STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

JOHN A. WAGNER
DIRECTOR

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GOVERNOR

March 14, 2011

ALL COUNTY LETTER 11-26

REASON FOR THIS TRANSMITTAL

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

TO: ALL COUNTY WELFARE DIRECTORS
ALL CONSORIUM PROJECT MANAGERS
ALL COUNTY CALFRESH COORDINATORS

SUBJECT: HEATHCOCK V. ALLENBY LAWSUIT – STATEWIDE POLICY REGARDING INITIATING COLLECTION ON OVERISSUANCE (O/I) CLAIMS REQUIREMENTS IN THE CALFRESH PROGRAM

REFERENCE: UNITED STATES DEPARTMENT OF AGRICULTURE (USDA), FOOD AND NUTRITION SERVICE (FNS) ADMINISTRATIVE NOTICE (AN) 01-35, ALL COUNTY INFORMATION NOTICE (ACIN) I-16-05, CODE OF FEDERAL REGULATIONS (CFR) 273.13 (a)(2) and 273.18 (e)(3)(iv), CALFRESH OVERISSUANCE NOTICES DFA 377.7B, DFA 377.7D, DFA 377.7D1, DFA 377.7D3, DFA 377.7F AND OVERISSUANCE BUDGET WORKSHEET NA 1263, MANUAL OF POLICIES AND PROCEDURES (MPP) 63-103.d (20), 63-103.d (21), 63-103.d (22), 63-504.261, 63-801.222, 63-801.431(a) AND 63-801.431(m)

The purpose of this letter is to provide clarification for giving adequate notice to households with overissuances (O/Is) as specified by the Rosie Heathcock et al v. Allenby lawsuit. The lawsuit requires all County Welfare Departments (CWDs) to provide adequate information on a CalFresh O/I Notices of Action (NOAs), by attaching the newly created *Overissuance Budget Worksheet* NOA, NA 1263, with each O/I NOA sent to a household. The new budget worksheet, which is attached, satisfies the requirements of the lawsuit and provides enough information to allow the household to make an informed decision about the correctness of an O/I NOA. Overissuance NOAs have also been modified as discussed in the “Forms” section below. CWDs must implement the above requirement as soon as administratively possible, but no later than six months from issuance of this All County Letter (ACL).

About The “Here’s Why” Section of the NOAs

In accordance with Manual of Policies and Procedures (MPP) Section 63-801.431(a) and the Code of Federal Regulations at (CFR) 273.13 (a) (2) and 273.18 (e) (3) (iv), the O/I NOAs issued by counties must include sufficient information for the household to understand the

reasons(s) for the proposed action, and whether the action is correct. The **"Here's Why"** section of the O/I NOA must also explain the specific reason(s) for the O/I, and provide sufficient detail to allow the household to determine if any "incorrect" information was used in the O/I determination. The following, at a minimum, must be explained in the "Here's Why" section of the O/I NOAs:

- The amount of benefits the household received; and
- The amount of benefits the household should have received;
- The time period benefits were over issued;
- The specific reason that caused the overissuance;
- The amount of the benefits that are to be repaid;
- How the household or sponsor may pay the claim;
- The type of error, i.e., Administrative Error (AE), Inadvertent Household Error (IHE), or Intentional Program Violation (IPV). The NOA used by the CWD is self-identifying, e.g., the DFA 377.7D3 is for AEs only.

Counties must review their O/I NOA messages to ensure that they address the specifics outlined above, and to also ensure that the reason and/or combination of reasons for an O/I are provided to the household in accordance with the above regulations, and requirements of the Rosie Heathcock et al v. Allenby lawsuit. Additionally, counties should review their policies and procedures for providing additional information to households through **"free form text"** in the **"Here's Why"** section of the O/I NOAs to aid CWDs in providing information which is sufficient enough be considered adequate information.

Forms

The *Overissuance Budget Worksheet* (NA 1263) is a newly developed required form and must be sent as an attachment with all the CalFresh O/I NOAs. The information on the budget worksheet must include the calculation used to determine the claim amount for each month the household incurred an O/I (MPP 63-504.261 and 63-801.431(m)).

