

September 6, 2023

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 23-73**

The purpose of this All County Letter is to provide County Welfare Departments with guidance regarding new California Food Assistance Program overissuance claims policy and noticing requirements, effective October 1, 2025. This letter also issues new and revised forms and notices.



KIM JOHNSON  
DIRECTOR

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**DEPARTMENT OF SOCIAL SERVICES**  
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GAVIN NEWSOM  
GOVERNOR

September 6, 2023

ALL COUNTY LETTER NO. 23-73

TO: ALL COUNTY WELFARE DIRECTORS  
ALL CONSORTIA PROJECT MANAGERS  
ALL CALFRESH PROGRAM SPECIALISTS  
ALL CALWORKS PROGRAM SPECIALISTS  
ALL QUALITY CONTROL SPECIALISTS

SUBJECT: CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) NEW  
OVERISSUANCE CLAIMS POLICY AND NOTICING  
REQUIREMENTS

REFERENCE: [ASSEMBLY BILL \(AB\) 135 \(CHAPTER 85, STATUTES OF 2021\);](#)  
[AB 1576 \(CHAPTER 287, STATUTES OF 1997\); ALL COUNTY](#)  
[INFORMATIONAL NOTICE \(ACIN\) I-52-97, ACIN I-67-01; ACIN I-](#)  
[87-20; ALL COUNTY LETTER \(ACL\) 97-50; ACL 98-66; ACL 99-](#)  
[78; ACL 06-60; ACL 16-108; ACL 18-50; ACL 18-50E; ACL 18-99;](#)  
[ACL 19-50; ACL 20-24, ACL 21-109, ACL 21-118; ACL 22-61; ACL](#)  
[22-61E; ACL 23-57; CALIFORNIA GOVERNMENT CODE](#)  
[SECTIONS 12419.2-3 AND 12419.5; MANUAL OF POLICIES AND](#)  
[PROCEDURES \(MPP\) 20-401\(i\)\(1\); MPP 20-400; MPP 20-402;](#)  
[MPP 20-404; MPP 23-400.211; MPP 63-801.431; MPP 63-801.45;](#)  
[MPP 63-801.7; MPP 63-801.736; SUPPLEMENTAL](#)  
[APPROPRIATIONS ACT \(PUBLIC LAW 105-18\); SENATE BILL](#)  
[187 \(CHAPTER 50, STATUTES OF 2022\); TITLE 7 CODE OF](#)  
[FEDERAL REGULATIONS SECTION 273.18\(e\)\(5\); 7 CFR](#)  
[273.18\(c\)\(1\)\(i\); WELFARE AND INSTITUTIONS CODE \(WIC\)](#)  
[10850, WIC 18930-18935](#)

The purpose of this All County Letter (ACL) is to provide County Welfare Departments (CWD) with guidance regarding new California Food Assistance Program (CFAP) overissuance (OI) claims policy and noticing requirements. This letter also issues new and revised forms and notices.

## **I. BACKGROUND**

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 resulted in the loss of federal Supplemental Nutrition Assistance Program (SNAP) benefits for certain qualified noncitizens. In response, California passed [Assembly Bill \(AB\) 1576 \(Chapter 287, Statutes of 1997\)](#). [AB 1576](#) created a state-funded nutrition assistance program, known as CFAP, which continues to operate today as a federal state option and replaces lost federal nutrition benefits for certain qualified noncitizens ([ACIN I-52-97](#)).

In 1997, California submitted the CFAP State Plan to the United States Department of Agriculture, Food and Nutrition Service (FNS) outlining the conditions and procedures for how state-funded food assistance benefits will operate in conjunction with federal SNAP benefits. Specifically, one of the conditions and procedures outlined in the CFAP State Plan is the establishment and collection of OI claims, as defined at [Title 7 Code of Federal Regulations \(CFR\) Section 271.2](#). According to the 1997 CFAP State Plan, CFAP OI claims are collected the same way as overissued federal SNAP benefits. Once collected, FNS reimburses the state for the value of CFAP OI claims collected.

Due to the upcoming CFAP expansion, which expands CFAP eligibility to individuals age 55 or older regardless of immigration status effective October 1, 2025 ([ACL 23-57](#)), California amended the CFAP State Plan. The amended CFAP State Plan includes an update to the procedures for collecting CFAP OIs. Because CFAP OIs are not federal debts, CFAP OI claims will now be collected directly by the state and the state will no longer be reimbursed by FNS for the value of these claims. This letter provides guidance on new CFAP overissuance policy and noticing requirements.

For the purposes of this letter, households that contain at least one CalFresh participant and at least one CFAP participant are referred to as “CFAP mixed households”.

## **II. CURRENT CFAP OI POLICY**

In accordance with [WIC Section 18932\(a\)](#) and to the maximum extent permitted by state law, the rules governing CalFresh must also apply to CFAP; therefore, existing CalFresh OI policies and procedures must be followed for all CFAP-only and CFAP mixed households, unless otherwise stated in state law or OI related policy guidance and publications, inclusive of this letter.

## **III. NEW CFAP OI POLICY AND REPORTING**

*Establishing Separate CFAP OI Claims for Mixed Households*

Effective October 1, 2025, CFAP OIs must be collected directly by the state. Beginning on this date, CalFresh and CFAP OIs must be calculated, established, and recouped, separately from one another for each month the household incurs an OI. If a CFAP mixed household is overissued benefits, the CWD must establish a separate CalFresh and CFAP OI claim for each month and based on which food benefits were overpaid. The CWD must create separate recovery accounts and send separate OI claim notices to households.

The CWD must continue to determine the type and amount of the claim, establish the claim, initiate collection on the claim, and utilize current methods for collecting the claim in accordance with [MPP 63-801.7](#). In addition, current OI claim establishment periods on all OI claim types remain unchanged by the new CFAP OI policy.

The CWD must apply the current OI threshold to each claim according to the claim type. This is inclusive of CFAP mixed households that are overpaid both CalFresh and CFAP benefits and incur two separate OIs under the new CFAP OI policies described in this letter.

#### *Benefit Reduction*

Effective October 1, 2025, benefit reduction must correspond to the funding source of the OI. As such, federal benefits cannot be reduced to repay a state OI claim, and conversely, state benefits cannot be reduced to repay a federal OI claim. When a household chooses to repay their CFAP and/or CalFresh OI claim through benefit reduction, the CWD must ensure the benefit reduction source corresponds with the funding source of the OI.

If a household is repaying an OI through benefit reduction and experiences a change in circumstances that causes their eligibility to change from state-funded benefits to federally-funded benefits or vice versa, the household must sign the new CFAP 377.7T – *CalFresh/California Food Assistance Program (CFAP) - State CalFresh Overissuance Repayment Agreement Transition Notice*. Because the funding source of the household's benefits has changed, repayment through benefit reduction is no longer an option. The transition agreement acknowledges a new agreement to repay the OI claim in full, in installments via a repayment agreement, or to request a state hearing. The CFAP 377.7T does not establish a new OI claim, rather, the notice informs the household of their responsibility to continue repaying the existing OI claim and of the new repayment options.

If a CFAP mixed household is repaying both a federal and state-funded OI claim and experiences a change that causes a transition to both funding sources, then the household must receive separate CFAP 377.7T notices with the corresponding information according to the funding source.

When a mixed household incurs both a CalFresh and CFAP OI and the household chooses to repay via benefit reduction, each reduction is set, in accordance with [MPP 63-801.736](#), at the appropriate percentage or dollar reduction rate, whichever is greater, per each OI claim. For example, a mixed household receives a monthly benefit allotment of \$160, \$100 in CalFresh benefits and \$60 in CFAP benefits. The mixed household incurs two Inadvertent Household Error (IHE) OIs, one for CalFresh and one for CFAP. The mixed household chooses to repay the OI via benefit reduction. Therefore, the mixed household will have two \$10 OI reductions to recover the CalFresh and CFAP OIs, until each of the OIs are repaid.

Administrative Error (AE) OI claims recovered via benefit reduction must only be collected for a total of 36 consecutive calendar months in accordance with [ACL 00-59](#). The new CFAP OI policy described in this letter does not affect existing OI claims establishment timeframes.

#### *CFAP OI Reporting*

Effective October 1, 2025, the CWD must use the appropriate OI forms and issue appropriate OI notices depending on whether the OI claim is a CFAP OI or a CalFresh OI. Accordingly, CFAP OI claims must not to be included on the federal FNS 209 – *Status of Claims Against Households* report and must be accounted for in accordance with state reporting procedures for state CFAP debts. CDSS has created a state version of the FNS 209 titled the CA 209 – *Status of Claims Against Households* report. CDSS will issue guidance on the new reporting form via a County Fiscal Letter.

#### **IV. FRANCHISE TAX BOARD INTERAGENCY INTERCEPT COLLECTION PROGRAM**

Per state regulations, the Franchise Tax Board Interagency Intercept Collection (FTB IIC) Program is designed to assist counties in the collection of delinquent OIs and CWDs must submit all eligible claims to CDSS on a continuous basis ([MPP 20-400](#), [MPP 20-402](#), and [MPP 20-404](#)).

Effective October 1, 2025, CFAP benefits will be paid from a state account; therefore, CWDs are required to submit delinquent CFAP OI claims to the FTB using the established process via the Welfare Intercept System. If the current or former household member does not have an SSN or ITIN do not submit to FTB.

#### **V. POLICY IMPLEMENTATION TIMELINE**

New OI claims established on or after October 1, 2025, on any CFAP case will be collected under the new claims policy outlined in this letter and reported on the new CA 209 report.

OI claims established before October 1, 2025, for a closed CFAP case are not affected by the new guidance provided in this ACL.

OI claims established before October 1, 2025, for an active CFAP case are not affected by the new guidance provided in this ACL and must be collected and accounted for on the FNS 209 report.

## **VI. CFAP OVERISSUANCE FORMS/NOTICES OF ACTION**

The CWD must send households relevant OI NOAs as outlined in [MPP 63-801.431](#) and include the newly revised NA 1263 – *CalFresh/California Food Assistance Program (CFAP) - State CalFresh Notice of Action* OI budget worksheet and/or the new *CFAP 1263- CalFresh/ California Food Assistance Program (CFAP) - State CalFresh Combined Household Notice of Action* OI budget worksheet. This notice explains the basis for the action to the household ([ACL 18-50](#) and [ACL 18-50E](#)). A copy of the notice must be preserved in the household's case record.

CFAP OI NOAs must inform CFAP recipients that an OI claim was established, the cause of the OI, amount owed, and the option to either set up a repayment agreement or request a State Hearing to dispute the OI. The following forms and notices will be updated or created to comply with the policy changes outlined in this letter effective October 1, 2025.

## **VII. REVISED FORM**

*NA 1263 (08/23) – No Substitute Permitted*  
**CALFRESH/CALIFORNIA FOOD ASSISTANCE (CFAP)- STATE CALFRESH NOTICE OF ACTION**

This required form is used as an attachment with all CalFresh/CFAP OI NOAs. The information on the budget worksheet includes the calculation used to determine the claim amount for each month the household incurred an OI. Changes to this form include two drop-down menus at the top of the form to allow the CWD to select which of the two food programs the OI budget worksheet applies. For each budget worksheet issued, the CWD must only choose one program. Additionally, the form is updated to include a drop-down menu to allow program recipients to read "CalFresh" or "CFAP" wherever the term 'CalFresh' used to be. These revisions allow the CWD to use the OI budget worksheet as an attachment for CalFresh-only households, CFAP-only households, and for CalFresh household members within a CFAP mixed household.

This form must not be used for CFAP mixed households. The CWD must use the CFAP 1263 form for CFAP household members within a CFAP mixed household. For more information on the CFAP 1263 form, refer to page eight of this letter.

