

February 19, 2020

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 19-76E**

The purpose of this erratum is to correct errors identified in All County Letter (ACL) No. 19-76 and transmit the revisions made to the California Work Opportunity and Responsibility to Kids (CalWORKs) M44-207K Notice of Action Messaging and Overpayment Notice of Action (NA 27H).



KIM JOHNSON  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



GAVIN NEWSOM  
GOVERNOR

February 19, 2020

**ERRATUM**

ALL COUNTY LETTER NO. 19-76E

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY CALWORKS PROGRAM SPECIALISTS  
ALL CALFRESH PROGRAM SPECIALISTS  
ALL COUNTY REFUGEE COORDINATORS  
ALL COUNTY CONSORTIA REPRESENTATIVES

SUBJECT: **ERRATUM TO THE IMPLEMENTATION OF SENATE BILL 80:  
CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS  
(CALWORKS) INCOME EXEMPTIONS AND INCOME REPORTING  
THRESHOLDS**

REFERENCE: [SENATE BILL \(SB\) 80 \(CHAPTER 27, STATUTES OF 2019\); MANUAL  
OF POLICIES AND PROCEDURES \(MPP\) SECTIONS 44- 315.5, AND  
ALL COUNTY LETTER \(ACL\) No. 19-76](#)

The purpose of this erratum is to correct an error in a zero grant example that was transmitted in [ACL No. 19-76](#), dated August 2, 2019. This erratum lists both the original language included in ACL No. 19-76 and corrected language for the impacted section. Deletions are marked in ~~strike through~~ and additions in **bold**.

In addition, this letter transmits revisions made to CalWORKs Notice of Action message M44-207K and Overpayment Notice of Action (NA 274H).

**INCOME REPORTING THRESHOLD (IRT)**

ACL No. 19-76 provides the following example, beginning on page four, paragraph four: "For example, if an AU's budget results in countable earnings that exceed the MAP their grant would be \$0. Similarly, if an AU's budget results in a ~~MAP of \$10 or less~~ **grant of less than \$10**, their issuance would be \$0."

**CHANGES MADE TO NOA MESSAGE M44-207K: DISCONTINUANCE**

- Amended the "Here's why" section to read: "You cannot get cash aid if your family's gross income is more than 130 percent of the Federal Poverty Level (FPL)."
- Added: "Your family size is \_\_\_\_\_."
- Added: "The 130 percent of the FPL for your family size is \_\_\_\_\_."

CHANGES MADE TO THE OVERPAYMENT NOTICE OF ACTION (NA 274H)

- Corrected the effective date from 7/1/2020 to 6/1/2020.

**CAMERA READY COPIES AND TRANSLATIONS**

For camera-ready copies in English, contact the Forms Management Unit at [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov). If your office has internet access you may obtain these publications from the [CDSS Forms and Publications](#) webpage.

When all translations are completed per [MPP Section 21-115.2](#), they are posted on an on-going basis on the [CDSS Translated Forms and Publications](#) webpage.

For questions on translated materials, please contact Language 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](#) and a local contact number.

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.

In the event that the CDSS does not provide translations of a form, it is the CWD's responsibility to provide translation services if an applicant or recipient requests them. More information regarding provisions for services to applicants and recipients who are non-English speaking or who have disabilities can be found in the [MPP Section 21-115](#). This ACL and other CDSS Letters and Notices are available on the [CDSS webpage](#).

If you have any questions concerning this letter, please contact the Early Engagement & Eligibility Bureau at (916) 654-1322.

Sincerely,

***Original Document Signed By:***

Jennifer Hernandez  
Deputy Director  
Family Engagement and Empowerment Division

Attachments

State of California  
Department of Social Services

Noa Msg Doc No.: M44-207K Page 1 of 1

Action : Discontinue

Issue: Income

Title: Financial Eligibility

Auto ID No.:

Source :

Issued by :

Reg Cite : ACL 19-76, Senate Bill  
(SB) 80 (Chapter 27, Statutes of 2019)

Use Form No. : NA 210

Original Date : 05-01-87

Revision Date : 02-01-20

#### MESSAGE:

As of \_\_\_\_\_, the county is stopping your cash aid.

Here's why:

You cannot get cash aid if your family's net countable income is more than 130 percent of the Federal Poverty Level (FPL).

