

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, Sacramento, California 95814



April 11, 2001

ALL COUNTY INFORMATION NOTICE NO. I-09-01

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: KINSHIP GUARDIANSHIP ASSISTANCE  
PAYMENT (Kin-GAP) PROGRAM**REASON FOR THIS TRANSMITTAL**

- State Law Change  
 Federal Law or Regulation  
                   Change  
 Court Order  
 Clarification Requested by  
                   One or More Counties  
 Initiated by CDSS

REFERENCE: ALL COUNTY INFORMATION NOTICE  
(ACIN) I-07-00 and ALL COUNTY LETTER (ACL) 00-70

The purpose of this notice is to transmit the revised Kin-GAP forms and notices of action (NOA). These forms and NOAs were revised as a result of the passage of AB 2876 (Budget Trailer Bill effective July 10, 2000). Please refer to ACL 00-70 dated November 13, 2000, for a description of the changes ensuing from AB 2876 within the Kin-GAP Program. Camera ready copies of the forms and notices are attached to this ACIN. Supplies will also be available from the California Department of Social Services (CDSS) Warehouse. Counties should submit orders on a GEN 727A to CDSS Warehouse, P.O. Box 22429, Sacramento, California 95822-3799.

Indicated below are the revised Kin-GAP forms and NOAs with explanations of the changes resulting from the passage of AB 2876:

KG 7 – Monthly Eligibility Report. Monthly reporting is no longer required for the Kin-GAP Program; therefore, the KG 7 is obsolete.

KG 2 – Statement of Facts Supporting Eligibility for Kinship Guardianship Assistance Payment Program. It is no longer required that a Kin-GAP case be discontinued if the child's parent(s) moves into the home of the Kin-GAP caretaker relative. Therefore, the question relating to the "parent(s) in the home" was deleted. Furthermore, due to a new requirement, a release of information statement pertaining to the social security number has been added.

KG 2A – Rights, Responsibilities, and Other Important Information. Kin-GAP children will no longer be eligible for an Immediate Need and Special Needs payment and Child Care Services. Additionally, it is no longer required that monthly reporting be completed and Kin-GAP children participate in the Welfare to Work Program. Therefore, all references to these areas have been deleted from the form. Please note that the statement that Kin-GAP caretaker relatives must report if either parent moves into the home will remain on the form. Even though the case will not be discontinued if either parent moves into the home, it does affect the federal portion of the Kin-GAP payment (CFL 00/01-05, Question 3). Additionally, a statement that a Kin-GAP child at age 16 is eligible for the Independent Living Program has been added.

Page Two

SOC 369 – “Agency-Relative Guardianship Disclosure”. Children receiving Kin-GAP will no longer be eligible to receive CalLearn benefits or services and it is no longer required that a Kin-GAP case be discontinued if the child’s parent(s) moves into the home of the Kin-GAP caretaker relative. Therefore, changes to this effect have been applied to the form. Additionally, a statement indicating that a Kin-GAP child must apply for Medi-Cal in order to receive Medi-Cal benefits between the ages of 18 to 21 and a release of information statement pertaining to the social security number have been added.

NA 1209 (Change NOA) – Children receiving Kin-GAP will no longer be eligible to receive Special Needs payments; therefore, the statement relating to this has been deleted.

NA 1210 (Discontinue NOA) – It is no longer required that a Kin-GAP case be discontinued if the child’s parent(s) moves into the home of the Kin-GAP caretaker relative; therefore, the question relating to this was deleted.

For camera-ready copies of English messages and English and Spanish forms, call Forms Management Unit (FMU) at 657-1907 or CALNET at 437-1907. If your office has Internet access, you may obtain various forms and Notice of Form Change (GEN 127) from the CDSS web page at: <http://www.dss.cahwnet.gov>. To accommodate agencies without Internet access, copies will be available by contacting FMU.