## **VIII. NEW FORMS/NOTICES**

*CFAP 842 (08/23) – Substitutes Permitted*  
**CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH CLAIM DETERMINATION WORKSHEET**

This new form mirrors the current CF 842 (2/14) – *Claim Determination Worksheet* but is redesigned and reformatted to comply with all accessibility standards. This form is used to document CFAP claims against any household that has received more food assistance benefits than it is entitled to receive. The purpose of this form is twofold: 1) internal documentation of individual claims, and 2) gathering information necessary to complete CA 209 monthly report.

*CFAP 377.7B (08/23) – No Substitute Permitted*  
**CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH OVERISSUANCE NOTICE FOR INADVERTENT HOUSEHOLD ERROR (IHE)**

This new notice is to inform CFAP households of an OI resulting from an IHE. This notice informs the household of their options to repay the OI or request a state hearing.

*CFAP 377.7B1 (08/23) – No Substitute Permitted*  
**CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH REPAYMENT FINAL NOTICE INADVERTENT HOUSEHOLD ERROR (IHE)**

This new final notice is used to inform CFAP households that failure to repay an OI due to an IHE, will result in action to recover the amount owed. The notice informs the household of their options to repay the OI or request a state hearing.

*CFAP 377.7C (08/23) – No Substitute Permitted*  
**CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH REPAYMENT AGREEMENT FOR INADVERTENT HOUSEHOLD ERRORS (IHE)**

This new notice is to inform CFAP households of the OI repayment agreement for an IHE claim, including terms and conditions. This notice includes an agreement completed by the CFAP household indicating the repayment method selected and accompanying signature.

*CFAP 377.7D2 (08/23) – No Substitute Permitted*  
**CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH REPAYMENT FINAL NOTICE COUNTY ADMINISTRATIVE ERROR (AE)**

This new final notice is used to inform CFAP households that failure to repay an OI due to an AE will result in action to recover the amount owed. The notice informs the household of their options to repay the OI or request a state hearing.

*CFAP 377.7D3 (08/23) – No Substitute Permitted*

***CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH  
OVERISSUANCE NOTICE COUNTY ADMINISTRATIVE ERROR (AE)***

This new notice is to inform CFAP households of an OI resulting from an AE. This notice informs the household of their options to repay the OI or request a state hearing.

***CFAP 377.7E1 (08/23) – No Substitute Permitted  
CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH  
REPAYMENT AGREEMENT FOR ADMINISTRATIVE ERRORS***

This new notice is to inform CFAP households of the OI repayment agreement for an AE claim, including terms and conditions. This notice includes an agreement completed by the CFAP household indicating the repayment method they will select and accompanying signature.

***CFAP 377.7F (08/23) – No Substitute Permitted  
CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH  
OVERISSUANCE NOTICE CHANGE FROM INADVERTENT HOUSEHOLD ERROR  
(IHE) TO INTENTIONAL PROGRAM VIOLATION (IPV)***

This new notice is to inform CFAP households of an OI change from IHE to IPV. This notice informs the household of their options to repay the OI or request a state hearing.

***CFAP 377.7F1 (08/23) – No Substitute Permitted  
CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH  
REPAYMENT FINAL NOTICE INTENTIONAL PROGRAM VIOLATION (IPV)***

This new final notice is used to inform CFAP households that failure to repay an OI due to an IPV will result in action to recover the appropriate amount owed. The notice informs the household of their options to repay the OI or request a state hearing.

***CFAP 377.7F2 (08/23) – No Substitute Permitted  
CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH  
OVERISSUANCE NOTICE INTENTIONAL PROGRAM VIOLATION (IPV)***

This new notice is to inform CFAP households of an OI resulting from an IPV. This notice informs the household of their options to repay the OI or request a state hearing.

***CFAP 377.7G (08/23) – No Substitute Permitted  
CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH  
INTENTIONAL PROGRAM VIOLATION (IPV) NOTICE DUE TO TRAFFICKING***

This new notice is to inform CFAP households of an OI resulting from an IPV due to trafficking. This notice informs the household of their options to repay the OI or request a state hearing.



*CFAP 377.7H (08/23) – No Substitute Permitted*  
**CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH**  
**INFORMATIONAL NOTICE OF POTENTIAL INTENTIONAL PROGRAM VIOLATION**  
**(IPV)**

This notice is to inform CFAP households of the potential CFAP IPV OI amount beyond the 24-month claim, which will become established and deemed collectable if an IPV is substantiated.

*CF 377.7T (08/23) – No Substitute Permitted*  
**CALFRESH/CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE**  
**CALFRESH OVERISSUANCE TRANSITION NOTICE**

This new notice is an OI notice/agreement that informs CalFresh and/or CFAP households of a change to an active OI impacting the current benefit reduction repayment plan. This notice/agreement informs the household that a change caused their benefits to change from CFAP to CalFresh or vice versa, and that a new repayment agreement must be completed. This notice includes an agreement completed by the household indicating the payment method they will select and an accompanying signature.

*CFAP 1263 (08/23) – No Substitute Permitted*  
**CALFRESH/STATE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE**  
**CALFRESH COMBINED HOUSEHOLD OVERISSUANCE BUDGET WORKSHEET**

This new form is used as an attachment with all CFAP mixed household OI NOAs. The information on the budget worksheet includes the calculation used to determine the CalFresh and CFAP OI claim amounts for each month the household incurred an OI, including the CFAP budgeting methodology and CFAP allotment. The form includes a row for the “Combined Budget” and a row for the “Federal Budget” for the OI month/year. This form is only to be used when a claim is established on a mixed household, even if the household subsequently transitions to a CalFresh-only or CFAP-only household.

## **IX. AUTOMATION TIMELINE**

Per [Sections 86 and 87 of AB 135 \(Chapter 85, Statutes of 2021\)](#), the CFAP expansion implementation is contingent upon the completion of required automation in CalSAWS. The automation to implement existing functionality or to develop new functionality to comply with the requirements in this letter will be implemented in the CalSAWS single system effective with the CFAP expansion implementation date, October 1, 2025. Additionally, CalSAWS automation will develop the ability to populate the new and revised forms/notices.

## **X. SUBSTITUTES AND OVERPRINTING**

Substitutes and overprinting modifications are not permitted, unless otherwise stated. Overprinting modifications for purposes other than those specified under [MPP 23-400.211](#) must be preapproved by CDSS before use of the forms by CWDs.

## **XI. COPIES AND TRANSLATIONS**

Forms referenced in this letter are available on the [CDSS Forms/Brochures](#) webpage, including Large Print versions. When CDSS completes all translations of a form, they are posted on the [Translated Forms and Publications](#) webpage. When made available by CDSS, forms translated into an individual's preferred language must be provided to the individual pursuant to [MPP Section 21-115.2](#). For questions on translated materials, please contact Language Services at (916) 651-8876. If translations are not 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.

Per [Government Code Section 7290, et seq.](#), the CWDs must 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 must be provided, free of charge, to the applicant/recipient. If CDSS does not provide translations of a form, it is the CWDs responsibility to read and interpret the form if an applicant or recipient requests it.

Additionally, the CWDs must provide auxiliary aids and services to persons who are deaf or hearing impaired, or persons with impaired speech, vision, or manual skills, where applicable. More information regarding provisions for services to applicants and recipients who have limited English proficiency or who have disabilities can be found in [MPP Section 21-115](#) and [ACL 19-45](#).

## **XII. HEARING RIGHTS**

CWDs are reminded that CFAP applicants and recipients have the same hearing rights as CalFresh applicants and recipients ([7 CFR 273.15](#), [MPP 22-004](#), [MPP 63-804](#) and [ACL 13-40](#)). Additionally, CFAP applicants and recipients have the same rights as CalFresh applicants and recipients to appeal the OI claim determination and request a state hearing for up to 90 days from the date of the NOA.

## **XIII. QUALITY CONTROL (QC) REVIEW**

Effective October 1, 2025, all QC reviewers must review the policy changes outlined in this letter and apply all rules pertaining to the CFAP expansion.

This ACL and other CDSS Letters and Notices are available online at:  
<https://www.cdss.ca.gov/inforesources/letters-and-notices>.

If you have any questions or need additional guidance regarding the information in this letter, please contact the CFAP Bureau at [CFAP@dss.ca.gov](mailto:CFAP@dss.ca.gov).

Sincerely,

***Original Document Signed By***

ALEXIS FERNÁNDEZ GARCIA  
Deputy Director  
Family Engagement and Empowerment Division

Attachments

**INSTRUCTIONS FOR THE CALFRESH/CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH OVERISSUANCE BUDGET WORKSHEET  
NA 1263 (08/23)**

This required form is used as an attachment with all CalFresh/CFAP OI NOAs. The information on the budget worksheet includes a calculation used to determine the claim amount for each month the household incurred an OI. Changes to this form include two drop-down menus at the top of the form to allow the CWD to select which of the two food programs the OI budget worksheet applies to. The CWD must only choose one program. Additionally, the form is updated to include a drop-down menu to allow for program recipients to read “CalFresh” or “CFAP” wherever the term ‘CalFresh’ was previously used. These revisions allow the CWD to use this OI budget worksheet as an attachment for CalFresh-only household OIs and CFAP-only household OIs. If a CFAP mixed household incurs both a CalFresh and CFAP OI, then the CWD must use two separate budget worksheets with the appropriate food program selected.

*TOP OF THE FORM UNDER ‘FORM TITLE’*

The form is revised to include a drop-down menu at the top of the form. The CWD must select the appropriate program for which the OI claim was established – CalFresh or CFAP.

*PART 1 – GROSS INCOME ELIGIBILITY, SECTION D, ITEM 3*

This portion of the form is revised to include a drop-down text field that includes the appropriate program for which the OI claim applies. The item reads “3. Total CalFresh/CFAP Overissuance (D1-D2)”. The CWD must select the appropriate program for which the OI claim applies to from the drop-down text field.

*PART 2 – NET INCOME ELIGIBILITY, SECTION L, ITEM 3*

This portion of the form is revised to include a drop-down text field that includes the appropriate program for which the OI claim applies. The item reads “3. Total CalFresh/CFAP Overissuance (L1-L2)”. The CWD must select the appropriate program for which the OI claim applies to from the drop-down text field.

*PART 3 – RESOURCE ELIGIBILITY, SECTION N, ITEM 3*

This portion of the form is revised to include a drop-down text field that includes the appropriate program for which the OI claim applies. The item reads “3. Total CalFresh/CFAP Overissuance (N1-N2)”. The CWD must select the appropriate program for which the OI claim applies to from the drop-down text field.