Your family size is \_\_\_\_\_

The 130 percent of the FPL for your family size is \_\_\_\_\_

Your family's needs and income are figured on this page.

**If you disagree, ask for a hearing.** The back of this notice tells you how.

**Medi-Cal:** This notice DOES NOT stop or change your Medi-Cal benefits. **Keep using your plastic Benefits Identification Card (s).** You will get another notice telling you about any changes to your health benefits.

**CalFresh:** This notice DOES NOT stop or change your food stamp benefits. You will get a separate notice telling you about any changes to your food stamp benefits.

Receiving Medi-Cal and/or CalFresh only DOES NOT count against your cash aid time limits.

**INSTRUCTIONS:** Use to discontinue cash aid when the family's income (AU + Non-AU members) is more than 130 percent of the Federal Poverty Level (FPL). Use the NA 210 (7/19).

Complete the following:

- Date of discontinuance
- Provide number of family members included in the Assistance Unit (AU)
- Provide the dollar value for 130 percent of the FPL for the AU size

This message replaces the M44-207K (1/01/20).

**NOTICE OF ACTION  
(Continued)**

Overpayment Amount Owed  
(For Overpayments Occurring on  
or after 6-1-2020)

COUNTY OF \_\_\_\_\_

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

**Overpayment Month and Year****Section A. Countable Income, Month of \_\_\_\_\_**

1. Total Self-Employment Income	\$			
2. Self-Employment Expenses:				
a. 40% Standard	-			
OR				
b. Actual	-			
3. Net Earnings from Self-Employment	=			
4. Total Disability-Based Unearned Income (DBI) (Assistance Unit + Non-Assistance Unit Members)	\$			
5. \$500 DBI Disregard (if #4 is greater than \$500)	-			
6. Nonexempt Unearned Disability-Based Income	=			
OR				
7. Unused DBI Disregard	=			
8. Net Earnings from Self-Employment (from above)	+			
9. Total Other Earned Income	+			
10. Unused Amount of \$500 (from #7)	-			
<b>11. Subtotal</b>	<b>=</b>			
12. Earned Income Disregard 50%.	-			
<b>13. Subtotal</b>	<b>=</b>			
14. Nonexempt Unearned Disability-Based Income (from #6)	+			
<b>15. Subtotal</b>	<b>=</b>			
16. Other Nonexempt Income (Assistance Unit + Non- Assistance Unit Members)	+			
<b>Net Countable Income</b>	<b>=</b>			

**Section B. Your Cash Aid, Month of \_\_\_\_\_**

1. Maximum Aid _____ Persons (Assistance Unit + Non-Assistance Unit Members)	\$			
2. Special Needs (Assistance Unit + Non-Assistance Unit Members)	+			
3. Net Countable Income from Section A	-			
<b>4. Subtotal</b>	=			
5. Maximum Aid _____ Persons (Assistance Unit only) (Penalized Persons)	\$			
6. Special Needs (Assistance Unit only)	+			
7. Maximum Aid Subtotal	=			
<b>8. Full Month Aid Subtotal</b> (Lowest Amount on Line 4 or 7)	=			
9. Line 8 Prorated for Part of Month	=			
10. Adjustments: 25% Child Support Penalty(ies)	-			
Other Penalties	-			
Overpayment	-			
Cal-Learn Penalties	-			
School Bonus (\$100 or \$500)	+			
<b>11. Monthly Cash Aid Amount</b> (Line 8 or 9 Adjusted)	\$			
<b>12. Overpayment</b>				
Cash Aid Paid to You	\$			
Correct Cash Aid Amount with Adjustments	-			
<b>Subtotal</b>	=			
<b>13. Cash Aid Paid to You</b>	\$			
Support Payments Collected for You	-			
<b>Subtotal</b>	=			
<b>14. Amount of Overpayment for Each Month</b> (Lesser of Subtotal 12 or 13)	=			

**TOTAL OVERPAYMENT (All Months) \$ \_\_\_\_\_**

Rules: These rules apply; you may review them at your Welfare Office: MPP 44-352, SB 1041 (Chapter 47, Statutes of 2012).

**State Hearing: If you think this action is wrong, you can ask for a hearing. Page 3 tells how.**

## 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		Date of Birth	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