CDSS has revised the Food Stamp O/I Repayment Notices (DFA 377.7B, DFA 377.7D, DFA 377.7D1, DFA 377.7D3 and DFA 377.7F), which are attached. The term "CalFresh" has replaced the term "Food Stamps" to all the forms because there has been a name change to the program; to all the DFA 377 revised forms "Overissuance" has replaced the term "Repayment" because these notices are initial notices that are sent to the household to inform them of an established overissuance. *CalFresh O/I Overissuance Notices* are required forms used to notify households they have either an administrative error (AE), inadvertent household errors (IHE), or intentional program violation (IPV). The DFA 377.7B is revised to delete the information referring to the Lomeli v. Saenz court case; the Lomeli v. Saenz court case does not apply to households with an IHE O/I (MPP 63-103.d (20), 63-103.d (21) and 63-103.d (22)). The DFA 377.7D3 is revised to add the title "Lomeli v. Saenz court case" above the provisions of the Lomeli v. Saenz court case (MPP 63-801.222). The notices are revised by moving the information about the overissuance period underneath the "Here's Why" section to enable the

household to be immediately aware of the amount of the O/I, and the period in which the O/I occurred in the household. A statement is added onto all the NOAs regarding the budget worksheet. It reads: "See how we figured the extra amount you got on the worksheet that came with this notice."

Note: All information included on the state developed forms is required to be included on forms generated by automated systems.

CAMERA-READY COPIES AND TRANSLATIONS

For camera-ready copies of the English language version of the NA BACK 9, NA 1263, DFA 377.7B, DFA 377.7D, DFA 377.7D1, DFA 377.7D3 and DFA 377.7F contact (CDSS) Forms Management Unit at: fmudss@dss.ca.gov. If your office has internet access, you may obtain this form from the CDSS web page at:

http://www.cdss.ca.gov/cdssweb/PG19.htm

When all translations are completed per MPP Section 21-115.2, they will be posted on an ongoing basis on our website. Copies of the translated forms and publications can be obtained at:

http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm.

For questions on translated materials, please contact Language Services at (916) 651-8876.

If you have any questions regarding the content of this letter, please contact Rosie Avena at (916) 654-1514, or email at rosie.avena@dss.ca.gov.

Sincerely,

Original Document Signed By:

CHARR LEE METSKER
Deputy Director
Welfare to Work Division

Attachments

NOTICE OF ACTION
(Continued)

COUNTY OF

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

Notice Date ______________________
Case Name ______________________
Number ______________________

Overissuance Month and Year	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY
Part 1 - GROSS INCOME ELIGIBILITY				
A. NONEXEMPT GROSS UNEARNED INCOME				
1. Cash Aid	$	$	$	$
2. Social Security, UIB, DIB, Pensions	$	$	$	$
3. Child/Spousal Support	$	$	$	$
4. Scholarships, Grants, Loans	$	$	$	$
5. Other	$	$	$	$
6. Gross Unearned Income (A1+A2+A3+A4+A5)	$	$	$	$
7. Less Child Support Paid (enter remainder in B5)	$	$	$	$
8. Total Gross Unearned Income (A6 - A7)	$	$	$	$
B. NONEXEMPT GROSS EARNED INCOME				
1. Gross Salary, Wages	$	$	$	$
2. Self-Employment	$	$	$	$
3. Training Allowance	$	$	$	$
4. Gross Earned Income (B1+B2+B3)	$	$	$	$
5. Less Remainder of child Support Paid	$	$	$	$
6. Total Gross Earned Income (B4-B5)	$	$	$	$
C. GROSS INCOME TEST Not figured for households with an elderly/disabled member. (MPP 63-503.323)				
1. Household size				
2. Maximum Gross Income Allowed from table	$	$	$	$
3. Total Countable Gross Monthly Income (A8+B6)	$	$	$	$
4. Gross Income eligible? (Is C3 less than or equal to C2?)	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
D. GROSS INCOME OVERISSUANCE (IF C4 IS NO)				
1. Amount Previously Issued	$	$	$	$
2. Correct Benefit	$	$	$	$
3. Total CalFresh Overissuance (D1-D2)	$	$	$	$
4. Minus Lost Benefits Not Restored	$	$	$	$
5. Minus Payment Received	$	$	$	$
6. Amount of Overissuance to be Collected (D3-D4-D5)	$	$	$	$
7. Minus Workfare Offset	$	$	$	$
8. Amount of Overissuance to be Collected (D6-D7)	$	$	$	$

PART 2 - NET INCOME ELIGIBILITY
(This section computes only if C4 is Yes.)