*PART 4 – NON-FINANCIAL ELIGIBILITY*

This portion of the form is revised to include a drop-down text field that includes the appropriate program for which the OI claim applies. The item reads “3. Total CalFresh/CFAP Overissuance (P1-P2)”. The CWD must select the appropriate program for which the OI claim applies to from the drop-down text field.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) -  
STATE CALFRESH CLAIM DETERMINATION WORKSHEET CFAP 842 (08/23)**

This new form mirrors the current CalFresh form, CF 842 (2/14) but is redesigned and reformatted to comply with all accessibility standards. The new form is a required form with substitutes permitted. This form is used to document CFAP claims against any household that has received more food assistance benefits than it is entitled to receive. The form's purpose is twofold: 1) internal documentation of individual claims, and 2) gathering information necessary to complete CA 209 monthly report. The CWD must use the CF 842 for all federal CalFresh OI claims and the CFAP 842 for all state-funded CFAP OIs, if applicable. CWDs must use the CF 842 and CFAP 842 for CFAP mixed households, when both federal and state-funded OI claims are established.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) -  
STATE CALFRESH OVERISSUANCE NOTICE FOR INADVERTENT HOUSEHOLD  
ERROR (IHE) CFAP 377.7B (08/23)**

This new notice mirrors the current CF 377.7B (4/18) – *CalFresh Overissuance Notice – Inadvertent Household Errors (IHE) Only*. The new notice is a required notice with no substitutes permitted. This notice is to inform CFAP households of an OI resulting from an IHE. This notice informs the household of their options to repay the OI or request a state hearing. The CWD must use the CF 377.7B for all federal CalFresh OIs claims and use the CFAP 377.7B for all state-funded CFAP OIs. The CWD must use the CF377.7B and CFAP 377.7B for CFAP mixed households, when both federal and state- funded OIs are established.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) -  
STATE CALFRESH REPAYMENT FINAL NOTICE INADVERTENT HOUSEHOLD  
ERROR (IHE) CFAP 377.7B1 (08/23)**

This new notice mirrors the current CF 377.7B1 (10/17) – *CalFresh Repayment Notice – Inadvertent Household Errors (IHE) Only Final Notice*. The new notice is a required notice with no substitutes permitted. This final notice is used to inform CFAP households that failure to repay on OI due to an IHE, will result in action to recover the amount owed. The notice informs the household of their options to repay the OI or request a state hearing. The CWD must use the CF 377.7B1 for all federal CalFresh OI claims and use the CFAP 377.7B1 for all state-funded CFAP OIs. CWDs must use the CF 377.7B1 and CFAP 377.7B1 for CFAP mixed households, when both federal and state-funded OIs are established.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP)  
– STATE CALFRESH REPAYMENT AGREEMENT FOR INADVERTENT  
HOUSEHOLD ERRORS ONLY CFAP 377.7C (08/23)**

This new notice mirrors the current CF 377.7C (2/14) – *CalFresh Repayment Agreement for Inadvertent Household Errors Only*. The new notice is a required notice with no substitutes permitted. This notice is used to inform CFAP households of the OI repayment agreement for an IHE, including terms and conditions.

The notice includes an agreement completed by the CFAP household indicating the repayment method selected and accompanying signature. The CWD must use the CF 377.7C for all federal CalFresh OI claims and use the CFAP 377.7C for all state-funded CFAP OI claims. CWDs must use the CF 377.7C and CFAP 377.7C for CFAP mixed, when both federal and state-funded OI claims are established.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH REPAYMENT FINAL NOTICE COUNTY ADMINISTRATIVE ERROR (AE) CFAP 377.7D2 (08/23)**

This new notice mirrors the current CF 377.7D2 (10/17) – *CalFresh Repayment Final Notice – County Administrative Error (AE)*. The new notice is a required notice with no substitutes permitted. This final notice is used to inform CFAP households that failure to repay an OI due to an AE, will result in action to recover the amount owed. The notice informs the household of their options to repay the OI or request a state hearing. The CWD must use the CF 377.7D2 for all federal CalFresh OI claims and use the CFAP 377.7D2 for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a CF 377.7D2 and a CFAP 377.7D2.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH OVERISSUANCE NOTICE COUNTY ADMINISTRATIVE ERROR (AE) CFAP 377.7D3 (08/23)**

This new notice mirrors the current CF 377.7D3 (10/17) – *CalFresh Overissuance Notice for Administrative Errors (AE)*. The new notice is a required notice with no substitutes permitted. This notice is to inform CFAP households of an OI resulting from an AE. This notice informs the household of their options to repay the OI or request a state hearing. The CWD must use the CF 377.7D3 for all federal CalFresh OI claims and use the CFAP 377.7D3 for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a CF 377.7D3 and a CFAP 377.7D3.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH REPAYMENT AGREEMENT FOR ADMINISTRATIVE ERRORS CFAP 377.7E1 (08/23)**

This new notice mirrors the current CF 377.7E1 (1/14) – *CalFresh Repayment Agreement for Administrative Errors Only*. The new notice is a required notice with no substitutes permitted.

This notice is to inform CFAP households of the OI repayment agreement for an AE, including terms and conditions. This notice includes an agreement completed by the CFAP indicating the payment method they will select and accompanying signature. The CWD must use the CF 377.7E1 for all federal CalFresh OI claims and use the CFAP 377.7E1 for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a CF 377.7E1 and a CFAP 377.7E1.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH OVERISSUANCE NOTICE CHANGE FROM INADVERTENT HOUSEHOLD ERROR (IHE) TO INTENTIONAL PROGRAM VIOLATION (IPV) CFAP 377.7F (08/23)**

This new notice mirrors the current CF 377.7F (10/17) – *CalFresh Overissuance Notice – Change From Inadvertent Household Error (IHE) To Intentional Program Violation (IPV)*. The new notice is a required notice with no substitutes permitted. This notice is to inform CFAP households of an OI change from IHE to IPV. This notice informs the household of their options to repay the OI or request a state hearing. The CWD must use the CF 377.7F for all federal CalFresh OI claims and use the CFAP 377.7F for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a CF 377.7F and a CFAP 377.7F.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH REPAYMENT FINAL NOTICE INTENTIONAL PROGRAM VIOLATION (IPV) CFAP 377.7F1 (08/23)**

This new notice mirrors the current CF 377.7F1 (10/17) – *CalFresh Repayment Final Notice – Intentional Program Violation (IPV)*. The new notice is a required notice with no substitutes permitted. This final notice is used to inform CFAP households that failure to repay an OI due to an IPV, will result in action to recover the appropriate amount. The notice informs the household of their options to repay the OI or request a state hearing. CWDs are to use this new notice as appropriate. CWDs must use the CF 377.7F1 for all federal CalFresh OI claims and use the CFAP 377.7F1 for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a CF 377.7F1 and a CFAP 377.7F1.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH OVERISSUANCE NOTICE INTENTIONAL PROGRAM VIOLATION (IPV) CFAP 377.7F2 (08/23)**

This new notice mirrors the current DFA 377.7F (6/18) – *Overissuance Notice – Intentional Program Violation (IPV)*. The new notice is a required notice with no substitutes permitted.

This notice is to inform CFAP households of an OI resulting from an IPV. This notice informs the household of their options to repay the OI or request a state hearing. CWDs are to use this new notice as appropriate. CWDs must use the DFA 377.7F for all federal CalFresh OI claims and use the CFAP 377.7F2 for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a DFA 377.7F and a CFAP 377.7F2.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH INTENTIONAL PROGRAM VIOLATION (IPV) NOTICE DUE TO TRAFFICKING CFAP 377.7G (08/23)**

This new notice mirrors the current CF 377.7G (3/18) – *CalFresh Intentional Program Violation (IPV) Notice – Due to Trafficking*. The new notice is a required notice with no substitutes permitted. This notice is to inform CFAP households of an OI resulting from an IPV due to trafficking. This notice informs the household of their options to repay the OI or request a state hearing. CWDs are to use this new notice as appropriate. CWDs must use the CF 377.7G for all federal CalFresh OI claims and use the CFAP 377.7G for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a CF 377.7G and a CFAP 377.7G.

**INSTRUCTIONS FOR THE CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH INFORMATIONAL NOTICE OF POTENTIAL INTENTIONAL PROGRAM VIOLATION (IPV) CFAP 377.7H (08/23)**

This new notice mirrors the current CF 377.7H (2/23) – *CalFresh Informational Notice – Potential Intentional Program Violation (IPV)*. The new notice is a required notice with no substitutes permitted. This notice informs CFAP households of the potential CFAP IPV OI amount beyond the 24-month claim, which will become established and deemed collectable if an IPV is substantiated. This notice informs the household of their options to repay the OI or request a state hearing. CWDs are to use this new notice as appropriate. CWDs must use the CF 377.7H for all federal CalFresh OI claims and use the CFAP 377.7H for all state-funded CFAP OI claims. For purposes of CFAP mixed households, if there is both a federal CalFresh OI claim and state-funded CFAP OI claim, then the CWD must use both a CF 377.7H and a CFAP 377.7H.

**INSTRUCTIONS FOR THE CALFRESH/CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH OVERISSUANCE TRANSITION NOTICE CFAP 377.7T (08/23)**

This new notice/agreement is used for CalFresh and CFAP households. The notice informs the household they have an OI that they are actively repaying with a benefit reduction but, due to a transition from CFAP to CalFresh, or vice versa, the household is required to complete a new repayment agreement.



The notice advises the household that they must continue to repay their OI and provides the terms and conditions, including the available methods to pay back the benefits and the option to request a state hearing. This notice includes an agreement for which the household selects the method they want to repay the OI and has a place for signature.

The new notice is a required notice with no substitutes permitted. The CWD must use the CFAP 377.7T for any federal CalFresh households under a benefit reduction repayment agreement that experience a change that causes the household to become eligible for state-funded CFAP. CWDs must also use the CFAP 377.7T for any state-funded CFAP household under a benefit reduction repayment agreement who experience a change that causes the household to become eligible for federal CalFresh.

***ADDRESSEE***

This line populates with the name(s) of all household members subject to the OI claim.

***STATE HEARING INFORMATION***

The state hearing disclaimer on the first page advises the household of the right to file a state hearing if they disagree with the information on the notice. The disclaimer also provides the appropriate timeframe to request a hearing. The CWD must enter the date indicating the last day to request a state hearing (90th day following the day on the NOA) in the following format mm/dd/yyyy.

### ***GENERAL NOTICE INFORMATION***

This section of the notice informs the federal CalFresh or state-funded CFAP household about important information regarding the household's CalFresh/CFAP OI repayment agreement in large uppercase bold font. This section notifies the household that changes in household circumstances have resulted in the transition of benefits from CFAP to CalFresh, or vice versa, and that the collecting CWD can no longer reduce monthly benefits to repay the OI. The appropriate CWD name must be included in the open text field on the notice. Additionally, the notice provides the household the specific date the appropriate CWD began reducing the household's benefits to repay the OI, continued responsibility to repay the OI, and requirement to choose a new repayment option. The effective benefit reduction date is an open text field and must be entered in the following format mm/dd/yyyy. The collecting CWD name must be included in the open text field. There is an open text field to include the appropriate food benefit program according to the established OI. Either CalFresh or CFAP must be entered in this open text field.

### ***TERMS AND CONDITIONS***

In this section, the notice informs the household of their continued responsibility to repay the OI in the current amount of OI as of the date of the NOA. CWDs must include the current amount of the OI as of the date of the NOA in the open text field. The CWD must also include whether the OI is a CalFresh or CFAP OI in the drop-down menu next to the total amount and the type of OI the household is assumed responsible to continue repaying (Administrative Error, Inadvertent Household Error, or Intentional Program Violation) next to the food program the OI applies to.

The terms and conditions also provide the household a summary of available repayment options. The first option listed is a lump sum payment. The notice instructs the household to fill out and return the included repayment form by a certain date. Include the date the repayment form must be returned in the open text field and format as mm/dd/yyyy.

The second option is to repay the OI through installments. The notice instructs the household to fill out and return the included repayment form by a certain date. Include the date the repayment form must be returned by. The open text field for the date must be entered as mm/dd/yyyy.

The third option allows the household to request a state hearing by completing and returning the last page of the notice if they disagree with the information on the notice. The notice provides a return due date for a state hearing request. The open text field for the date must be formatted as mm/dd/yyyy. The household has 90 days from the date of the notice to request a state hearing.

Following the three options provided to the household on how to repay the OI, there is a statement advising the household to call their county if they have questions about the

notice. Include the phone number of the appropriate county, in the open phone number text field and format as (XXX) XXX-XXXX.

Additionally, this section provides general information and eligibility requirements for CalFresh and CFAP, including a statement that OIs must be repaid to the original food program and cannot be repaid with other food program benefits.