For all translated messages and Russian and Asian (Cambodian, Chinese, and Vietnamese) versions of forms, call Language Translation Services (LTS) at (916) 654-1282 or CALNET 464-1282. If you need several forms, fax your request to (916) 654-3429 or e-mail your request to [ISU@dss.ca.gov](mailto:ISU@dss.ca.gov). Your Forms Coordinator now receives all translations as soon as they become available, if your county is on the LTS mailing list. Once you have established an e-mail address, please contact FMU by telephone or e-mail at, [fmud@dss.ca.gov](mailto:fmud@dss.ca.gov). FMU will then place you on their e-mail list.

If you have questions about these forms, NOAs, or eligibility to Kin-GAP, please contact your Foster Care Eligibility Funding Consultant at (916) 324-5809. Services questions pertaining to the Kin-GAP Program should be directed to the Foster Care Policy Bureau at (916) 445-0813.

Sincerely,

Original Document signed by

SYLVIA PIZZINI  
Deputy Director  
Children and Family Services Division

Enclosures

c: CWDA

**STATEMENTS OF FACTS SUPPORTING ELIGIBILITY FOR KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (Kin-GAP) PROGRAM:** *The legal guardian should complete in ink all questions to the left of the heavy black line with information about the child for whom they are the legal guardian. If there are multiple children, one form per child should be completed.*

**ELIGIBILITY WORKER ONLY**

APPLICATION  
 REDETERMINATION

CASE NAME

CASE NUMBER

1. Child Name 2.  Male  Female

3. Address

4. Birth date 5. Birthplace

6. Social Security # Applied For?  Yes  No

7. Citizen of U.S.?  Yes  No 8. Alien Status:

9. Does the child have medical insurance?  Yes  No

If yes, list policy number, company name, and name of policy:

10. Does the child have real or personal property?  Yes  No

If yes, list property type (land, cash, auto, motorcycle, life insurance, trust fund, bank account, bond, etc.) and its value:

11. Does the child have income?  Yes  No  Unknown\*  
If yes, list amounts below. If application pending, check associated box.

| INCOME TYPE         | AMOUNT | PENDING                  |
|---------------------|--------|--------------------------|
| Social Security     |        | <input type="checkbox"/> |
| Child Support       |        | <input type="checkbox"/> |
| Railroad Retirement |        | <input type="checkbox"/> |
| SSI/SSP             |        | <input type="checkbox"/> |
| Veteran's Benefits  |        | <input type="checkbox"/> |
| Salary/Wages        |        | <input type="checkbox"/> |
| Other (specify)     |        | <input type="checkbox"/> |
| Total Amount/Month  |        | <input type="checkbox"/> |

\* If unknown, please explain:

12. Name of School or Training Program:

13. If child has salary/wages, is the child attending school at least half-time?  Yes  No

14. Does the child have an Independent Living Program Plan?  Yes  No

15. Does the child attend school on a full-time basis?  Yes  No

**COMPLETE BELOW FOR CHILDREN 17 AND OLDER**

16. Expected graduation/completion before 19th birthday?  Yes  No

**VERIFICATION**

AGE

SOCIAL SECURITY NUMBER

CITIZENSHIP/ALIEN STATUS

DHS 6155

CHILD'S PROPERTY

CHILD'S INCOME/PENDING INCOME

ILP

VERIFIED BY SCHOOL YES

SCHOOL ATTENDANCE

GRADUATION

- 17) Does this child have a child(ren) of his/her own?  Yes  No
- 18) Do you have guardianship of the child which was granted by a California court?  Yes  No

**VERIFICATION**

**Directions:** Complete number 19 when applying for aid or if there are any changes in this information since the last time you completed this form.

| 19) PARENTAL INFORMATION                     |          |          |          |
|--|----------|----------|----------|
| Name   | PARENT 1 | PARENT 2 | PARENT 3 |
| Relationship                                 |          |          |          |
| Maiden Name                                  |          |          |          |
| Date of Birth                                |          |          |          |
| Birthplace                                   |          |          |          |
| Social Security #                            |          |          |          |
| Address                                      |          |          |          |
| Telephone #                                  |          |          |          |
| U.S. Citizen (yes or no)                     |          |          |          |
| Veteran (Branch, Years in Service, Serial #) |          |          |          |