E. NONEXEMPT GROSS UNEARNED INCOME (A8)	$	$	$	$
F. NONEXEMPT GROSS EARNED INCOME				
1. Gross Earned Income (B6)	$	$	$	$
2. Adjusted Gross Earned Income (80% of E)	$	$	$	$
G. TOTAL NONEXEMPT GROSS INCOME (E+F2)	$	$	$	$
H. STANDARD/DEPENDENT CARE/HOMELESS SHELTER/DEDUCTION				
1. Standard Deduction	$	$	$	$
2. Excess Medical Expenses (Only compute excess medical expenses for households with elderly/disabled members.)	$	$	$	$
3. Dependent Care (100% of costs)	$	$	$	$
4. Homeless Shelter Deduction	$	$	$	$
5. Total Deductions (H1+H2+H3+H4)	$	$	$	$
6. Total Adjusted Income (G-H5)	$	$	$	$

Overissuance Month and Year	MM/CCYY	MM/CCYY	MM/CCYY	MM/CCYY
I. SHELTER DEDUCTIONS				
1. Total Housing Cost	$	$	$	$
2. Total Utility Allowance	$	$	$	$
3. Total Shelter Costs (I1+I2)	$	$	$	$
4. Allowable Shelter Costs (50% of H6)	$	$	$	$
5. Excess Shelter Costs (I3-I4)	$	$	$	$
6. Maximum Allowance for Shelter (Enter amount shown on I5 for households with an elderly/disabled member)	$	$	$	$
7. Allowable Shelter Deduction (Lesser of I5 or I6) (Enter amount shown on I5 for households with an elderly/disabled member.)	$	$	$	$
J. NET COUNTABLE MONTHLY INCOME (H6-I7)	$	$	$	$
K. NET INCOME TEST				
1. Household Size				
2. Maximum Net Income allowable from table	$	$	$	$
3. Net Income eligible? (Is J less than or equal to K2?)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
L. NET INCOME OVERISSUANCE				
1. Amount Previously Issued	$	$	$	$
2. Correct Benefit	$	$	$	$
3. Total CalFresh Overissuance (L1-L2)	$	$	$	$
4. Minus Lost Benefits Not Restored	$	$	$	$
5. Minus payment Received	$	$	$	$
6. Amount of Overissuance to be Collected (L3-L4-L5)	$	$	$	$
7. Minus Workfare Offset	$	$	$	$
8. Amount of Overissuance to be Collected (L6-L7)	$	$	$	$

PART 3 - RESOURCE ELIGIBILITY

M. COUNTABLE RESOURCES				
1. Total Resources	$	$	$	$
2. Maximum Resource Level	$	$	$	$
3. Resource Eligible? (Is M1 less than or equal to M2?)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
N. RESOURCE OVERISSUANCE (IF M3 IS NO)				
1. Amount Previously Issued	$	$	$	$
2. Correct Benefit	$	$	$	$
3. Total CalFresh Overissuance (N1-N2)	$	$	$	$
4. Minus Lost Benefits Not Restored	$	$	$	$
5. Minus Payment Received	$	$	$	$
6. Amount of Overissuance to be Collected (N3-N4-N5)	$	$	$	$
7. Minus Workfare Offset	$	$	$	$
8. Amount of Overissuance to be Collected (N6-N7)	$	$	$	$

PART 4 - NON-FINANCIAL ELIGIBILITY

O. HOUSEHOLD COMPOSITION				
1. Previous Household Size				
2. Correct Household Size				
P. NON-FINANCIAL OVERISSUANCE				
1. Amount Previously Issued	$	$	$	$
2. Correct Benefit	$	$	$	$
3. Total CalFresh Overissuance (P1-P2)	$	$	$	$
4. Minus Lost Benefits Not Restored	$	$	$	$
5. Minus Payment Received	$	$	$	$
6. Amount of Overissuance to be Collected (P3-P4-P5)	$	$	$	$
7. Minus Workfare Offset	$	$	$	$
8. Amount of Overissuance to be Collected (P6-P7)	$	$	$	$

COUNTY OF

CALFRESH OVERISSUANCE NOTICE FOR INADVERTENT HOUSEHOLD ERRORS ONLY

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 unless you already had a hearing on the amount you owe. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

Your household made a mistake.