#### **NOTE**

This section provides general information regarding payment and collection of the OI, repayment responsibility for adults, discrepant OI collection methods, collection methods for closed cases, and legal fees/court rated fees and other fees. This section also provides information on the right to review the CWD's records related to the OI, clarification that the repayment agreement is based on current ability to pay, and steps to take if the household's ability to pay changes.

A statement regarding the completion, signature requirement, and submission of the agreement is also included with next steps.

#### **AGREEMENT**

This section of the notice must be filled out by the household. In the agreement, the household must enter their name in an open text field, as an understanding that the agreement is between the CWD and the household because extra food benefits that were issued. The open text field for the collecting CWD name must be completed.

The household may select one of the two options to repay the OI, or a combination of each option, by selecting the corresponding check box(es). The selection must be noticeable enough for the CWD to understand the selected option. If the household leaves the check boxes blank without a check mark or indication that a check box was selected but fills out the appropriate information for one or both, then the CWD must contact the household to confirm the household's option(s) before proceeding with the option(s) for which the household filled out.

If the household selects the lump sum payment option, they must include the amount of the lump sum payment they wish to pay towards their OI, either partial or in full. The open due date text field must be formatted as mm/dd/yyyy (the household does not fill this out and must be included prior to sending out). If the household selects installments, they must include the amount of monthly payments they wish to pay toward the OI. The open text fields for the due date for installments is provided as a certain day each month beginning on a certain date. For the day of the month, the CWD must enter as number 1 - 31 depending on when payment is due (the household does not fill this out and must be included prior to sending out). CWDs must enter the last day of the month in which the OI claim is due. The open text field date for which the installments will begin must be formatted as mm/dd/yyyy (the household does not fill this out and must be pre-populated prior to sending out). If the household does not

select an option(s) or their selection is unclear, then the CWD must contact the household to get further information.

Lastly, this section includes an area for the household member to sign, date, and include the CWD name.

***TO BE COMPLETED BY THE CWD***

This section is for CWD-use only and includes open text fields to include the name of the CWD staff that accepted the OI agreement, the date the agreement was accepted (must be formatted as mm/dd/yyyy), and the CWD name for which the agreement is being accepted. Additionally, this section provides an open text field for CWDs to include payment locations and signature of the Authorized County Official.

**INSTRUCTIONS FOR THE CALFRESH/CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) – STATE CALFRESH COMBINED HOUSEHOLD NOTICE OF ACTION CFAP 1263 (08/23)**

This required form is used as an attachment and must be included with all CFAP mixed household OI NOAs. The information on the budget worksheet includes a calculation used to determine the CalFresh and CFAP OI claim amounts for each month the household incurred an OI, including the CFAP budgeting methodology and CFAP allotment. The form includes a column for the “Combined Budget” and a column for how the “Federal Budget” for the OI month/year. This form is only to be provided to CFAP mixed households.

This form displays two OI months. The “Combined Budget” includes the full CalFresh and CFAP allotments and is calculated using all household members (CalFresh and CFAP) presuming they are all federally eligible. The “Federal Budget” includes the federal only allotment and is calculated using federally eligible members only. Special rules for the federal CalFresh budget include the following:

- Count all income of the federal household members;
- Count the federal member’s share of an excluded person’s income, if any;
  - Do not count CFAP ‘qualified noncitizens’ income (also known as legacy CFAP members);
  - Do not count the CFAP ‘qualified noncitizens’ (also known as legacy CFAP members) share of an excluded person’s income

To calculate the CFAP allotment the CWD must subtract the “Federal Allotment” from the “Combined Allotment”. The difference is the CFAP allotment. The federal share is the “Federal Allotment” amount and the CFAP share is the “Combined Allotment” minus the “Federal Allotment”.

***FEDERAL/COMBINED ALLOTMENT FOR FEDERAL AND CFAP SHARE***

- If “Combined Allotment” is **less than** the “Federal Allotment”, then the federal share is the amount in the “Combined Allotment” and the CFAP share is zero.
- If the “Combined Allotment” is **more than** the “Federal Allotment”, then the federal share is the amount in the “Federal Allotment” and the CFAP share is the difference between the “Combined Allotment” and “Federal Allotment”.

This form shows the two budgets side by side and allows households to understand the calculations used to determine the federal CalFresh and CFAP claim amount for each month the household incurred an OI based on the combined and federal budgets.

The form includes two open text fields under the text “Overissuance Month/Year”, the appropriate month and year for which the OI(s) pertain to must be included in the open text fields. If the household experiences more than two OI months, then additional forms will need to be provided to capture all months for which OIs were established.

*PART 1 – GROSS INCOME ELIGIBILITY – IN THIS SECTION ALL GROSS INCOME ELIGIBILITY MUST BE CALCULATED FOR THE COMBINED AND FEDERAL BUDGET. THE APPROPRIATE PRORATIONS MUST BE APPLIED, IF APPLICABLE.*

- A. Nonexempt Gross Unearned Income - In this section all non-exempt unearned income must be calculated for the combined and federal budgets. The appropriate prorations must be applied, if applicable.
- A1. Include all nonexempt gross unearned Cash Aid Income.
  - A2. Include all nonexempt gross unearned Social Security, Unemployment Insurance Benefits, Disability Insurance Benefits, and Pensions.
  - A3. Include all nonexempt gross unearned Child/Spousal Support income.
  - A4. Include all nonexempt gross unearned Scholarships, Grants, and Loans.
  - A5. Include all other nonexempt gross unearned income.
  - A6. Include all nonexempt unreported gross income.
  - A7. Include all gross unearned income including unreported gross unearned income (A1+A2+A3+A4+A5+A6).
  - A8. Include less child support paid.
  - A9. Total nonexempt gross unearned income (A7-A8).
- B. Nonexempt Gross Earned Income - In this section all non-exempt earned income must be calculated for the combined and federal budgets. The appropriate prorations must be applied, if applicable.
- B1. Include all nonexempt gross salary and wages.
  - B2. Include all nonexempt gross self-employment.
  - B3. Include all nonexempt gross training allowance.
  - B4. Include all nonexempt gross income (B1+B2+B3).
  - B5. Include all nonexempt unreported gross earned income.

B6. Include all nonexempt gross earned income including unreported gross earned income (B4+B5).

B7. Include less remained of child support paid, if not fully used in A8.

B8. Include total nonexempt gross earned income (B6-B7) and if negative amount, enter zero.

- C. Gross Income Test - In this section the household is tested for the gross income test based on their total gross income. This section is not applicable to households with an elderly/disabled member. Do not prorate in this section.

C1. Include the household size. Note, the combined allotment budget includes all federal CalFresh and CFAP household members, while the federal allotment budget must only include the federally eligible members.

C2. Include the maximum gross income allowed for the program based on household size.

C3. Include total countable gross monthly income (A9+B8).

C4. Select from the drop-down menu if the household is gross income eligible - Yes/No/NA (Is C3 less than or equal to C2?).

- D. Gross Income Overissuance (If C4 is No).

D1. Include amount previously issued.

D2. Include correct benefit amount.

D3. Include total OI (D1 – D2).

D4. Include minus lost benefits not restored.

D5. Include minus payment received.

D6. Include amount of OI to be collected.

D7. Include minus workfare offset.

D8. Include amount of OI to be collected (D6-D7).

***PART 2 – NET INCOME ELIGIBILITY – IN THIS SECTION NET INCOME ELIGIBILITY MUST BE CALCULATED FOR THE COMBINED AND FEDERAL BUDGET. THE APPROPRIATE PRORATIONS MUST BE APPLIED, IF APPLICABLE. NOTE, THIS SECTION COMPUTES ONLY IF C4 IS YES.***

- E. Include nonexempt gross unearned income from A9.

- F. Nonexempt Gross Earned Income - In this section the household's nonexempt gross earned income must be calculated for the combined and federal budget. Do not prorate in this section.

F1. Include gross earned income from B4. This does not include unreported income).

F2. Include adjusted gross earned income which is 80 percent of F1.

F3. Include unreported gross earned income from B5.

F4. Include total countable earned income (F2 +F3).

F5. Include less remained child support paid from B7, if not fully used in A8.

F6. Include total gross earned income (F4-F5). If negative amount, enter zero.

G. Include total nonexempt gross income (E+F6)

H. Standard/Dependent Care/Homeless Shelter/Deduction – In this section the household's deductions must be calculated for the combined and federal budget. The appropriate prorations must be applied, if applicable.

H1. Include the standard deduction.

H2. Include excess medical expenses (only compute excess medical expenses for households with elderly/disabled members).

H3. Include dependent care expenses (100 percent of costs).

H4. Include homeless shelter deduction.

H5. Include the total amount of deductions (H1+H2+H3+H4).

H6. Include the total adjusted income with deductions (G-H5).

I. Shelter Deductions – In this section the household's shelter deductions must be calculated for the combined and federal budget. The appropriate prorations must be applied, if applicable.

I1. Include total housing cost (rent or mortgage including property tax and insurance).

I2. Include maximum utility allowance.

I3. Include total shelter costs(I1+I3).

I4. Include allowable shelter costs (50 percent of H6).

I5. Excess shelter costs (I3-I4).

I6. Include maximum allowance for shelter (Enter the amount shown on I5 for households with an elderly/disabled member if higher than I6).

I7. Include allowable shelter deduction (lesser of I5 or I6). Enter the amount shown on I5 for households with an elderly/disabled member if higher than I6.

J. Include Net Countable Monthly Income (H6-I7).

K. Net Income Test - In this section the household will be tested for the net income test based on their total net income including deductions. Do not prorate in this section.

K1. Include the household size. Note, the combined allotment budget includes all federal CalFresh and CFAP household members, while the federal allotment budget must only include the federally eligible members.

K2. Include maximum net income allowed for the program based on household size.

K3. Select from the drop-down menu if the household is net income eligible -Yes/ No/NA (Is J less than or equal to K2?).

- L. Net Income Overissuance – In this section the household's net income OI (both federal CalFresh and CFAP) must be calculated for the month/year in which the OI was established.

L1. Include the combined allotment total amount. The amount will only be included in the combined budget.

L2. Include the federal allotment total amount. The amount will only be included in the federal budget.

L3. Include the allotment amount that was previously issued/authorized to the household.

L4. Include the correct allotment amount that the household was eligible for in that month/year.

L5. Include total OI for each budget – combined budget and federal budget (L3-L4).

L6. Include minus lost benefits not restored.

L7. Include minus payments received.

L8. Include amount of OI to be collected for each budget – combined budget and federal budget (L5-L6-L7).

L9. Include minus workfare offset.

L10. Include total amount of OI to be collected for each budget – combined budget and federal budget (L8-L9).

- M. CFAP Benefit Amount – In this section the household's CFAP benefit allotment amount must be calculated for the month/year in which the OI was established. The CFAP amounts are calculated once both the combined and federal budgets are calculated.

M1. Include the combined allotment total amount. The amount will only be included in the combined budget. Same amount at L1.

M2. Include the federal allotment total amount. The amount will only be included in the federal budget. Same amount as L2.

M3. Include the CFAP benefit allotment. The amount will only be included in the federal budget since the CFAP allotment amount is the combined allotment minus the federal allotment (M1-M2).

M4. Include the amount of the CFAP OI. The OI will be calculated by subtracting the federal budget total OI in L5 from the combined budget total OI in L5.

***PART 3 – RESOURCE ELIGIBILITY – IN THIS SECTION THE COUNTABLE RESOURCE ELIGIBILITY AND RESOURCE OVERISSUANCE MUST BE CALCULATED FOR THE COMBINED AND FEDERAL BUDGET.***

- N. Countable Resources – In this section the household's countable resources must be calculated for the combined and federal budget. Do not prorate in this section.



N1. Include total resources.

N2. Include maximum resource level allowed for the program based on household composition.

