

May 14, 2018

ALL COUNTY LETTER (ACL) NO. 18-49

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CALWORKS PROGRAM SPECIALISTS
ALL CONSORTIA PROJECT MANAGERS
ALL QUALITY CONTROL PROGRAM COORDINATORS
ALL COUNTY SPECIAL INVESTIGATIVE UNIT CHIEFS

SUBJECT: CALFRESH IMPLEMENTATION OF CF 377.7G – CALFRESH
INTENTIONAL PROGRAM VIOLATION (IPV) NOTICE DUE TO
TRAFFICKING

REFERENCE: TITLE 7 CODE OF FEDERAL REGULATIONS (CFR)
[§273.18\(e\)\(3\)](#), [§273.16\(c\)](#), [§271.2](#); MANUAL OF POLICIES AND
PROCEDURES (MPP) [§63-801.431](#), [§63-801.33](#), [§63-801.732](#),
[§23-400.111](#), [§22-004.21](#); [ACIN NO I-73-11](#)

The purpose of this ACL is to provide County Welfare Departments (CWDs) with a copy of a new form developed by the California Department of Social Services (CDSS), the *CalFresh Intentional Program Violation (IPV) Notice Due to Trafficking (CF 377.7G)*. The CF 377.7G is a CalFresh Notice of Action (NOA) for recipients, in cases resulting in an IPV for trafficking and repayment owed.

Background

In 2016, CDSS convened a NOA Workgroup, whose membership included internal stakeholders, county data system operators, consortia, and advocates. The purpose of the workgroup was to update and standardize CalFresh overissuance notices. In addition to revising and updating existing NOA forms, the implementation of a new NOA form was established to address repayment of benefits specifically pertaining to IPV for trafficking. This was necessary as the trafficking of benefits does not result in overpayment or overissuances, and therefore a standard or existing NOA could not be

used to address repayment. In addition to the CF 377.7G, the Notice of Administrative Disqualification, [CF 377.7A](#), will continue to be mailed out to those disqualified from the CalFresh program.

Summary of the CalFresh 377.7G Form

The CF 377.7G is a NOA for IPV's resulting from CalFresh benefits that were trafficked by recipients. Trafficking is defined by the Code of Federal Regulations, pursuant to [7 CFR §271.2](#), as "*The buying, selling, stealing, or otherwise effecting an exchange of Supplemental Nutrition Assistance Program (SNAP) benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food...*". The CF 377.7G NOA alerts recipients that if they do not begin repayment, action could be taken to recover amounts subject to claim. Pursuant to [MPP 22-004.21](#), the NOA informs recipients of options to repay or request a state hearing should there be a disagreement to the dollar amount owed.

Implementation Timeline

The CWDs shall begin using the CF 377.7G at the issuance of this ACL, or as soon as administratively feasible.

NO SUBSTITUTES PERMITTED – NO FORMATTING CHANGES

In accordance with the CDSS [MPP §23-400.111](#), all NOAs are required forms with no substitutes permitted. Neither the CWDs or Statewide Automated Welfare System (SAWS) may modify or restructure the formatting or text of any NOA form. However, overprinting modifications may be permitted. Overprinting modifications for purposes other than those specified under [MPP §23-400.211](#) must be pre-approved by CDSS before use of the forms by CWDs.

Camera Ready Copies and Translations

For a camera-ready copy in English, contact the [CDSS Forms Management Unit](#) at fmudds@dss.ca.gov. You may obtain this CalFresh form from the [Forms Listed By Program, CDSS Webpage](#) at: <http://www.cdss.ca.gov/inforesources/Forms-Brochures/Forms-by-Program>.

When all translations are completed per [MPP §21-115.2](#), they are posted on an on-going basis on the CDSS webpage. [Translated forms](#) can be obtained at: <http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications>.

For questions on translated materials, please contact the CDSS Language and Services at (916) 651-8876. Until translations are available, recipients who have elected to

receive materials in languages other than English should be sent the English version of the form or notice along with the [GEN 1365 – Notice of Language Services](http://www.cdss.ca.gov/cdssweb/entres/forms/Multi/GEN1365MUL.pdf) at:
<http://www.cdss.ca.gov/cdssweb/entres/forms/Multi/GEN1365MUL.pdf>

In the event that CDSS does not provide translations of a form, it is the CWD's responsibility to provide interpreter services if an applicant or recipient requests them. In addition, the CWDs shall ensure that individuals with disabilities are provided services, such as auxiliary aids and services to persons who are deaf or hearing impaired, or persons with impaired speech, vision or manual skills where necessary. More information regarding translations can be found in [MPP §21-115](#).

The CWDs shall ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees and qualified employees of other agencies or community resources. These services shall be provided free of charge to the applicant/recipient.

[This ACL and other CDSS Letters and Notices are available on the internet at:](http://www.cdss.ca.gov/inforesources/Letters-and-Notices)
<http://www.cdss.ca.gov/inforesources/Letters-and-Notices>.

If you have any questions regarding this ACL, please contact your CalFresh County Consultant or the CalFresh Policy Bureau at (916) 654-1896.

Sincerely,

Original Document Signed By:

TODD R. BLAND
Deputy Director
Family Engagement and
Empowerment Division

Attachment

**CALFRESH INTENTIONAL PROGRAM
VIOLATION (IPV) NOTICE
DUE TO TRAFFICKING**

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

COUNTY OF _____

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: You are no longer eligible to appeal the disqualification action in a State Hearing. If you disagree with the amount you owe, and the amount you owe was not part of the hearing decision, you may ask for a State Hearing by filling out the back of this form and returning it by _____.

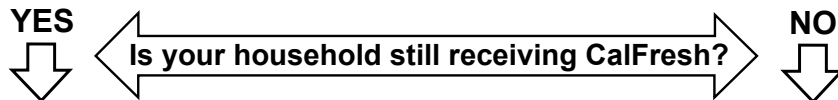
1. You trafficked your benefits.

You need to pay back the \$ _____ you trafficked from _____ to _____. Please see below for your options to repay.

2. It was determined that you have committed an Intentional Program Violation (IPV) for trafficking your benefits. Here's how this happened:

- ☐ A state hearing decision found you committed an IPV.
- ☐ A court decision found you committed an IPV.
- ☐ You signed a Disqualification Consent Agreement on _____.
- ☐ You signed an Administrative Disqualification Hearing Waiver on _____.

3. Your options to repay:



1. Agree to a 20% or \$20 repayment plan

If you don't respond, we'll assume you agree to a 20% or \$20 reduction (whichever is more) in your CalFresh benefits. This will start on _____ DATE _____.

OR



2. Agree to a higher repayment plan

Fill out and return the included repayment form by _____ DATE + 90 _____.

OR



3. Agree to pay in full



1. Agree to a repayment plan

Fill out and return the included repayment form by _____ DATE + 30 _____.

OR



2. Agree to pay in full

- Note:**
- You do not have to use SSI benefits to pay back the amount owed.
 - Collection will be from all adults who were part of the household when the trafficking occurred.
 - You may review and copy the county's records related to the amount owed.
 - If you do not pay back the amount owed, agree to a repayment plan, or have your benefits reduced, the county may use other ways of collecting the amount owed such as: through the courts, through the county, deductions from your income tax refund, or federal government collection action.
 - If the claim becomes past due or the household is sued, you may have to pay additional processing charges or court costs.

These rules apply: MPP 63-801.23. You may review them online at cdss.ca.gov or at your local county 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 have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, 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 CalFresh benefits 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, CalFresh 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 ☐ CalFresh
☐ 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 ☐ CalFresh ☐ 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