described on the reverse side of this form.

COMMENTS:

The law and/or regulations governing this action are:

Department of Social Services Eligibility and Assistance Standards Manual Section 46-337

If you have any questions please contact me.

County/State Representative		Agency
Telephone	Date:	