N3. Select from the drop-down menu if the household is resource eligible - Yes/No/NA (Is N1 less than or equal to N2?).

O. Resource Overissuance (if N3 is No) – In this section the household's resource OI (both federal CalFresh and CFAP) must be calculated for the month/year in which the OI was established.

O1. Include the allotment amount that was previously issued/authorized to the household.

O2. Include the correct allotment amount that the household was eligible for in that month/year.

O3. Include total OI for each budget – combined budget and federal budget (O1-O2).

O4. Include minus lost benefits not restored.

O5. Include minus payments received.

O6. Include amount of OI to be collected for each budget – combined budget and federal budget (O3-O4-O5).

O7. Include minus workfare offset.

O8. Include total amount of OI to be collected for each budget – combined budget and federal budget (O6-O7).

***PART 4 – NON-FINANCIAL ELIGIBILITY – IN THIS SECTION THE HOUSEHOLD COMPOSITION AND NON-FINANCIAL OVERISSUANCE MUST BE CALCULATED FOR THE COMBINED AND FEDERAL BUDGET.***

P. Household Composition – In this section the household's previous household size and correct household size will be included for both the combined and federal budgets.

P1. Include the previously used household size for the OI month/year.

P2. Include the correct household size.

Q. Non-Financial Overissuance – In this section the household's non-financial OI (both federal CalFresh and CFAP) must be calculated for the month/year in which the OI was established.

Q1. Include the allotment amount that was previously issued/authorized to the household.

Q2. Include the correct allotment amount that the household was eligible for in that month/year.

- Q3. Include total OI for each budget – combined budget and federal budget (Q1-Q2).
- Q4. Include minus lost benefits not restored.
- Q5. Include minus payments received.
- Q6. Include amount of OI to be collected for each budget – combined budget and federal budget (Q3-Q4-Q5).
- Q7. Include minus workfare offset.
- Q8. Include total amount of OI to be collected for each budget – combined budget and federal budget (Q6-Q7).

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
OVERISSUANCE NOTICE  
INADVERTENT HOUSEHOLD ERROR (IHE)**

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

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

(Addressee)

**Questions? Ask your Worker.**

**State Hearing:** If you disagree with us, you can ask for a hearing. Pages 2 and 3 tells you how. If you ask for a hearing before \_\_\_\_\_ your benefits may not be changed until a decision is made.

**1. We paid you too much  
CFAP benefits.**

\$ \_\_\_\_\_ was overissued to you from \_\_\_\_\_ to \_\_\_\_\_.  
You need to pay \$ \_\_\_\_\_. Please see below for your options to repay.

**2. You made a mistake. Here's why this happened:**

**3. Your options to repay:**

**YES**

Are you still receiving CFAP benefits?

**NO**

**\$ 1. Pay in full**

**OR**

**2. Join the 10% or \$10 repayment plan**

If you don't respond, we'll assume you agree to a 10% or \$10 reduction (whichever is more) in your CFAP benefits until your balance is paid off. This will start on \_\_\_\_\_.

**OR**

**3. Agree to another repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**4. Ask for a state hearing**

If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

**\$ 1. Pay in full**

**OR**

**2. Agree to a repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**3. Ask for a state hearing**

If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

If you are NO LONGER receiving CFAP, we **MUST** hear from you. If we do not hear from you by \_\_\_\_\_, we may take your state income tax refund, or use other ways of collecting the amount owed.

- Note:**
- You do not have to use SSI benefits to pay back the overissuance.
  - Collection will be from all adults in the household when the overissuance occurred.
  - You may review and copy the county's records related to this overissuance.
  - If you do not pay back the overissuance, agree to a repayment plan, or have your benefits reduced, the county will use other ways of collecting the amount owed, such as through the courts or state government collection action.
  - If you stop receiving CFAP before the overissuance is paid back, we may take what you owe out of your state income tax refund.
  - If the claim becomes past due or the household is sued, you may have to pay court or other costs.
  - Your repayment agreement will be based on your current ability to pay. If your ability to pay changes, contact the county about changing your monthly payments.

These rules apply: MPP 63-801.21; MPP 63-804. You may review them online at [cdss.ca.gov](http://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		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

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
REPAYMENT FINAL NOTICE  
INADVERTENT HOUSEHOLD ERROR (IHE)**

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

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

(Addressee)

Questions? Ask your Worker.

**State Hearing: If you disagree with us, you can ask for a hearing unless you have already had a hearing on the amount you owe. Pages 2 and 3 tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.**

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

**1. We told you before that we paid you too much CFAP benefits.** You still owe \$ \_\_\_\_\_ because we overissued you \$ \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_. Please see below for your options to repay.

**2. You made a mistake. Here's why this happened:**

**3. You did not agree to repay OR did not repay as agreed. Your options to repay:**

YES



Are you still receiving CFAP benefits?

NO



**\$ 1. Pay in full**

**OR**

**(S) 2. Join the 10% or \$10 repayment plan**

If you don't respond, we'll assume you agree to a 10% or \$10 reduction (whichever is more) in your CFAP benefits until your balance is paid off. This will start on \_\_\_\_\_.

**OR**

**3. Agree to another repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_. You must tell us when you cannot pay as agreed. If your ability to pay changes, explain why you cannot pay and contact the county about changing your monthly payments.

**OR**

**4. Ask for a state hearing**

If you disagree with us, this is your last chance to ask for a state hearing by filling out the back page and returning it by \_\_\_\_\_.

**\$ 1. Pay in full**

**OR**

**2. Agree to a repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_. You must tell us when you cannot pay as agreed. If your ability to pay changes, explain why you cannot pay and contact the county about changing your monthly payments.

**OR**

**3. Ask for a state hearing**

If you disagree with us, this is your last chance to ask for a state hearing by filling out the back page and returning it by \_\_\_\_\_.

If you are NO LONGER receiving CFAP benefits, we **MUST** hear from you. If we do not hear from you by \_\_\_\_\_, we may take your state income tax refund, or use other ways of collecting the amount owed.

- Note:**
- You do not have to use SSI benefits to pay back the overissuance.
  - Collection will be from all adults in the household when the overissuance occurred.
  - You may review and copy the county's records related to this overissuance.
  - If you do not pay back the overissuance, agree to a repayment plan, or have your benefits reduced, the county will use other ways of collecting the amount owed, such as through the courts or state government collection action.
  - If you stop receiving CFAP benefits before the overissuance is paid back, we may take what you owe out of your state income tax refund.
  - If the claim becomes past due or the household is sued, you may have to pay court or other costs.
  - Your repayment agreement will be based on your current ability to pay. If your ability to pay changes, contact the county about changing your monthly payments.

These rules apply: MPP 63-801.21; MPP 63-804. You may review them online at [cdss.ca.gov](http://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.

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## TO ASK FOR A HEARING:

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**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



## CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) - STATE CALFRESH REPAYMENT AGREEMENT FOR INADVERTENT HOUSEHOLD ERRORS (IHE)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Case Number: \_\_\_\_\_

Worker: \_\_\_\_\_

Case Name: \_\_\_\_\_

### TERMS AND CONDITIONS

You or a member of your household made a mistake.

You must repay extra CFAP benefits by using one or more methods listed here:

1. **Lump Sum Payment** - You may repay in full the amount owed at one time with cash and/or CFAP benefits
2. **Benefit Reduction** - If you are getting CFAP benefits now, you may repay by having your household's benefits reduced for all or part of the amount owed. Repayment by this method will be 10% of your monthly benefit or \$10 each month, whichever is more.
3. **Installments** - You may repay the amount owed in monthly payments with cash and/or with CFAP benefits.
4. **Ordered Repayment**  
☐ The court or Administrative Law Judge ordered that you repay as indicated below. These repayment terms cannot be changed by you or by the county.

If we have not already talked to you about the terms of this Agreement, or if you have any questions, call the welfare collector at: \_\_\_\_\_

After you complete and sign this Agreement, return all copies to the county in the envelope provided. Do not send cash with this Agreement. When approved by the county, a signed copy of this Agreement will be sent to you.

### AGREEMENT

I \_\_\_\_\_, understand this Agreement is between me and \_\_\_\_\_ County because extra CFAP benefits in the amount of \$ \_\_\_\_\_ were issued. I agree to repay this amount by the method(s) checked below:

☐ **Lump Sum Payment.**

☐ I will repay by a lump sum cash payment of \$ \_\_\_\_\_ due on \_\_\_\_\_.

☐ I will repay by a lump sum CFAP benefits payment of \$ \_\_\_\_\_ due on \_\_\_\_\_ each month, beginning \_\_\_\_\_.

☐ **Benefit Reduction**

☐ I will repay by having my household's CFAP benefits reduced by \$ \_\_\_\_\_ each month, beginning \_\_\_\_\_.

☐ **Installments.**

☐ I will repay by monthly cash payments of \$ \_\_\_\_\_ due on the \_\_\_\_\_ day of each month beginning \_\_\_\_\_.

☐ I will repay by monthly CFAP benefit payments of \$ \_\_\_\_\_ due on the \_\_\_\_\_ day of each month beginning \_\_\_\_\_.

**These rules apply:**

MPP 63-801.21; MPP 63-804. You may review them online at [cdss.ca.gov](http://cdss.ca.gov) or at your local County office.

**I also understand and agree that:**

1. My repayment schedule is based on my current ability to pay as figured by the county. Any changes in my ability to pay may change my monthly payments.
2. If anything changes, I may ask the county to refigure the terms checked above.
3. If I do not pay as agreed and I do not get a new payment schedule, the county may ask that the total amount owed be paid now.
4. If I do not pay as agreed and the county sues me to collect the amount owed, I may also be required to pay collection costs, attorney fees, and court costs.
5. If I do not pay, the county may take my state income tax refund and/or ask the court to attach my wages or any property I own.
6. I will be subject to involuntary collection action(s) if payment is not received by the due date and the claim becomes delinquent.
7. If this inadvertent household error is later found to be an intentional program violation, penalties will apply even if I pay back what I owe.

Signature:	Date:	County:
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**To be completed by the County:**

The above signed Agreement has been accepted by \_\_\_\_\_  
on \_\_\_\_\_ for \_\_\_\_\_ County. Payments should be made at:

\_\_\_\_\_  
(Signature of Authorized County Official)

**These rules apply:**

MPP 63-801.21; MPP 63-804. You may review them online at [cdss.ca.gov](http://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.

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#### **Cal-Learn:**

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
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## 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.

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## TO ASK FOR A HEARING:

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- **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.

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**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

California Health & Human Services Agency  
**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
REPAYMENT FINAL NOTICE  
COUNTY ADMINISTRATIVE ERROR (AE)**

California Department of Social Services

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

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Case Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Worker Number : \_\_\_\_\_  
Telephone Number : \_\_\_\_\_  
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. If you ask for a hearing before \_\_\_\_\_ your benefits will not be changed before the hearing. Pages 2 and 3 tells you how.

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

**1. We told you before that we paid you too much CFAP benefits.** You still owe \$ \_\_\_\_\_ because we overissued you \$ \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_. Please see below for your options to repay.

**2. The county made a mistake. Here's why this happened:**

**3. You did not agree to repay OR did not repay as agreed. Your options to repay:**

**YES**



Are you still receiving CFAP benefits?

**NO**



- \$ 1. Pay in full**
- OR**
- \$ 2. Join the 5% or \$10 repayment plan**  
If you don't respond by \_\_\_\_\_, we'll assume you agree to a 5% or \$10 reduction (whichever is more) in your CFAP benefits for up to 36 months. This will start on \_\_\_\_\_.
- OR**
- \$ 3. Agree to another repayment plan**  
Fill out and return the included repayment form by \_\_\_\_\_. You must tell us when you cannot pay as agreed. If your ability to pay changes, explain why you cannot pay and contact the county about changing your monthly payments.
- OR**
- \$ 4. Ask for a state hearing**  
If you disagree with us this is your last chance to ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

- \$ 1. Pay in full**
- OR**
- \$ 2. Agree to a repayment plan**  
Fill out and return the included repayment form by \_\_\_\_\_. You must tell us when you cannot pay as agreed. If your ability to pay changes, explain why you cannot pay and contact the county about changing your monthly payments.
- OR**
- \$ 3. Ask for a state hearing**  
If you disagree with us, this is your last chance to ask for a state hearing by filling out the back page and returning it by \_\_\_\_\_.  
If you are NO LONGER receiving CFAP benefits, we **MUST** hear from you. If we do not hear from you by \_\_\_\_\_, we may take your state income tax refund, or use other ways of collecting the amount owed.

- Note:**
- You do not have to use SSI benefits to pay back the overissuance.
  - Collection will be from all adults in the household when the overissuance occurred.
  - You may review and copy the county's records related to this overissuance.
  - If you stop receiving CFAP benefits before the overissuance is paid back, we may take what you owe out of your state income tax refund.
  - If you do not pay back the overissuance, agree to a repayment plan, or have your benefits reduced, the county will use other ways of collecting the amount owed such as through the courts or state government collection action.
  - If the claim becomes past due or the household is sued, you may have to pay court or other costs.
  - Your repayment agreement will be based on your current ability to pay. If your ability to pay changes, contact the county about changing your monthly payments.
  - Lomeli v. Saenz: States are authorized to forgive any part of your claim if we believe you are unable to pay. We will collect the amount above by reducing your monthly allotment by 5% or \$10.00, whichever is greater, for up to a total of 36 months. Any remaining balance will be forgiven.

**These rules apply:** MPP 63-801.22, MPP 63-801.43, and MPP 801.7. You may review them online at [cdss.ca.gov](http://cdss.ca.gov) or at your local county office.

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- 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	

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Street Address	City	State	Zip Code
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**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

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
OVERISSUANCE NOTICE  
COUNTY ADMINISTRATIVE ERROR (AE)**

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

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

(ADDRESSEE)

**Questions? Ask your Worker.**

**State Hearing: If you disagree with us, you can ask for a hearing. Pages 2 and 3 tells how. If you ask for a hearing before \_\_\_\_\_ your benefits may not be changed until a decision is made.**

**1. We paid you too much CFAP benefits.**

\$ \_\_\_\_\_ was overissued to you from \_\_\_\_\_ to \_\_\_\_\_.  
You need to pay \$ \_\_\_\_\_. Please see below for your options to repay.

**2. The county made a mistake. Here's why this happened:**

**3. Your options to repay:**

**YES****Are you still receiving CFAP benefits?****NO**

**\$ 1. Pay in full**

**OR**

**2. Join the 5% or \$10 repayment plan**

If you don't respond, we'll assume you agree to a 5% or \$10 reduction (whichever is more) in your CFAP benefits for up to 36 months. This will start on \_\_\_\_\_.

**OR**

**3. Agree to another repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**4. Ask for a state hearing**

If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

**\$ 1. Pay in full**

**OR**

**2. Agree to a repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**3. Ask for a state hearing**

If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

If you are NO LONGER receiving CFAP benefits, we **MUST** hear from you. If we do not hear from you by \_\_\_\_\_, we may take your state income tax refund, or use other ways of collecting the amount owed.

- Note:**
- If you are not receiving CFAP benefits, the overissuance must be repaid if it is more than \$125.
  - You do not have to use SSI benefits to pay back the overissuance.
  - Collection will be from all adults in the household when the overissuance occurred.
  - You may review and copy the county's records related to this overissuance.
  - If you do not pay back the overissuance, agree to a repayment plan, or have your benefits reduced, the county will use other ways of collecting the amount owed, such as through the courts or state government collection action.
  - If you stop receiving CFAP benefits before the overissuance is paid back, we may take what you owe out of your state income tax refund.
  - If the claim becomes past due or the household is sued, you may have to pay court or other costs.
  - Your repayment agreement will be based on your current ability to pay. If your ability to pay changes, contact the county about changing your monthly payments.
  - Lomeli v. Saenz: Federal law requires us to forgive any part of your claim if we believe you are unable to repay. We will collect the amount above by reducing your monthly allotment by 5% or \$10.00, whichever is greater, for up to a total of 36 months. Any remaining balance will be forgiven.

These rules apply: MPP 63-801.22, 63-801.43, 63-801.7, 63-804, Lomeli v. Saenz and Duarte v. Saenz. You may review them online at [cdss.ca.gov](http://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		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

## CALIFORNIA FOOD ASSISTANCE PROGRAM (CFAP) — STATE CALFRESH REPAYMENT AGREEMENT FOR ADMINISTRATIVE ERRORS

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Case Number: \_\_\_\_\_  
Worker: \_\_\_\_\_  
Case Name: \_\_\_\_\_

### TERMS AND CONDITIONS

The County Welfare Department made a mistake in the amount of your CFAP benefits. You must repay extra CFAP benefits by using one or more methods listed here:

1. **Lump Sum Payment** - You may repay in full the amount owed at one time with cash and/or CFAP benefits.
2. **Benefit Reduction** - If you are getting CFAP benefits now, you may repay by having your household's benefits reduced for all or part of the amount owed. You may wish to talk to us about the amount to be reduced.
3. **Installments** - You may repay the amount owed in monthly payments with cash or with CFAP benefits.
4. **Ordered Repayment**  
☐ The court or Administrative Law Judge ordered that you repay as indicated below. These repayment terms cannot be changed by you or by the county.

If we have not already talked to you about the terms of this Agreement, or if you have any questions, call the welfare collector at \_\_\_\_\_.

After you complete and sign this Agreement, return all copies to the county in the envelope provided. Do not send cash or CFAP benefits through the mail with this Agreement form. When approved by the county, a signed copy of this Agreement will be sent to you.

### AGREEMENT

I, \_\_\_\_\_, understand this Agreement is between me and \_\_\_\_\_ County because extra CFAP benefits in the amount of \$\_\_\_\_\_ were overissued due to the county's error. I agree to repay this amount by the method(s) checked below:

☐ **Lump Sum Payment.**

- ☐ I will repay by a lump sum cash payment of \$\_\_\_\_\_ due on \_\_\_\_\_.
- ☐ I will repay by a lump sum CFAP benefit payment of \$\_\_\_\_\_ due on \_\_\_\_\_.

☐ **Benefit Reduction**

- ☐ I will repay by having my household's benefits reduced by \$\_\_\_\_\_ each month, beginning \_\_\_\_\_.

☐ **Installments.**

- ☐ I will repay by monthly cash payments of \$\_\_\_\_\_ due on the \_\_\_\_\_ day of each month beginning \_\_\_\_\_.
- ☐ I will repay by monthly CFAP benefit payments of \$\_\_\_\_\_ due on the \_\_\_\_\_ day of each month beginning \_\_\_\_\_.

**These rules apply:**

MPP 63-801.22; MPP 63-801.31; MPP 63 801.41. You may review them online at [cdss.ca.gov](http://cdss.ca.gov) or at your local county office.

**I also understand and agree that:**

1. My repayment schedule is based on my current ability to pay as figured by the county. Any changes in my ability to pay may change my monthly payments.
2. If anything changes, I may ask the county to refigure the terms checked above.
3. If I do not pay as agreed and I do not get a new payment schedule, the county may ask that the total amount owed be paid now.
4. If I do not pay as agreed and the county sues me to collect the amount owed, I may also be required to pay collection costs, attorney fees, and court costs.
5. If I do not pay, the county may take my state income tax refund and/or ask the court to attach my wages or any property I own.
6. I will be subject to involuntary collection action(s) if payment is not received by the due date and the claim becomes delinquent.

Signature:	Date:	County:
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**To be completed by the County:**

The above signed Agreement has been accepted by \_\_\_\_\_  
on \_\_\_\_\_ for \_\_\_\_\_ County. Payments should be made at:

\_\_\_\_\_  
(Signature of Authorized County Official)

**These rules apply:**

MPP 63-801.22; MPP 63-801.31; MPP 63 801.41. You may review them online at [cdss.ca.gov](http://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		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

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
OVERISSUANCE NOTICE  
CHANGE FROM INADVERTENT HOUSEHOLD  
ERROR (IHE) TO INTENTIONAL PROGRAM  
VIOLATION (IPV)**

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

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Case Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Worker Number : \_\_\_\_\_  
Telephone Number : \_\_\_\_\_  
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 pages 2 and 3 and returning it by \_\_\_\_\_.**

**1. You have been told we paid you too much CFAP benefits.** You need to pay back the \$\_\_\_\_\_ we overissued you from \_\_\_\_\_ to \_\_\_\_\_. Please see below for your options to repay.

**2. Here's why this happened:**

A court or state administrative hearing decided that your Inadvertent Household Error (IHE) is an Intentional Program Violation (IPV) or you have signed a Disqualification Consent Agreement or an Administrative Disqualification Hearing Waiver. This notice has information about the amount you now owe, which may be more than the amount you were told about before.

**3. Your options to repay:**

**YES**

**Are you still receiving CFAP benefits?**

**NO**

**\$ 1. Pay in full**

**OR**

**(\$ 2. Join the 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 CFAP benefits. This will start on \_\_\_\_\_.

**OR**

**3. Agree to another repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**4. Ask for a state hearing**

If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

**\$ 1. Pay in full**

**OR**

**2. Agree to a repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**3. Ask for a state hearing**

If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

If you are NO LONGER receiving CFAP benefits, we **MUST** hear from you. If we do not hear from you by \_\_\_\_\_, we may take your state income tax refund, or use other ways of collecting the amount owed.

- Note:**
- You do not have to use SSI benefits to pay back the overissuance.
  - Collection will be from all adults in the household when the overissuance occurred.
  - You may review and copy the county's records related to this overissuance.
  - If you do not pay back the overissuance, 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 or state government collection action.
  - If you stop receiving CFAP benefits before the overissuance is paid back, we may take what you owe out of your state income tax refund.
  - If the claim becomes past due or the household is sued, you may have to pay court or other costs.
  - Your repayment agreement will be based on your current ability to pay. If your ability to pay changes, contact the county about changing your monthly payments.
  - Because this is now an Intentional Program Violation, penalties will apply even if you agree to repay what you owe.

These rules apply: MPP 63-801.43; MPP 63-801.23. You may review them online at [cdss.ca.gov](http://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		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

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
REPAYMENT FINAL NOTICE  
INTENTIONAL PROGRAM VIOLATION (IPV)**

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

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

(ADDRESSEE)

**Questions? Ask your Worker.**

**State Hearing: If you disagree with us, you can ask for a hearing unless you have already had a hearing on the amount you owe. Pages 2 and 3 tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.**

**Warning:** If you think we are wrong, this is your last chance to ask for a hearing. If you continue participating in CFAP the county can lower your CFAP benefits to collect the overissuance. If you stop participating in CFAP before the overissuance is paid back, the county may take what you owe out of your state income tax refund.

**1. We told you before that we paid you too much CFAP benefits.** You still owe \$\_\_\_\_\_ because we overissued you \$\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_. Please see below for your options to repay.

**2. You intentionally applied for benefits you should not have. Here's why this happened:**

**3. You did not agree to repay OR did not repay as agreed. Your options to repay:**



Are you still receiving CFAP benefits?



**\$ 1. Pay in full**

**OR**



**2. Join the 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 CFAP benefits until your balance is paid off. This will start on \_\_\_\_\_.

**OR**



**3. Agree to another repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_. You must tell us when you cannot pay as agreed. If your ability to pay changes, explain why you cannot pay and contact the county about changing your monthly payments.