GUARDIANSHIP VERIFIED

CHILD SUPPORT REFERRAL

- NOT ELIGIBLE
- ELIGIBLE
  - FEDERAL
  - NONFEDERAL
  - OTHER

LEGAL GUARDIAN:  
I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

|  |      |
|--|------|
| SIGNATURE OF LEGAL GUARDIAN                |      |
| COUNTY WHERE SIGNED                        | DATE |
| SIGNATURE OF ELIGIBILITY WORKER            | DATE |
| SIGNATURE OF ELIGIBILITY WORKER SUPERVISOR | DATE |

**RELEASE OF INFORMATION**

You and any member of your family for whom you are applying for aid must give us a Social Security Number(s) (SSN). The SSN(s) are needed to determine your eligibility. Failure to cooperate may result in denial or discontinuance of aid. Authority: **Welfare and Institutions Code, Section 11268.**

# AGENCY-RELATIVE GUARDIANSHIP DISCLOSURE

ONE COPY TO: Relative Caregiver  
Child's Social Services Record  
Child's Eligibility Record

**NOTE:** THIS DISCLOSURE MUST BE COMPLETED PRIOR TO ANY CHANGE IN CUSTODIAL STATUS OF RELATIVE FOSTER PARENT

|                                 |                |                         |
|---------------------------------|----------------|-------------------------|
| NAME OF CHILD:                  |                | CAREGIVER'S NAME:       |
| DATE PLACED WITH THIS RELATIVE: | DATE OF BIRTH: | SOCIAL SECURITY NUMBER: |

**Initial Here:**

\_\_\_\_\_ I understand that I am not required to change custodial status from relative caregiver to legal guardian. However, if I decide to become a legal guardian, court dependency may be dismissed.

\_\_\_\_\_ I have been provided a Guardianship Pamphlet.

1.  **AFDC-Foster Care to Kin-GAP**

**Initial Here:**

\_\_\_\_\_ I understand that by becoming a relative legal guardian of \_\_\_\_\_:

- The child's payment will change from \$\_\_\_\_\_ to \$\_\_\_\_\_ per month.
- The child will no longer be eligible to receive an AFDC-Foster Care payment.
- The child will no longer be eligible to receive a clothing allowance or a specialized care increment.
- Once the child reaches age 18, the child must apply for Medi-Cal benefits in order to receive Medi-Cal to age 21.

N/A

2.  **AFDC-FC to CalWORKs**

**Initial Here:**

\_\_\_\_\_ I understand that by becoming a relative legal guardian of \_\_\_\_\_:

- The child's payment will change from \$\_\_\_\_\_ to \$\_\_\_\_\_ per month.
- The child will not receive an AFDC-Foster Care payment.
- The child will not receive a clothing allowance or a specialized care increment.

N/A

3.  **CalWORKs to Kin-GAP**

**Initial Here:**

\_\_\_\_\_ I understand that by becoming a relative legal guardian of \_\_\_\_\_:

- The child's payment will change from \$\_\_\_\_\_ to \$\_\_\_\_\_ per month.
- The child cannot get both CalWORKs and Kin-GAP payments.
- The child will no longer be eligible to receive Cal-Learn benefits.
- The child will no longer be eligible to receive child care services.

N/A

4.  **Remain CalWORKs**

**Initial Here:**

---

---

**Services**

If you become guardian of this child and the court dependency is terminated:

**Initial Here:**

\_\_\_\_\_ I understand that the child and I will no longer be assigned a social worker;  
\_\_\_\_\_ I understand that the child and I will no longer be required to go to court;  
\_\_\_\_\_ I understand that the child will no longer have a court appointed attorney;  
\_\_\_\_\_ I understand that I am not prevented from adopting this child at any time in the future;  
\_\_\_\_\_ I understand that I may still contact the county if I need assistance at \_\_\_\_\_;  
\_\_\_\_\_ Other: \_\_\_\_\_

**Some Important Kin-GAP Information**

These are some of the important things you should know about Kin-GAP:

**Initial Here:**

\_\_\_\_\_ I understand the child's Kin-GAP payment will be stopped:

- \* If the child or I move out of state;
- \* If a child who is 16 years or older fails to meet school attendance requirements.

