STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 445-4458

September 3, 1982

ALL-COUNTY INFORMATION NOTICE I-124-82

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: STATE-ONLY AFDC-U PROGRAM IMPLEMENTATION

REFERENCE: CHAPTER 327, STATUTES OF 1982 (SB 1326)

As you were informed in our letter of July 17, 1982 to All County Welfare Directors, the new state law (SB 1326) limits eligibility for benefits under the State-only AFDC-U Program to no more than three months in any 12-month period. In that letter we indicated that prior to implementing this and other related program changes, an attempt would be made to clarify certain areas of legislative intent. Clarification was amended into SB 1325 (Alquist). We had hoped that SB 1325 would be passed by the Legislature prior to the end of the Legislative Session on August 31, 1982. However, the bill did not pass and the provisions of SB 1326 stand. We advise that counties begin to take those administrative actions which are necessary in order to discontinue those cases from aid which were on aid under the State-only AFDC-U on June 30, 1982.

We are revising our previous draft of regulations to implement SB 1326. We plan to file emergency regulations with the Secretary of State no later than September 15, 1982 to be effective on the date of filing. Major elements of these regulations will be to:

1. Limit program eligibility to three months of benefits for State-only AFDC-U commencing with the beginning date of aid and ending exactly three months later;

   Clarify the linkage between Emergency Assistance and State-only AFDC-U;

   EXAMPLE

Beginning date of aid for Emergency Assistance	07/05/82
End date of Emergency Assistance	08/03/82
Beginning date of aid State-only AFDC-U	08/04/82
Discontinuance date	11/03/82

2. Allow benefits to those pregnant women, one-person FBUs, where the basis of deprivation for the unborn, if born, would be State-only AFDC-U as follows:

   Aid pregnant women, one-person FBUs, for three months prior to birth, and aid father and newborn child for four months (one - Emergency Assistance, three - State-only AFDC-U) after birth; or at the option of pregnant woman, aid entire family for four months (one - Emergency Assistance, three - State-only AFDC-U) after birth of child;

3. Provide a new definition of principal wage earner for the State-only AFDC-U Program. The definition will allow the family to designate principal wage earner;

4. Allow a time-limited Notice of Action for approval of Emergency Assistance and State-only AFDC-U, thus eliminating the need for a separate discontinuance notice.

In preparation for implementing the State-only AFDC-U Program, we have developed language for counties to use when sending Notices of Action. Attached are the notice of action messages which are to be used with the appropriate Notice of Action forms. The attached language is provided to you now for advance planning. We intend to make the use of this language mandatory. These Notices of Action are not to be used until the regulations are filed.

We will notify you when the regulations concerning the State-only AFDC-U Program are filed and when to begin using the Notices of Action.

SB 1326 also allows counties to provide employment-related services to recipients of aid. However, the bill specifies that any reimbursements to the counties for the costs of providing these services are conditioned upon the availability of federal funds under the federal Emergency Assistance program. The Department of Social Services is now working with the Federal Government to clarify the types of employment services that will be eligible for federal funding in the context of this legislation. When this clarification is obtained, we will file regulations which will specify what services will be claimable. Until these regulations are filed, reimbursement is not available for any costs relating to these services.

If you have any questions, please contact your AFDC Program Management Consultant at (916) 445-4458.

Sincerely,

Kyle S. McKinsey

KYLE S. McKINSEY
Deputy Director
Welfare Program Operations

Attachments

cc: CWDA

Attachment

State AFDC-U

Cases prior to July 1, 1982

DISCONTINUANCE NOTICE

Reason(s) for the Action

There has been a change in the law. Beginning July 1, 1982, families receiving aid under the State-only AFDC-U Program can get aid for no more than 3 months in any 12-month period. By the effective date of this notice you will have received aid for the maximum number of months allowed under this program. According to our records, you received aid as follows: _____.

(insert months or periods of aid; e.g., July, August, September or 7/13 - 8/11, 8/12 - 9/11, 9/12 - 10/11)

We have also reviewed our records to determine if you would be eligible for aid under the federal AFDC-U Program, which has no time limit. According to our information you are not eligible because neither parent in your home has a recent work history of at least six calendar quarters in which $50 or more was earned or in which work-related training was received. If this information is not correct or your circumstances change, contact your Eligibility Worker at once.

Regulation Citation: MPP Sections _____

Attachment

APPROVAL AND DISCONTINUANCE OF EMERGENCY ASSISTANCE AND STATE-ONLY AFDC-U

A monthly aid payment of $_____ is approved effective _____. You will receive aid under a combination of Emergency Assistance and the State-only AFDC-U Programs. Under this combination of programs, families can get aid for up to 4 months in any 12-month period. Unless your family circumstances change, your eligibility period will end on _____. Your first check, covering the period _____ through _____, will be for $_____.