Too many CalFresh benefits were issued to:
☐ the household.
☐ the household, whom you sponsored.

Here's why:

You must repay the extra CalFresh benefits.
_________ in extra CalFresh benefits were issued for the period _______________________________ .

The household received $ __________ in CalFresh benefits.

The household should have received $ _________ in CalFresh benefits. $__________ (extra CalFresh benefits) is what you received minus what you should have received.

☐ This amount was reduced by $ _________ because we owed the household benefits from past months or we received repayment of part of the amount owed. You now owe $ __________.

See how we figured the extra amount you got on the worksheet that came with this notice.

- You do not have to use any SSI benefits you get to repay this overissuance.
- You may ask for a hearing if you feel you received extra CalFresh benefits because the County Welfare Department made a mistake.
- Collection will be from all adults in the household when the overissuance occurred.

YOU MUST EITHER:

Pay for the extra CalFresh benefits in full, or complete, sign and return the enclosed Repayment Agreement (DFA 377.7C) form and pay as agreed.

PROGRAM ACTIONS:

- Your repayment agreement will be based on your current ability to pay as figured by the county. Any changes in your ability to pay may change your monthly payments.
- If you do not sign and return the agreement within 30 days after the date of this notice, the amount of CalFresh benefits you get will be reduced by _________ % beginning __________.
- If you do not repay, the county may use other ways of collecting the amount owed, such as through the courts, other collection agency methods and by a federal government collection action.
- If this inadvertent household error is later found to be an Intentional Program Violation, penalties will apply even if you agree to repay what you owe.
- If the claim becomes delinquent or the household is sued, you may be subject to additional processing charges or court costs.
- If you do not repay the amount owed, the county may take your state/federal income tax refund and/or ask the court to attach your wages or any property you own.

Warning: If you believe this overissuance is wrong, this is your last chance to ask for a hearing. If you stay on CalFresh, the county can lower your CalFresh benefits to collect the overissuance. If you go off CalFresh before the overissuance is paid back, the county may take what you owe out of your income tax refund.

Rules: These rules apply: MPP 63-801.21, Duarte v. Saenz.

You may review them at your welfare office.

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

COUNTY OF

CALFRESH OVERISSUANCE NOTICE FOR ADMINISTRATIVE ERRORS ONLY

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

The County Welfare Department made a mistake.

Too many CalFresh benefits were issued to:

☐ the household.

☐ the household, whom you sponsored.

Here's why:

You must repay the extra CalFresh benefits.
$__________ in extra CalFresh benefits were issued for the period ___________________________.

The household received $ _________ in CalFresh benefits.

The household should have received $ ________ in CalFresh.
$ ________ (extra CalFresh benefits) is what you received minus what you should have received.

This amount was reduced by $ ___________ because we received repayment of part of the amount owed. You now owe
$ ____________.

See how we figured the extra amount you got on the worksheet that came with this notice.

- You do not have to use any SSI benefits you get to repay this overissuance.
- Collection will be from all adults in the household when the overissuance occurred.

YOU MUST EITHER:

Pay for the extra CalFresh benefits in full, or complete, sign and return the enclosed Repayment Agreement (DFA 377.7E) form and pay as agreed.

Rules: These rules apply: MPP 63-801.43, 63-801.22, 63-801.7, 63-801.4.
You may review them at your welfare office.

Warning: If you believe this overissuance is wrong, this is your last chance to ask for a hearing. If you stay on CalFresh the county can lower your CalFresh benefits to collect the overissuance unless it was the county's fault. If you go off CalFresh before the overissuance is paid back, the county may take what you owe out of your state/federal income tax refund as allowed by law.

PROGRAM ACTIONS:

- Your repayment agreement will be based on your current ability to pay as figured by the county. Any changes in your ability to pay may change your monthly payments.
- If you do not sign and return the agreement within 30 days after the date of this notice, we cannot reduce the amount of CalFresh benefits you get.
- If you do not repay, the county may use other ways of collecting the amount owed, such as through the courts, other collection agency methods and by a federal government collection action.
- If this Administrative Error is later found to be an Intentional Program Violation, penalties will apply even if you agree to repay what you owe.
- If the claim becomes delinquent or the household is sued, you may be subject to additional processing charges or court costs.
- If you do not repay the amount owed, the county may take your state/federal income tax refund and/or ask the court to attach your wages or any property you own.