\_\_\_\_\_ I understand that I will be required to complete an annual review of the child's circumstances with the county and to report within 5 days any changes which may affect the child's eligibility for the program.



\_\_\_\_\_ I understand that if I move to another county, the child's rate may change.

---

---

I have read the above and understand all of the permanency options that are available to me (adoption, legal guardianship, long-term foster care). After considering all the options, I have voluntarily chosen legal guardianship with the associated payment noted above.

I have chose option #            1            2            3            4 (*Circle one*)

|   |       |  |       |
|---|-------|--|-------|
| SIGNATURE OF SOCIAL WORKER:<br> |       | SIGNATURE OF RELATIVE LEGAL GUARDIAN:<br> |       |
| TITLE/AGENCY:   |       |  |       |
| ADDRESS:  |       | ADDRESS:   |       |
|   |       |  |       |
| TELEPHONE NUMBER<br>(    )  | DATE: | TELEPHONE NUMBER<br>(    )   | DATE: |

**RELEASE OF INFORMATION**

You and any member of your family for whom you are applying for aid must give us a Social Security Number(s) (SSN). The SSN(s) are needed to determine your eligibility. Failure to cooperate may result in denial or discontinuance of aid. Authority: **Welfare and Institutions Code, Section 11268.**

## RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

### For the Kin-GAP Program

These pages give you your rights and responsibilities and other important information. The county needs your facts and the child's facts to see if the child is eligible for Kin-GAP cash aid, food stamps, and/or Medi-Cal/State CMSP and to figure how much the child will get if the child is eligible. If you need more information or have questions, ask your worker.

Kin-GAP cash aid includes Kinship Guardianship Assistance Payment (Kin-GAP) Program.

Medi-Cal/State-run County Medical Services Program (CMSP) includes Full Medi-Cal/State CMSP benefits and Restricted Medi-Cal/CMSP emergency and pregnancy related care only.

### YOUR RIGHTS

1. To be treated equally without regard to race, color, national origin, religion, political affiliation, marital status, sex, disability, or age. You may file a complaint of discrimination if you feel the child has been discriminated against by first speaking with your county's designated civil rights representative or by writing to the

State Civil Rights Bureau

744 P Street, MS 15-70

P.O. Box 944243

Sacramento, CA 94244-2430

or by calling **collect** (916) 654-2107 or for the hearing impaired TDD (916)-654-2098.

2. To tell the county if the child has a disability and needs help applying for or continuing to receive Kin-GAP cash aid, benefits, and services.
3. To ask for help to complete the application for any other cash aid, food stamp, or Medi-Cal/State CMSP program.
4. To ask for forms and notices to be translated if you don't read English.
5. To be treated with courtesy, consideration and respect.
6. To be interviewed promptly by the county when you apply and to have the eligibility determined within 45 days.
7. To discuss the child's case with the county and to review the child's case yourself when you request to do so.
8. To get Medi-Cal/State CMSP as soon as possible if the child has a medical emergency or is pregnant, if eligible.
9. To continue getting Kin-GAP and Medi-Cal benefits without a break if you move from one county to another if the child stays eligible.

10. To be told the rules for retroactive Medi-Cal/State CMSP eligibility.
11. Where available, to choose prepaid health plan (PHP), fee-for-service coverage (if available), Health Maintenance Organization (HMO), or Medi-Cal when the child is eligible for Medi-Cal/State CMSP.
12. To ask to have the child's Medi-Cal Benefits Identification Card (BIC), replaced if lost in the mail, damaged, or destroyed. The county will tell you if you are eligible. The child's BIC may also be replaced if lost or stolen.
13. To ask for extra money if the child's income drops or stops.
14. To be notified in writing when the child's application is approved, denied, or when the child's benefits change or stop.
15. To have the child's records kept confidential by the county and state, unless the child is getting Kin-GAP or Medi-Cal and there is a felony arrest warrant issued for the child, or as otherwise provided by law.
16. To talk with someone from the county or file a formal complaint with the state if you don't agree with an action taken by the county. You may call toll-free at 1-800-952-5253 or for the hearing impaired, TDD 1-800-952-8349.
17. To ask for a State Hearing within 90 days of the county's action and, if you think the child was not getting the right State CMSP services.
18. To ask for a State Hearing, you can write to your county or call the State toll-free telephone numbers listed in Item 16 above.
19. To appeal all State CMSP eligibility issues, you can **only write** to your county.
20. To be represented at a State hearing by yourself, a household member, friend, attorney, or other person of your choice. NOTE: You may get free legal help at your local legal aid office or welfare rights group.

