NOTICE OF ACTION

FORM AND INSTRUCTIONS -
For Approved Relatives, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians or Non-Minor Dependents Residing In A Supervised Independent Living Setting:

COUNTY OF

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

(4) Notice Date: _____
(5) Case Name: _____
(6) Case WorkerNumber: _____
(7) Case Worker Name: _____
(8) Case Number: _____
(9) Telephone: _____
(10) Address: _____

(1) Name:
(2) Address:
(3) City, State Zip:

This is to inform you that you were overpaid AFDC-Foster Care benefits

(11) for _____ for
(NAME OF CHILD)

(12) the period of _____ to _____
(MM/DD/YYYY) (MM/DD/YYYY)

(13) Total amount you received: $ _____
(14) Total amount you should have received:$ _____
(15) Total amount of Overpayment: $ _____
(16) Date of Discovery: _____ Collection is permitted if demand within one year of discovery.
(17) You are required to repay the overpayment amount of $_____.
(18) Reason for the overpayment:

☐ **(A)** From _____ (date) the child/youth was not residing in your home and you failed to report that to your county social worker and you received payments for him/her that you were not entitled to.
☐ **(B)** Other: _____

By law we can collect foster care overpayments if the adult caretaker caused the overpayment. We cannot require you to repay the overpayment if you meet an **exception.** Exceptions to repayment are:

- The overpayment was exclusively caused by county administrative error, or
- Both the county and the foster care provider did not know of or contribute to the cause of the overpayment.
- The minor's absence was temporary and the funds were used to maintain the home for their return or used to support their needs.

If you disagree with the reason for overpayment or the amount of the overpayment, you may request a hearing. Please see following pages for hearing instructions.

If you agree with the reason for overpayment and the overpayment amount, you must do one of the following within 90 calendar days from the day the county gave or mailed you this notice:

1) Make a one time payment of the total amount;
Please pay by check or money order, made payable to:

Send to:

2) Sign a written payment agreement. You must contact the worker at the top of this page to discuss the terms of a written payment agreement.

If you have any questions regarding the overpayment computation or repayment arrangements, please contact the worker at the top of this form.

(19) Insert overpayment calculations and substantiation of time periods by month as required in regulation. See MPP Section 45-305. Attach a page if additional space is needed.

Relevant Law: Welfare and Institutions Code section 11466.24, Manual of Policies and Procedures (MPP) sections 22-009, 45-304, 45-305, and 45-306.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

To request a Hearing:

If you think this action is wrong, you can ask for either an informal hearing provided by the County or a formal State hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

In order to request an informal hearing, your request must be made no later than 30 calendar days after this notice was mailed to you. You may send your request by any of the following methods.

In writing: ☐ Email requests: ☐

Phone requests: ☐

Address

Your request should state why you want the informal hearing and if you will need a free interpreter. If so, please indicate what language or dialect you speak.

You may appeal the informal hearing decision at a formal State hearing. You may request the formal State hearing within 90 calendar days after the informal hearing decision is mailed to you. If the informal hearing is requested but not held, the 90 days will begin 31 calendar days from the date of this notice.

If you choose a formal State hearing, please note that you must request that State hearing within 90 calendar days of the receipt of this notice.

If you have any questions, contact the worker at the top of the first page of this form.

TDD - For Hearing Impaired

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Overpayment _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE