CASH ASSISTANCE PROGRAM FOR IMMIGRANTS
STATE INTERIM ASSISTANCE REIMBURSEMENT AUTHORIZATION

NAME (PLEASE PRINT)	SOCIAL SECURITY NUMBER

I have applied for public assistance in _____ County. I understand that if I apply for benefits under the Cash Assistance Program for Immigrants (CAPI), any public assistance paid on my behalf by the county after I file a CAPI application and while my eligibility for CAPI benefits is being determined is considered interim assistance. (Assistance financed in any part with federal or state funds will not be considered interim assistance.)

In consideration of any interim assistance paid on my behalf, I authorize the entity responsible for determining CAPI eligibility and benefit amounts to reimburse the county by deducting from my first CAPI payment the amount of interim assistance paid on my behalf during my CAPI eligibility period. The amount to be reimbursed to the county shall be deducted from my first CAPI payment and shall not exceed the amount of that payment.

☐ Initial Claim — beginning with the month for which I am found eligible for a CAPI payment and ending with the month my CAPI payments begin;

or

☐ Post Eligibility — beginning with the month for which my CAPI payments are reinstated after a period of suspension or termination and ending with the month my payments resume.

I understand that after deducting the amount of the reimbursement to the county, the entity responsible for determining CAPI eligibility and benefit amounts will issue, or request issuance of, a payment for any balance due on my behalf immediately. The responsible entity will issue, or request issuance of, this CAPI payment no later than ten (10) working days from the date it makes the determination of my CAPI eligibility and benefit amount.

I understand that if I feel that the amount deducted from my CAPI retroactive payments is more than the amount of public assistance paid on my behalf by _____ county, I have a right to request a fair hearing from the California Department of Social Services. If I desire a fair hearing, I must file a request for a fair hearing within ninety (90) days after the date my initial Notice of Approval was issued.

I understand that this authorization is effective immediately and that it will cease to have effect:

☐ Initial Claim — at the end of one (1) year from the date the entity responsible for determining CAPI eligibility and benefit amounts receives this signed form, unless I file for CAPI within that time, or one of the events listed below occurs earlier, in which case the authorization will cease to have effect as of the date of such event:

- The State makes an initial payment or reinstates payment on my claim:
- The State denies my claim and I do not file a timely appeal of that determination:
- The county and I agree to terminate this agreement.

or

☐ Post Eligibility — at the end of one (1) year from the date the entity responsible for determining CAPI eligibility and benefit amounts receives this signed form or at the end of the maximum period within which to request review of the determination to suspend or terminate my CAPI payments, whichever period of time is longer, unless I file a timely request for review, or one of the events listed above occurs in which case the authorization will cease to have effect as of the date of such event.

I declare under penalty of perjury under the laws of the State of California that the information I have given on this form is true, correct, and complete.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE SIGNED