## YOUR RESPONSIBILITIES

### Citizenship/Immigration Status

To sign under penalty of perjury that the child applying for Kin-GAP cash aid is a U.S. citizen, U.S. national or has lawful immigration status. Information you give us on immigration status will be checked with the U.S. Immigration and Naturalization Service (INS). Information we get from INS may affect the child's eligibility.

### Social Security Number (SSN) Rules

The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration and other agencies. Differences may be checked out with employers, banks or others. Making false statements or failing to report all facts or situations which affect eligibility and aid payments for Kin-GAP and Medi-Cal/State CMSP may result in repayment of benefits and/or criminal or civil action.

**Kin-GAP and Food Stamps:** You must give us the SSN for each applicant or recipient of Kin-GAP and/or food stamps. If you refuse to give us either a SSN or proof of application for a SSN, the child will not be able to get Kin-GAP. For Kin-GAP, you must give proof of application for a SSN within 30 days of application for Kin-GAP and give the SSN to the county when you get it.

**Authority: Welfare and Institutions Code Section 11268.**

### Verification(s)

To give proof to support the child's eligibility. If you can't get proof, you will need to give the name of some other person or agency we may contact to get the proof. We will help you get proof when you can't get it.

### Cooperation

To cooperate with county, state and federal staff. For Kin-GAP, a county worker can come to your home at any time to check out your facts, including seeing each family member, without calling ahead of time. The child may not get benefits or your benefits may be stopped if you don't cooperate.

### Kin-GAP AND MEDI-CAL

To apply for any benefits or income anyone is eligible to get, such as: Unemployment (UIB) or Disability benefits, Veterans benefits, or Social Security etc.

### Child/Spousal and Medical Support

To cooperate with the county and the District Attorney/Family Support Division (DA/FSD) to:

- identify and locate any absent parent in your case;
- tell the county or the DA/FSD any time you get information about the absent parent, such as place of residence or work location;
- determine the paternity of any child in your case when needed;
- obtain medical support money from any absent parent and, obtain child support money;
- give the DA/FSD any medical support money and, any child/spousal support money the child gets;
- tell the county about medical coverage or money for medical services paid by either parent.

### MEDI-CAL

#### Benefits Identification Card (BIC)

- **To never throw the child's BIC away** (unless we give the child a new BIC). You need to keep the child's BIC even if the child stops getting Medi-Cal. The child can use the same BIC if the child gets Kin-GAP or Medi-Cal again.
- To take the BIC to the child's medical provider when the child is sick or has an appointment.
- To take the BIC to the medical provider who treated the child in an emergency situation as soon as possible after the emergency.

#### Health Care Coverage/Insurance

- To tell the county and any health care provider of any health care coverage/insurance the child has.
- To retain any health insurance available to the child at no or reasonable cost.
- To use any prepaid health plans, health maintenance organization or health care insurance plans the child has before using Medi-Cal/State CMSP, unless the plan does not offer the medical service needed. You need to use them because Medi-Cal will not pay for any service paid for and/or provided by these medical insurance plans.



## YOUR REPORTING RESPONSIBILITIES

You must report all changes related to the child to the county. If you're not sure how to report changes, what changes to report, or what proof we need, ask your worker.