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- 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:

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- 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.
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OR

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HEARING REQUEST

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☐ 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

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

COUNTY OF

CALFRESH OVERISSUANCE NOTICE FOR ADMINISTRATIVE ERRORS ONLY

Notice Date : ______
Case
Name : ______
Number : ______
Worker
Name : ______
Number : ______
Telephone : ______
Address : ______

(ADDRESSEE)

Questions? Ask your Worker.

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The household should have received $ _______ in CalFresh benefits. $ ________ (extra CalFresh benefits) is what you received minus what you should have received.

This amount was reduced by $___________ because we received repayment of part of the amount owed. You now owe $_______________.

See how we figured the extra amount you got on the worksheet that came with this notice.

- You do not have to use any SSI benefits you get to repay this overissuance.
- Collection will be from all adults in the household when the overissuance occurred.

YOU MUST EITHER:

Pay for the extra CalFresh benefits in full, or complete, sign and return the enclosed Repayment Agreement (DFA 377.7E1) form and pay as agreed.

Rules: These rules apply: MPP 63-801.43, 63-801.22, 63-801.7, 63-801.4.
You may review them at your welfare office.

Warning: If you think this overissuance is wrong, this is your last chance to ask for a hearing. The back of this page tells how. If you stay on CalFresh, the County can collect the overissuance by lowering your monthly CalFresh benefits. If you go off of CalFresh before the overissuance is paid back, the county may take what you owe out of your state/federal income tax refund.

PROGRAM ACTIONS:

- Your repayment agreement will be based on your current ability to pay as figured by the county. Any changes in your ability to pay may change your monthly payments.
- If you do not sign and return the agreement within 30 days after the date of this notice the amount of CalFresh benefits you get will be reduced by ______ % beginning ____________.
- If you do not repay, the county may use other ways of collecting the amount owed, such as through the courts, other collection agency methods and by a federal government collection action.
- If this Administrative Error is later found to be an Intentional Program Violation, penalties will apply even if you agree to repay what you owe.
- If the claim becomes delinquent or the household is sued, you may be subject to additional processing charges or court costs.
- If you do not repay the amount owed, the county may take your state/federal income tax refund and/or ask the court to attach your wages or any property you own.

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: ______________________

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☐ **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

COUNTY OF

CALFRESH OVERISSUANCE NOTICE FOR ADMINISTRATIVE ERRORS ONLY

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

The County Welfare Department made a mistake.

Too many CalFresh benefits were issued to:

- ☐ the household.
- ☐ the household, whom you sponsored.

Here's why:

You must repay the extra CalFresh benefits.
$__________ in extra CalFresh benefits were issued for the period ____________________________.
The household received $ __________ in CalFresh benefits.
The household should have received $ ________ in CalFresh benefits. $ __________ (extra CalFresh benefits) is what you received minus what you should have received.
This amount was reduced by $ __________ because we received repayment of part of the amount owed. You now owe $ ___________.

See how we figured the extra amount you got on the worksheet that came with this notice.

- You do not have to use any SSI benefits you get to repay this overissuance.

LOMELI V. SAENZ

- Federal regulations require us to have a rule to forgive any part of your claim if we believe you are unable to repay the claim. We only forgive a part of a claim where the county has made a mistake. Because the county made a mistake, we will collect the above amount by reducing your monthly allotment by 5% or $10.00, whichever is greater, for up to a total of 36 months. At the end of that period, any balance remaining on the overissuance will be forgiven and will not be collected.
- Collection will be from all adults in the household when the overissuance occurred.

YOU MUST EITHER:

Pay for the extra CalFresh benefits in full, or complete, sign and return the enclosed Repayment Agreement (DFA 377.7E1) form and pay as agreed.

Warning: If you think this overissuance is wrong, this is your last chance to ask for a hearing. The back of this page tells how. If you stay on CalFresh, the County can collect the overissuance by lowering your monthly CalFresh benefits. If you go off of CalFresh before the overissuance is paid back, the county may take what you owe out of your state/federal income tax refund.

