Cash Assistance Program for Immigrants

Notice of Overpayment - Waiver Approval

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date: _____

Case Name: _____

Number Worker: _____

Number: _____

Telephone: _____

Address: _____

_____

_____

(ADDRESSEE)

Questions? Ask your Worker.
State Hearing: If you think this action is wrong, you ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

We previously notified you of your Cash Assistance Program for Immigrants (CAPI) overpayment in the amount of $ _____ for the period _____ through _____. Your request for waiver of this overpayment is approved. This means you will NOT have to pay the money back.

Medi-Cal: This notice does NOT change or stop Medi-Cal benefits. If there is a change in your Medi-Cal benefits, you will receive another notice. **Keep your plastic Benefits Identification Card(s).**
Rules: These rules apply; you may review them at your welfare office: MPP 49-001 through 49-070

The form originally included with this letter is outdated and has been removed. To access a more current version, please visit the NA BACK 9.