### HOW YOU MUST REPORT

**For Kin-GAP**, you must report all changes related to the child to the county within 5 days.

### WHEN YOU MUST REPORT

**For Kin-GAP**, you must report when:

1. The child gets money (including lump sums) from work, relatives, Social Security, Unemployment Insurance Benefits (UIB), Veterans benefits, tax refunds, accident or injury settlements, or any other source.
2. The child gets medical support money.
3. The child's job or training program changes.
4. The child's income or source of income changes, starts, or stops, including self-employment.
5. The child age 16 or older starts or stops school, college, or training.
6. The child moves out of your home.
7. You and/or the child moves to another address, plans to move (including out of state), or gets a new mailing address. If you move to another county and you want to keep getting benefits, you must tell the county giving you aid and/or benefits.
8. The child gets payments or allowances for job, training, or school expenses, such as educational grants and loans, transportation to and from job or training, etc.
9. The child gets married, separated, divorced, or died.
10. The child gets, sells, gives away or transfers real property, such as a home, buildings or land; or business or personal property, such as money, a bank account, a motor vehicle, a boat, a trust fund, etc.
11. The child's physical or mental illness begins or ends.
12. The child's citizenship or immigration status changes or the child gets a letter, form or new card from the INS.
13. The child becomes pregnant, gives birth, or ends a pregnancy.
14. The child or you goes to or gets out of jail/prison or juvenile hall.
15. The child's health care coverage/insurance changes or becomes available as a result of employment.
16. The child's parent(s) move into the home.

### School Attendance and Immunizations

You must provide proof when requested by the county that:

- all school-age children receiving Kin-GAP are attending school, and
- Kin-GAP children under the age of 6 have received age appropriate immunizations.

### Proof of Facts

If you ask for Kin-GAP within one year of the date it stopped, the county must look at your prior case file to see if it already has the proof needed to determine your eligibility when:

- you cannot get the proof, or
- there is a cost to you to get the proof, or
- processing your application would be delayed because it would take too long for you to get the proof.

If you ask for Kin-GAP within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

If you have new changes since the child last got Kin-GAP, the county will need new proof.

## OTHER IMPORTANT INFORMATION

### Kin-GAP Only

#### California Department of Education (CDE) Child Care

Child care benefits are available from CDE. Contact your local Resource and Referral Agency for more information.

#### Transitional Medi-Cal (TMC)

The child may get Medi-Cal for up to 12 months if the child goes off Kin-GAP because the child is working. The child must have gotten Kin-GAP for at least three of the last six months before cash aid stopped. To get more than six months of TMC, the child's income must be under certain limits and the child must meet TMC reporting rules.

#### Independent Living Program (ILP)

When the child reaches age 16, the child is eligible for ILP. ILP provides life skills education and services to foster youth age 16 or older. Please contact the county ILP Coordinator for assistance.

#### Income Disregards

If the child is participating in ILP, any income earned as part of the program is exempt. When the child has income other than ILP, the child may be entitled to other income deductions. NOTE: This income must still be reported.

### Kin-GAP MONTHLY REPORTING

#### Budgeting Rules

The amount of Kin-GAP that the child can get depends on the child's income and allowable expenses.

#### Property Limit

There is a \$2000.00 limit on the amount of property (e.g., bank accounts, stocks, etc.) that the child can have and still get Kin-GAP. The individual vehicle value limit is \$4650. If the child has only one vehicle which is registered, and it has a value of less than \$4650, it will not be counted as part of the limit. If the child's vehicle is worth more than \$4650, anything over the limit will be used as part of the total property limit to determine eligibility, unless the vehicle is needed by the household for certain reasons. Your worker can tell you what these are. If the child has a vehicle that is unregistered, its value will be figured differently and your worker can explain to you how it is done.

#### \*Transfer of Assets Rule

The child can sell, exchange or change the form of their property holdings, if they get fair market value for the property (asset). If they do not get fair market value for the asset, the child will get a period of ineligibility. The period of ineligibility is figured by subtracting the amount received from the fair market value of the asset and then dividing that amount by the need standard for the family. The amount is rounded down to the next lower whole number. The whole number is the number of months the child is ineligible.

### AVAILABLE SERVICES

#### Women, Infants and Children (WIC) Supplemental Nutrition Program

The WIC Program is only for pregnant and breast feeding women, infants and children under age 5, who are at medical-nutritional risk. For more facts about WIC, call your local county health department or the phone number for "WIC" in the telephone book.