**OR**



**4. Ask for a state hearing**

If you disagree with us, this is your last chance to ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.

**\$ 1. Pay in full**

**OR**



**2. Agree to a repayment plan**

Fill out and return the included repayment form by \_\_\_\_\_. You must tell us when you cannot pay as agreed. If your ability to pay changes, explain why you cannot pay and contact the county about changing your monthly payments.

**OR**



**3. Ask for a state hearing**

If you disagree with us, this is your last chance to ask for a state hearing by filling out the back page and returning it by \_\_\_\_\_.

If you are NO LONGER receiving CFAP benefits, we **MUST** hear from you. If we do not hear from you by \_\_\_\_\_, we may take your state income tax refund, or use other ways of collecting the amount owed.

- Note:**
- You do not have to use SSI benefits to pay back the overissuance.
  - Collection will be from all adults in the household when the overissuance occurred.
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  - If the claim becomes past due or the household is sued, you may have to pay court or other costs.
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These rules apply: MPP 63-801.43; MPP 63-801.23. You may review them online at [cdss.ca.gov](http://cdss.ca.gov) or at your local county office.

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- 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:**

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You do not have to take part in the activities.

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## OTHER INFORMATION

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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.

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### 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

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
OVERISSUANCE NOTICE  
INTENTIONAL PROGRAM VIOLATION (IPV)**

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

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

(ADDRESSEE)

**Questions? Ask your Worker.**

**State Hearing: If you disagree with us, you can ask for a hearing. Pages 2 and 3 tells you how. If you ask for a hearing before \_\_\_\_\_ your benefits may not be changed until a decision is made.**

**1. We paid you too much CFAP benefits.**

You need to pay back the \$ \_\_\_\_\_ we overissued from \_\_\_\_\_ to \_\_\_\_\_. Please see below for your options to repay.

**2. You have intentionally got benefits you should not have. Here's why this happened:**

**3. Your options to repay:**

**YES**

Are you still receiving CFAP benefits?

**NO**

**\$ 1. Pay in full**

**OR**

**2. Join the 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 CFAP benefits until your balance is paid off. This will start on \_\_\_\_\_.

**OR**

**3. Agree to another repayment plan**  
 Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**4. Ask for a state hearing**  
 If you disagree with us, ask for a state hearing by filling out the back of this form and returning it by \_\_\_\_\_.

**\$ 1. Pay in full**

**OR**

**2. Agree to a repayment plan**  
 Fill out and return the included repayment form by \_\_\_\_\_.

**OR**

**3. Ask for a state hearing**  
 If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by \_\_\_\_\_.  
 If you are NO LONGER receiving CFAP, we **MUST** hear from you. If we do not hear from you by \_\_\_\_\_, we may take your state income tax refund, or use other ways of collecting the amount owed.

- Note:**
- You do not have to use SSI benefits to pay back the overissuance.
  - Collection will be from all adults in the household when the overissuance occurred.
  - You may review and copy the county's records related to this overissuance.
  - If you do not pay back the overissuance, agree to a repayment plan, or have your benefits reduced, the county will use other ways of collecting the amount owed, such as through the courts or state government collection action.
  - If you stop receiving CFAP before the overissuance is paid back, we may take what you owe out of your state income tax refund.
  - If the claim becomes past due or the household is sued, you may have to pay court or other costs.
  - Your repayment agreement will be based on your current ability to pay. If your ability to pay changes, contact the county about changing your monthly payments.
  - If this Intentional Program Violation was an Inadvertent Household Error, penalties will apply even if you agree to repay what you owe.

These rules apply: MPP 63-801.43; MPP 63-801.23. You may review them online at [cdss.ca.gov](http://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		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

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE  
CALFRESH INTENTIONAL PROGRAM  
VIOLATION (IPV) NOTICE  
DUE TO TRAFFICKING**

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

Notice Date : \_\_\_\_\_  
Case Name : \_\_\_\_\_  
Case Number : \_\_\_\_\_  
Worker Name : \_\_\_\_\_  
Worker Number : \_\_\_\_\_  
Telephone Number : \_\_\_\_\_  
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 page 2 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 CFAP 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 state income tax refund, or state 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](http://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		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

**CALIFORNIA FOOD ASSISTANCE  
PROGRAM (CFAP) - STATE CALFRESH  
INFORMATIONAL NOTICE POTENTIAL  
INTENTIONAL PROGRAM VIOLATION (IPV)**

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

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

(Addressee)

Questions? Ask your Worker.

State Hearing: This notice does not establish a new overissuance. There is no action for a judge to change. **Questions? Ask your Worker.**

**1. You may owe more CFAP benefits if found to have intentionally violated program rules through prosecution or an Administrative Disqualification Hearing.**

The original amount we told you that you need to pay back is \$\_\_\_\_\_ overissued from \_\_\_\_\_ to \_\_\_\_\_. If you are found to have committed an IPV, you will owe more. The additional amount you need to pay will be \$\_\_\_\_\_ overissued from \_\_\_\_\_ to \_\_\_\_\_.

**2. You may have intentionally received benefits you should not have. Here's why this happened:**

**Note:**

- You will receive another notice at a later date if you are found to have committed an IPV establishing the additional amount owed. You may appeal that notice if you disagree.
- If you are in a repayment agreement for the original amount and found to have committed an IPV you will have to set up a new repayment agreement for the new overissuance amount.
- If you are found to have committed an IPV the new overissuance amount will be collected from all adults who were in the household when the overissuance occurred.
- If you are found to have **NOT** committed an IPV there will be no change to the overissuance amount you owe and any current repayment agreement in place will remain unchanged.
- You may review and copy the county's records related to this overissuance.
- If an Intentional Program Violation was at first an Inadvertent Household Error, the new overissuance amount and penalties will apply even if you agree to repay what you owe.

These rules apply: MPP 63-801.23; MPP 63-801.32; MPP 63-801.43; WIC 18901. You may review them online at [cdss.ca.gov](http://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		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

**CALFRESH/CALIFORNIA FOOD  
ASSISTANCE PROGRAM (CFAP)  
STATE CALFRESH  
OVERISSUANCE REPAYMENT  
AGREEMENT TRANSITION NOTICE**

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

Notice Date : \_\_\_\_\_

Case Name : \_\_\_\_\_

Case Number : \_\_\_\_\_

Worker Name : \_\_\_\_\_

Worker Number : \_\_\_\_\_

Telephone Number : \_\_\_\_\_

Address : \_\_\_\_\_  
\_\_\_\_\_

(Addressee)

[ ]

[ ]

[ ]

[ ]

Questions? Ask your Worker.

**State Hearing: If you disagree with us, you can ask for a hearing. The last 2 pages tell you how. If you ask for a hearing before \_\_\_\_\_ your benefits may not be changed until a decision is made.**

**IMPORTANT INFORMATION ABOUT YOUR CALFRESH/CFAP  
OVERISSUANCE REPAYMENT AGREEMENT**

**There was a change in your household.**

On \_\_\_\_\_, \_\_\_\_\_ County began reducing your household's monthly food benefits to repay the extra food benefits your household received. **Your household experienced a change that caused your food benefits to change from CFAP to CalFresh or CalFresh to CFAP.** Due to this change, we can no longer collect the overissuance by reducing your monthly benefits.

Even though you can no longer repay the overissuance by having your household's benefits reduced, your household is still responsible for repaying the \_\_\_\_\_ overissuance and you are now required to choose a new overissuance repayment option.

**TERMS AND CONDITIONS**

**Your household is still responsible for repaying the \$ \_\_\_\_\_ overissuance.**

**Here are your options:**

**1. Lump Sum Payment.**

Fill out and return the included repayment form by \_\_\_\_\_.

**2. Installments.**

Fill out and return the included repayment form by \_\_\_\_\_.

**3. Ask for a state hearing.**

If you disagree with us, ask for a state hearing by filling out the last page and returning it by \_\_\_\_\_.

If you have any questions about this notice call the county at \_\_\_\_\_.

**These rules apply:**

MPP 63-801; MPP 63-804. You may review them online at [cdss.ca.gov](http://cdss.ca.gov) or at your local County office.

**TERMS AND CONDITIONS (Continued)**

The CDSS offers a federal food program called CalFresh. To receive federal food benefits, you must meet federal rules, which require United States citizenship or certain immigration statuses (7 CFR 273.2(f)(1)(ii)(A) and MPP 63-403). The CDSS also offers a state food program called the California Food Assistance Program (CFAP), also known as state CalFresh, because some immigrants are not eligible to receive federal CalFresh. If immigration status is the only reason for not being eligible for CalFresh, then you or a household member may be eligible for CFAP. An overissuance, whether CalFresh or CFAP, must be repaid to the original food program and cannot be repaid with other food program benefits.

**Note:**

- You do not have to use SSI benefits to pay back the overissuance.
- Collection will be from all adults in the household when the overissuance occurred.
- You may review and copy the county's records related to this overissuance.
- If you do not pay back the overissuance or agree to a repayment plan the County may use other ways of collecting the amount owed, such as through the courts or federal/state government collection action.
- If you stop receiving CalFresh benefits before the overissuance is paid back, we may take what you owe out of your federal/state income tax refund.
- If the claim becomes past due or the household is sued, you may have to pay court or other costs.
- Your repayment agreement will be based on your current ability to pay. If your ability to pay changes, contact the County about changing your monthly payments.

**After you complete and sign this Agreement, return all copies to the County in the envelope provided. Do not send cash with this Agreement. When approved by the County, a signed copy of this Agreement will be sent to you.**

**AGREEMENT**

I, \_\_\_\_\_, understand this Agreement is between me and \_\_\_\_\_ County because extra food benefits were issued. I agree to repay extra food benefits by the method(s) checked below:

☐ **Lump Sum Payment**

I will repay by a lump sum payment of \$\_\_\_\_\_ due on \_\_\_\_\_.

☐ **Installment**

I will repay by monthly payments of \$\_\_\_\_\_ due on the \_\_\_\_\_ day of each month beginning \_\_\_\_\_.

Signature:	Date:	County:
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**To be completed by the County:**

The above signed Agreement has been accepted by \_\_\_\_\_ on \_\_\_\_\_  
for \_\_\_\_\_ County. Payments should be made at:

\_\_\_\_\_  
(Signature of Authorized County Official)

**These rules apply:**

MPP 63-801; MPP 63-804. You may review them online at [cdss.ca.gov](http://cdss.ca.gov) or at your local County office.

## YOUR HEARING RIGHTS

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- 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.

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- 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

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## 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

**CALIFORNIA FOOD ASSISTANCE PROGRAM  
(CFAP) - STATE CALFRESH CLAIM DETERMINATION WORKSHEET**

Case Transfer Status: <input type="checkbox"/> To <input type="checkbox"/> From		Case Number:	Case Number:
1. Case Name:		2. Case Number:	
3. Head of Household (If Different):		Social Security Number:	
Address:			
4. Another Adult:		Social Security Number:	
Address:			
5. Another Adult:		Social Security Number:	
Address:			
6. Date of Discovery:	7. CF Case Status: <input type="checkbox"/> Active <input type="checkbox"/> Discontinued	8. Basis for Claim Determination: <input type="checkbox"/> Administrative Error <input type="checkbox"/> Inadvertent Household Error <input type="checkbox"/> Potential IVP	9. Effective Date of Disqualification:
10. Explanation of Overissuance <i>(If applicable, include date change occurred and date reported)</i>			

11. SUMMARY OF CFAP OVERISSUANCE  
ACTUAL BASIS FOR ISSUANCE

Issuance Month/Year	Household Size	Adjusted Income	Allotment	Issuance Verification								
				ATP/ HIR	DMI	Other	Redemption					
Continues on page 3		11a. Subtotal ▶										
Documentation												

CORRECT BASIS FOR ISSUANCE							
Issuance Month/Year	Household Size	Adjusted Income	Allotment	Issuance Verification			
				ATP/HIR	DMI	Other	Redemption
Continues on page 5		11b. Total ▶					
12. Total CFAP overissuance (subtotal continues on page 5)		11a Minus 11b ▶					
Documentation							

13. Claim offsetting lost benefits not restored.	Date	Date
A. Total CFAP overissuance <i>(from 12 above)</i> .		
B. Minus lost benefits not restored.		
C. Minus payment received.		
D. Amount of CFAP claim to be collected.		