PROGRAM ACTIONS:

- Your repayment agreement will be based on your current ability to pay as figured by the county. Any changes in your ability to pay may change your monthly payments.
- If you do not sign and return the agreement within 30 days after the date of this notice, the amount of CalFresh benefits you get will be reduced by ______ % beginning_____________.
- If you do not repay, the county may use other ways of collecting the amount owed, such as through the courts, other collection agency methods and by a federal government collection action.
- If this Administrative Error is later found to be an Intentional Program Violation, penalties will apply even if you agree to repay what you owe.
- If the claim becomes delinquent or the household is sued, you may be subject to additional processing charges or court costs.
- If you do not repay the amount owed, the county may take your state/federal income tax refund and/or ask the court to attach your wages or any property you own.

Rules: These rules apply: MPP 63-801.22, 63-801.43, 63-801.7, Lomeli v. Saenz and Duarte v. Saenz.

You may review them at your welfare office.

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: ____

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☐ **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

COUNTY OF

CALFRESH OVERISSUANCE NOTICE FOR AN INTENTIONAL PROGRAM VIOLATION (IPV) OR STATUS CHANGE FROM INADVERTENT HOUSEHOLD ERROR (IHE) TO AN IPV

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: You can ask for a hearing on this action, **unless** you already had a hearing on the **cause** of this overissuance. If you think the new amount of CalFresh benefits you owe is incorrect, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

Your household made a mistake.

Too many CalFresh benefits were issued to:

☐ the household.
☐ the household, whom you sponsored.

Here's why:

☐ **You have already been told about this overissuance of CalFresh and the County may have been giving you less CalFresh benefits each month because of it. It has been decided in court or by state administrative hearing that this is an Intentional Program Violation (IPV) or you have signed a Disqualification Consent Agreement or an Administrative Disqualification Hearing Waiver and this is now an IPV. This notice has information about the amount you now owe, which may be more than the amount you were told about before. The County has been collecting the overissuance at 10% or $10 (whichever is more) of your monthly allotment. The county can now collect up to 20% or $20 (whichever is more) of your monthly allotment, so the amount of CalFresh benefits that you get may change.**

You must repay the extra CalFresh benefits.
$___________ in extra CalFresh benefits were issued for the period __________________________ .

The household received $ __________ in CalFresh benefits.

The household should have received $________________in CalFresh benefits. $ __________ (extra CalFresh benefits) is what you received minus what you should have received.

☐ This amount was reduced by $____________ because we owed the household benefits from past months or we received repayment of part of the amount owed.

☐ This amount was increased by $_____________because your overissuance has been refigured since it became an IPV.

You now owe $_____________ .

Rules: These rules apply: MPP 63-801.43, 63-801.23.
You may review them at your welfare office.

- You do not have to use any SSI benefits you get to repay this overissuance.
- Collection will be from all adults in the household when the overissuance occurred.

See how we figured the extra amount you got on the worksheet that came with this notice.

YOU MUST EITHER:

Pay for the extra CalFresh benefits in full, or complete, sign and return the enclosed Repayment Agreement (DFA 377.7G) form and pay as agreed.

PROGRAM ACTIONS:

- Your repayment agreement will be based on your current ability to pay as figured by the county. Any changes in your ability to pay may change your monthly payments.
- If you do not sign and return the agreement within 30 days after the date of this notice the amount of CalFresh you get will be reduced by ________ % beginning ___________.
- If you do not repay, the county may use other ways of collecting the amount owed, such as through the courts, other collection agency methods and by a federal government collection action.
- If this Intentional Program Violation was an Inadvertent Household Error, penalties will apply even if you agree to repay what you owe.
- If the claim becomes delinquent or the household is sued, you may be subject to additional processing charges or court costs.
- If you do not repay the amount owed, the county may take your state/federal income tax refund and/or ask the court to attach your wages or any property you own.

Warning: If you believe this overissuance is wrong, this is your last chance to ask for a hearing. If you stay on CalFresh the county can lower your CalFresh benefits to collect the overissuance. If you go off CalFresh before the overissuance is paid back, the county may take what you owe out of your income tax refund.

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- 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:

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OTHER INFORMATION

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TO ASK FOR A HEARING:

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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: ____

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☐ **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