In addition to approving your aid for these programs, we reviewed your application to determine if you were eligible for aid under the federal AFDC-U Program, which has no time limits. According to our information, you are not eligible because neither parent in your home has a recent work history of at least six calendar quarters in which $50 or more was earned or in which work-related training was received. If this information is not correct or your circumstances change, contact your Eligibility Worker at once.

Regulation Citation: MPP Sections _____

19 DID YOU OR YOUR FAMILY HAVE ANY M .CAL EXPENSES WITHIN THE LAST 4 MONTHS? ☐ YES ☐ NO

20 DO YOU OR YOUR FAMILY HAVE ANY OF THE FOLLOWING SPECIAL NEEDS? Check each item.

	YES	NO		YES	NO
A. Special diet (prescribed by doctor)	☐	☐	E. Housework (unavailable from other household members)	☐	☐
B. Special transportation need	☐	☐	F. Very high use of utilities	☐	☐
C. Special telephone equipment	☐	☐	G. Special laundry service	☐	☐
D. Replacement of essential household items, lost or damaged due to unusual circumstances	☐	☐	H. Other (specify)_____	☐	☐

21 DO YOU OR YOUR FAMILY WANT TO APPLY FOR FOOD STAMPS? ☐ YES ☐ NO

COMPLETE THE REST OF THIS PAGE IN THE PRESENCE OF AN ELIGIBILITY WORKER

CERTIFICATION

I have read and received a copy of the coversheet attached to this form. I am aware of, understand and agree to meet all my responsibilities as described on the coversheet.

I understand that the statements I have made on this form are subject to investigation and verification. I am also aware that my case may be selected for an additional review to ensure that my eligibility was determined correctly.

After answering all questions, you and your spouse or other parent of the child(ren) living in the home for whom aid is requested must sign this form. If you make a mark, a witness must also sign below. An interpreter or someone completing this form for you also must sign.

"I declare under penalty of perjury that the above statements of fact are true and correct."

SIGNATURE (OR MARK) OF APPLICANT/RECIPIENT OR CARETAKER RELATIVE ▶	DATE SIGNED	COUNTY WHERE SIGNED
SIGNATURE OF SPOUSE OR OTHER PARENT ▶	DATE SIGNED	COUNTY WHERE SIGNED
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON COMPLETING FORM FOR APPLICANT/RECIPIENT ▶		DATE SIGNED

SOCIAL SERVICES

The following services are free of charge, if you are eligible for cash aid. Your answers to these questions will not affect your eligibility.

A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.

1. Do you want more information about CHDP services? ☐ YES ☐ NO
2. Do you want CHDP medical or dental services? ☐ YES ☐ NO

B. Do you want to talk to a social worker or want information about services which may be available to you or about any of the following:

Discrimination, personal adjustment, other living arrangements, alcoholism, drug addiction or mental/emotional problems, special services for blind or visually impaired children and adults, child care, etc.? ☐ YES ☐ NO

C. Family Planning Services may be available to help you voluntarily limit family size, decide when you want to have children and prevent unwanted pregnancies. Do you or any member of your family want family planning information? ☐ YES ☐ NO

COUNTY USE ONLY

☐ *MC 213*

☐ *Special Need Verified*

☐ *Non-Recurring Special Need Verified*

☐ *CA 2 FS Supplement*

☐ *CHDP Brochure and explanation given*

☐ *Referred*
☐ *Date:*

☐ *Other Services Referral:*

☐ *Family Planning Information Given*

☐ *Referred* _____ *Date*

COUNTY USE ONLY

YES	NO	
☐	☐	*Deprivation requirements met*
☐	☐	*Age requirements met*
☐	☐	*Pregnancy verified*
☐	☐	*Sponsored alien requirements met*
☐	☐	*Residency requirements met*
☐	☐	*Citizenship requirements met*
☐	☐	*School requirements met*
☐	☐	*Work registration requirements met*
☐	☐	*Federal financial participation requirements met*
☐	☐	*Income within limits*
☐	☐	*Employment/earnings verified*
☐	☐	*Total real/personal property within limit $* _____
☐	☐	*Real property utilizations requirements met*

Other Comments:

☐ *Ineligible (reason)* _____

☐ *Eligible (effective date)*_____

Signature of EW ▶	Date
Signature of Supervisor ▶	Date