Eligibility Worker <i>(Signature)</i> :	Date:
Supervisor <i>(Signature)</i> :	Date:
Review Officer <i>(Approval Signature)</i> :	Date:

<p>Action <i>(Planned/Taken)</i>:</p>
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**14. SUMMARY OF CFAP OVERISSUANCE (CONTINUATION)**  
**Include all other overissuance months not listed on pages 2 & 3.**

ACTUAL BASIS FOR ISSUANCE							
Issuance Month/Year	Household Size	Adjusted Income	Allotment	Issuance Verification			
				ATP/HIR	DMI	Other	Redemption
Total on this page		14a. Subtotal ▶					
Total page 2		11a. Subtotal ▶					
15. Total all pages		15a. Total ▶ (14a + 11a)					
16. Total CFAP overissuance							
Documentation							

CORRECT BASIS FOR ISSUANCE							
Issuance Month/Year	Household Size	Adjusted Income	Allotment	Issuance Verification			
				ATP/HIR	DMI	Other	Redemption
Total this page		14b. Subtotal ▶					
Total page 3		11b. Subtotal ▶					
16. Total both pages		15b. Total (14b + 11b) ▶					
17. Total CFAP overissuance.		11a. Minus 11b ▶					
Documentation							

18. Claim offsetting lost benefits not restored.	Date	Date
A. Total CFAP overissuance ( <i>from page 6</i> ).		
B. Minus lost benefits not restored.		
C. Minus payment received.		
D. Amount of CFAP claim to be collected.		

Eligibility Worker ( <i>Signature</i> ):	Date:
Supervisor ( <i>Signature</i> ):	Date:

**Documentation**



**CALFRESH/CALIFORNIA FOOD  
ASSISTANCE PROGRAM  
(CFAP) - STATE CALFRESH  
COMBINED HOUSEHOLD NOTICE OF  
ACTION (CONTINUED)**

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

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

Part 1 - Gross Income Eligibility				
<b>A. NONEXEMPT GROSS UNEARNED INCOME</b>	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Cash Aid				
2. Social Security, UIB, DIB, Pensions				
3. Child/Spousal Support				
4. Scholarships, Grants, Loans				
5. Other				
6. Unreported Gross Unearned Income				
7. Gross Unearned Income (A1+A2+A3+A4+A5+A6)				
8. Less Child Support Paid (enter remainder in B7)				
9. Total Gross Unearned Income (A7 - A8)				
<b>B. NONEXEMPT GROSS EARNED INCOME</b>	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Gross Salary, Wages				
2. Self-Employment				
3. Training Allowance				
4. Gross Earned Income (B1+B2+B3)				
5. Unreported Gross Earned Income				
6. Adjusted Gross Earned Income (B4+B5) (including unreported income)				
7. Less Remainder of Child Support Paid (If not fully used in Section A)				
8. Total Gross Earned Income (B6-B7) (If negative amount, enter zero)				

C. GROSS INCOME TEST Not figured for households with an elderly/disabled member. (MPP 63-503.323)	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Household size				
2. Maximum Gross Income Allowed from table				
3. Total Countable Gross Monthly Income (A9+B8)				
4. Gross Income eligible? (Is C3 less than or equal to C2)				

D. GROSS INCOME OVERISSUANCE (IF C4 IS NO)	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Amount Previously Issued				
2. Correct Benefit				
3. Total _____ 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 (A9)	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget

F. NONEXEMPT GROSS EARNED INCOME	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Gross Earned Income (Not Including unreported income)(B4)				
2. Adjusted Gross Earned Income (80% of F1)				
3. Unreported Gross Earned Income				
4. Total Countable Earned Income (F2+F3)				
5. Less remainder of Child Support Paid (B7) (If not fully used in Section A)				
6. Total Gross Earned Income (F4 - F5) (If negative amount, enter zero)				

G. TOTAL NONEXEMPT GROSS INCOME (E+F6)	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget

H. STANDARD/DEPENDENT CARE/HOMELESS SHELTER/DEDUCTION	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
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)				

I. SHELTER DEDUCTIONS	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
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)	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget

K. NET INCOME TEST	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Household size				
2. Maximum Net Income allowable from table				
3. Net Income eligible? (Is J less than or equal to K2?)				

L. NET INCOME OVERISSUANCE	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Combined Allotment				
2. Federal Allotment				
3. Amount Previously Issued/Authorized				
4. Correct Benefit				
5. Total _____ Overissuance (L3-L4)				
6. Minus Lost Benefits Not Restored				
7. Minus payment Received				
8. Amount of Overissuance to be Collected (L5-L6-L7)				
9. Minus Workfare Offset				
10. Amount of Overissuance to be Collected (L8-L9)				

M. CFAP BENEFIT AMOUNT	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Combined Allotment				
2. Federal Allotment				
3. CFAP Benefit Allotment				
4. Amount of CFAP Overissuance (Combined Budget L5-Federal Budget L5)				

### PART 3 - RESOURCE ELIGIBILITY

N. COUNTABLE RESOURCES	OVERISSUANCE MONTH/YEAR			
	Combined Budget	Federal Budget	Combined Budget	Federal Budget
1. Total Resources				
2. Maximum Resource Level Resource				
3. Eligible? (Is N1 less than or equal to N2?)				

<b>O. RESOURCE OVERISSUANCE (IF N3 IS NO)</b>	<b>OVERISSUANCE MONTH/YEAR</b>			
	<b>Combined Budget</b>	<b>Federal Budget</b>	<b>Combined Budget</b>	<b>Federal Budget</b>
1. Amount Previously Issued/Authorized				
2. Correct Benefit				
3. Total Overissuance (O1-NO)				
4. Minus Lost Benefits Not Restored				
5. Minus Payment Received				
6. Amount of Overissuance to be Collected (O3-O4-O5)				
7. Minus Workfare Offset				
8. Amount of Overissuance to be Collected (O6-O7)				

**PART 4 - NON-FINANCIAL ELIGIBILITY**

<b>P. HOUSEHOLD COMPOSITION</b>	<b>OVERISSUANCE MONTH/YEAR</b>			
	<b>Combined Budget</b>	<b>Federal Budget</b>	<b>Combined Budget</b>	<b>Federal Budget</b>
1. Previous Household Size				
2. Correct Household Size				

<b>Q. NON-FINANCIAL OVERISSUANCE</b>	<b>OVERISSUANCE MONTH/YEAR</b>			
	<b>Combined Budget</b>	<b>Federal Budget</b>	<b>Combined Budget</b>	<b>Federal Budget</b>
1. Amount Previously Issued/Authorized				
2. Correct Benefit				
3. Total Overissuance (Q1-Q2)				
4. Minus Lost Benefits Not Restored				
5. Minus Payment Received				
6. Amount of Overissuance to be Collected (Q3-Q4-Q5)				
7. Minus Workfare Offset				
8. Amount of Overissuance to be Collected (Q6-Q7)				

These rules apply: MPP 63-801.3 and MPP 63-502.373. You may review them online at [cdss.ca.gov](https://cdss.ca.gov) or at your local county office

**CALFRESH/CALIFORNIA FOOD  
ASSISTANCE PROGRAM  
(CFAP) - STATE CALFRESH  
NOTICE OF ACTION (CONTINUED)**

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

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

**Part 1 - Gross Income Eligibility**

A. NONEXEMPT GROSS UNEARNED INCOME	OVERISSUANCE MONTH/YEAR			
1. Cash Aid				
2. Social Security, UIB, DIB, Pensions				
3. Child/Spousal Support				
4. Scholarships, Grants, Loans				
5. Other				
6. Unreported Gross Unearned Income				
7. Gross Unearned Income (A1+A2+A3+A4+A5+A6)				
8. Less Child Support Paid (enter remainder in B7)				
9. Total Gross Unearned Income (A7 - A8)				

B. NONEXEMPT GROSS EARNED INCOME	OVERISSUANCE MONTH/YEAR			
1. Gross Salary, Wages				
2. Self-Employment				
3. Training Allowance				
4. Gross Earned Income (B1+B2+B3)				
5. Unreported Gross Earned Income				
6. Adjusted Gross Earned Income (B4+B5) (including unreported income)				
7. Less Remainder of Child Support Paid (If not fully used in Section A)				
8. Total Gross Earned Income (B6-B7) (If negative amount, enter zero)				

C. GROSS INCOME TEST Not figured for households with an elderly/disabled member. (MPP 63-503.323)	OVERISSUANCE MONTH/YEAR			
1. Household size				
2. Maximum Gross Income Allowed from table				
3. Total Countable Gross Monthly Income (A9+B8)				
4. Gross Income eligible? (Is C3 less than or equal to C2)				

D. GROSS INCOME OVERISSUANCE (IF C4 IS NO)	OVERISSUANCE MONTH/YEAR			
1. Amount Previously Issued				
2. Correct Benefit				
3. Total _____ 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 (A9)	OVERISSUANCE MONTH/YEAR			



F. NONEXEMPT GROSS EARNED INCOME	OVERISSUANCE MONTH/YEAR			
1. Gross Earned Income (Not Including unreported income)(B4)				
2. Adjusted Gross Earned Income (80% of F1)				
3. Unreported Gross Earned Income				
4. Total Countable Earned Income (F2+F3)				
5. Less remainder of Child Support Paid (B7) (If not fully used in Section A)				
6. Total Gross Earned Income (F4 - F5) (If negative amount, enter zero)				

G. TOTAL NONEXEMPT GROSS INCOME (E+F6)	OVERISSUANCE MONTH/YEAR			

H. STANDARD/DEPENDENT CARE/HOMELESS SHELTER/DEDUCTION	OVERISSUANCE MONTH/YEAR			
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)				

I. SHELTER DEDUCTIONS	OVERISSUANCE MONTH/YEAR			
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)	OVERISSUANCE MONTH/YEAR			

K. NET INCOME TEST	OVERISSUANCE MONTH/YEAR			
1. Household size				
2. Maximum Net Income allowable from table				
3. Net Income eligible? (Is J less than or equal to K2?)				

L. NET INCOME OVERISSUANCE	OVERISSUANCE MONTH/YEAR			
1. Amount Previously Issued/Authorized				
2. Correct Benefit				
3. Total _____ 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	OVERISSUANCE MONTH/YEAR			
1. Total Resources				
2. Maximum Resource Level				
3. Resource Eligible? (Is M1 less than or equal to M2)				

N. RESOURCE OVERISSUANCE (IF N3 IS NO)	OVERISSUANCE MONTH/YEAR			
1. Amount Previously Issued/Authorized				
2. Correct Benefit				
3. Total _____ 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**

<b>O. HOUSEHOLD COMPOSITION</b>	<b>OVERISSUANCE MONTH/YEAR</b>			
1. Previous Household Size				
2. Correct Household Size				

<b>P. NON-FINANCIAL OVERISSUANCE</b>	<b>OVERISSUANCE MONTH/YEAR</b>			
1. Amount Previously Issued/Authorized				
2. Correct Benefit				
3. Total _____ 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)				

These rules apply: MPP 63-801.3 and MPP 63-502.373. You may review them online at [cdss.ca.gov](http://cdss.ca.gov) or at your local county office.