#### Voter Registration

If the child wants to register to vote, ask your worker to send you a registration form. If the child needs help filling it out, ask your worker. You can mail the form yourself. The child's eligibility for aid will not be affected whether or not the child registers. Your worker will not tell the child how to vote.

#### Other Benefits

You or any one in your household may apply for any other benefit program such as CalWORKs, Food Stamps, Medi-Cal, Adoptions Assistance Payment Program, In-Home Supportive Services, etc.

## PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting Kin-GAP benefits, you can be legally prosecuted, and can be charged with committing a felony if more than \$400 is wrongly paid out for Kin-GAP, or Medi-Cal because you did not report all of the facts or changes in income, property, or family status.

### Kin-GAP Penalties

If you do not follow Kin-GAP rules, you may be fined up to \$10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by a court of law or an administrative hearing of committing certain types of fraud, the child's Kin-GAP can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

| <b>RELATIVE LEGAL GUARDIAN CERTIFICATION</b>  | <b>ELIGIBILITY WORKER'S CERTIFICATION</b>   |
|---|---|
| <ul style="list-style-type: none"> <li>I understand my rights and responsibilities and agree to comply with my responsibilities.</li> <li>I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect the child's eligibility or benefit level.</li> <li>I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (KG 2A).</li> </ul> | <p><b>I certify that the relative legal guardian appears to understand:</b></p> <ul style="list-style-type: none"> <li>his/her rights and responsibilities and</li> <li>the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect the child's eligibility or benefit level.</li> </ul> <p><b>I also certify that the applicant/recipient was given a copy of:</b></p> <ul style="list-style-type: none"> <li>The Rights, Responsibilities, and Other Important Information (KG 2A).</li> </ul> |
| Signature (Relative Legal Guardian)   | Date  |
| Witness, if You Signed With An "X"  | Date  |
| Eligibility Worker's Signature  | Eligibility Worker's Number<br>Date   |

# NOTICE OF ACTION - CHANGE

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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

**INSTRUCTIONS:** Use when there is a change in the amount of Kin-GAP paid.

As of \_\_\_\_\_, the County is changing your Kin-GAP cash aid from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ per month.

Here's why:

The aid you got was for \_\_\_\_\_.

- There was a change in the amount of income received.
- The child's age changed.
- You will get an infant supplement on behalf of \_\_\_\_\_.
- You are no longer eligible to receive \_\_\_\_\_.
- Because you moved to \_\_\_\_\_ County.
- Other \_\_\_\_\_.

## 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.

### If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

### If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop:  Cash Aid  Food Stamps  Child Care

### While You Wait for a Hearing Decision for:

#### Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

#### Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but 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 Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## 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:

Cash Aid      Food Stamps      Medi-Cal

Other (list) \_\_\_\_\_

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

# NOTICE OF ACTION - DISCONTINUE

(ADDRESSEE)

┌

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Number : \_\_\_\_\_  
Telephone : \_\_\_\_\_  
Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

**INSTRUCTIONS:** Use to discontinue Kin-GAP case when there is no longer an eligible child in the home. Specify the Name of the child in the space provided.

As of \_\_\_\_\_, the County is stopping your Kin-GAP cash aid for \_\_\_\_\_.

Here's why:

- He/she no longer lives with you.
- He/she no longer meets the age rules.
- The child has too much income.
- The child has too much property. See attached page.
  - If the County figured that the child's car or other vehicle was worth more than you think it's worth, you can give the County proof that it is worth less. Ask the County how. If you can prove it is worth less the child may get Kin-GAP cash aid.
- The legal guardianship was terminated.
- You moved out of the State of California.
- You did not return your completed redetermination paperwork.
- Other.

## 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.

### If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

### If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop:  Cash Aid  Food Stamps  Child Care

### While You Wait for a Hearing Decision for:

#### Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

#### Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but 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 Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## 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:

Cash Aid      Food Stamps      Medi-Cal

Other (list) \_\_\_\_\_

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 \_\_\_\_\_