DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

April 29, 2002

ALL COUNTY INFORMATION NOTICE NO. I-32-02

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY PROBATION OFFICERS

REASON FOR THIS TRANSMITTAL

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

SUBJECT: **SUPPORTIVE TRANSITIONAL EMANCIPATION PROGRAM (STEP) FORMS AND NOTICES OF ACTION**

REFERENCE: ALL COUNTY LETTER 02-25
ALL COUNTY INFORMATION NOTICE (ACIN) I-93-01

The purpose of this ACIN is to transmit the new forms and Notices of Action (NOA) for STEP. These forms and NOAs were developed by a workgroup of State and county staff. Camera ready copies of the forms are attached to this ACIN. The NOA messages are attached to this ACIN and should be put on the appropriate NOA template.

Forms

The following new forms will be used for the STEP Program:

- STEP 1 – Statement of Facts for Supportive Transitional Emancipation Program. This form is completed by the STEP youth and is used to collect information necessary to determine STEP eligibility at the time of application.

- STEP 2 –Referral, Transmittal, and Communication Form. This form is completed by the Independent Living Program (ILP) caseworker and transmitted to the eligibility worker (EW) in order to aid the EW in the determination of eligibility.

NOAs

The following NOAs have been developed for the STEP Program.

- Approval NOA – informs the youth/provider that STEP and Medi-Cal benefits have been approved.

- Denial NOA – informs the youth/provider that STEP has been denied and the reasons why.

- Change NOA – informs the youth/provider that STEP payments have been changed and the reasons why.

- Discontinuance – Provider NOA – informs the provider that STEP payments have been discontinued and the reasons why.

- Discontinuance – Youth NOA – informs the youth that STEP payments have been discontinued and the reasons why.

If you have any questions about these forms, NOAs, or eligibility to STEP, please contact your Foster Care Eligibility Consultant at (916) 324-5809.

Sincerely,

Original Document
Signed By

SYLVIA PIZZINI
Deputy Director
Children and Family Services Division

Enclosures

c: CWDA

STEP 1 - STATEMENT OF FACTS FOR SUPPORTIVE TRANSITIONAL EMANCIPATION PROGRAM (STEP)

Instructions: *Please complete this form when applying for STEP.*

Name	Date of birth (MM/DD/YY)	☐ Male ☐ Female	**VERIFICATION**
Social Security Number	Have you applied for SSI/SSP or are you receiving SSi/SSP? ☐ Yes, Date of application_____ ☐ No.		Case Number: Age Verified
Address:	City / State / Zip		Previous Valid Authority for Placement Verified
Mailing Address:	City / State / Zip		

Do you have other medical insurance (through work or parents)? ☐ Yes ☐ No

Name of Insurance Company:_____

Policy #:_____

Other Health Coverage
☐ DHSS 6155

Were you in the Foster Care System or receiving a Kin-GAP payment on the day before your 18th birthday *(or later)*?

☐ Yes ☐ No If so, in which county:_____

Transitional Independent Living Plan Verified

Are you participating in the Independent Living Program?

If so, name of caseworker/social worker:_____

Caseworker/social worker's phone number:_____

County of Responsibility

What are your living arrangements?

☐ Foster Parent/Legal Guardian/Relative Provider -- Name: _____

☐ Transitional Housing -- Name of facility: _____

☐ Other Foster Care Facility -- Name:_____

Other:_____

Payee

☐ Eligible
☐ Not Eligible

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this Statement of Facts are true and correct to the best of my knowledge. I understand that if I: 1) move, 2) have any changes in my living arrangements, such as moving back in with my parents, 3) get married, 4) become pregnant, or 5) have any changes in my medical coverage, I must notify my county worker within 5 days.

Signature of Eligibility Worker

Signature:	Date:	Date:

STEP 2 - REFERRAL, TRANSMITTAL, AND COMMUNICATION FORM

Instructions: *Case worker use this form at initial application, annual redetermination, any change in address or circumstances of the youth, and at closure if the youth fails to participate in his/her Transitional Independent Living Plan (TILP).*

☐ Initial ☐ Annual Redetermination ☐ Change ☐ Closure

Youth's Name:	Date of Birth
Case Number:	Social Security #:

Youth's Address: City State Zip

Youth's Phone:

☐ Male ☐ Female

Youth's Living Arrangement:

☐ Foster Parent/Legal Guardian/Relative Provider -- Name:_____

☐ Transitional Housing -- Name of facility:_____

☐ Other Foster Care Facility -- Name:_____

☐ Other:_____

TILP

☐ Initial Plan Date:_____

☐ Last Plan Update:_____

Is child participating in activities consistent with the plan? ☐ Yes ☐ No

If No, last month of TILP participation?_____

Residency:

Is Youth a California resident? ☐ Yes ☐ No

Other information/changes:

Signature of Placement Worker

ALL INFORMATION RECORDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature	Date

State of California
Department of Social Services

Auto ID No.:
Source:
Issued by:
Reg Cite:

Action: Approve
Issue: Application Processing
Title: Basic STEP Approval
Use Form No.: NA 290
Original Date: 4/9/2002
Revision Date:

MESSAGE:

The County has approved your STEP cash aid and Medi-Cal for _____ _____. The cash aid payment for your first month of aid is $_____ ___ .

Your first day of cash aid is _____ ___. Your first day of Medi-Cal is the first day of the month you applied for aid.

[ ] The cash aid payment for your first month of aid is only for a part of a month. It is for the time from your first day of cash aid, shown above, through the end of the month. If nothing changes, next month's cash aid will be for a full month.

Medi-Cal Cards: Soon you will get a plastic Benefits Identification Card in the mail for each eligible person. Take the card(s) to your medical provider when needing care. DO NOT THROW AWAY YOUR CARDS. They will be good as long as you get Medi-Cal.

INSTRUCTIONS: Use to approve STEP and Medi-Cal.

State of California
Department of Social Services

Auto ID No.:
Source:
Issued by:
Reg Cite:

Action: Deny
Issue:
Title: No STEP Eligible Child
Use Form No.: NA 290
Original Date: 4/9/2002
Revision Date:

MESSAGE:

The County has denied your application for STEP cash aid dated _____.

Here's why:

You are not eligible for STEP for one or more of the following reasons:

[ ] You are not between the ages of 18 and 21.

[ ] You were not in the foster care system or receiving a Kin-GAP Payment on the day before your 18th birthday.

[ ] You are not a resident of California.

[ ] You do not have a Transitional Independent Living Plan and/or you are not participating in activities consistent with the Plan.

[ ] You are currently receiving aid from another program.

[ ] The county with responsibility for your case, _____, is not currently participating in this program.

[ ] Other _____

INSTRUCTIONS: Use to deny STEP when there is no eligibility.

State of California
Department of Social Services

Auto ID No.:
Source:
Issued by:
Reg Cite:

Action: Change
Issue: Aid Payments
Title: Change to STEP Payments
Use Form No.: NA 290
Original Date: 4/9/2002
Revision Date:

MESSAGE:

There is a change in your STEP payment.

Here’s why:

_____

_____

_____

INSTRUCTIONS: Use when there is a change in the STEP Payment or payee.

State of California
Department of Social Services

NOA Msg Doc No.: STEP 4 Page 1 of 1
Action: Discontinue--Provider
Issue: Aid Payments
Title: Discontinue STEP payments to a Provider

Auto ID No.:
Source:
Issued by:
Reg Cite:

Use Form No.: NA 290
Original Date: 4/9/2002
Revision Date:

MESSAGE:

As of _____, the County is stopping your STEP cash aid for ____ _____.

Here's why:

[ ] He/she no longer lives with you.

[ ] He/she no longer meets the age rules.

[ ] He/she is no longer participating in the Transitional Independent Living Plan.

[ ] He/she is not a resident of California.

[ ] The youth's whereabouts are unknown.

[ ] Other

INSTRUCTIONS: Use to discontinue STEP case when the youth is no longer eligible and is living in the home of a provider.

State of California
Department of Social Services

NOA Msg Doc No.: STEP 5 Page 1 of 1
Action: Discontinue--Youth
Issue: Aid Payments
Title: Discontinue STEP payments to a Youth

Auto ID No.:
Source:
Issued by:
Reg Cite:

Use Form No.: NA 209
Original Date: 4/9/2002
Revision Date:

MESSAGE:

As of _____, the County is stopping your STEP cash aid.

Here's why:

[ ] You no longer meet the age rules.

[ ] You are not participating in the Transitional Independent Living Plan.

[ ] You are not a resident of California.

[ ] Your whereabouts are unknown.

[ ] Other

INSTRUCTIONS: Use to discontinue STEP case when the youth is no longer eligible and is their own payee.