State of California – Health and Human Services Agency

California Department of Social Services

CASH ASSISTANCE PROGRAM FOR IMMIGRANTS NOTICE OF OVERPAYMENT - WAIVER DENIAL

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 the back of this form and returning it by _____.

We previously notified you of your Cash Assistance Program for Immigrants (CAPI) overpayment in the amount of $ _____ for the period _____ through _____. Your request for waiver of this overpayment is denied. This means you will have to pay the money back.

Recovery of an overpayment can be waived if BOTH of the following are true:

- You were not at fault in connection with causing or accepting the overpayment.

AND

- You could not pay your bills for food, clothing, housing, medical care, or other necessary expenses if you had to pay us back.

Your waiver request is being denied because:

☐ You made an incorrect statement or a statement you should have known was incorrect.

☐ You failed to give us timely information that you knew or should have known was important.

☐ You accepted and cashed payments that you either knew or could have been expected to know were incorrect.

☐ You received and cashed duplicate payments for the same period.

☐ You have been overpaid in the past for similar reasons.

☐ You could afford to pay your bills for food, clothing, housing, medical care or other necessary expenses and still repay the overpayment either in full or by installments.

☐ Other (explain)

Repaying the Overpayment

☐ CHANGE IN BENEFITS

Effective _____, your CAPI payments are changed from $ _____ to $ _____ because we will be collecting $ _____ per month to recover your CAPI overpayment.

If you prefer, you can repay the full amount. Contact your worker to find out how.

☐ REPAYMENT REQUIRED BECAUSE YOU NO LONGER RECEIVE CAPI BENEFITS

Repay the full amount or arrange to pay by installments. Contact your worker to find out how.

Medi-Cal: This notice does NOT change or stop Medi-Cal benefits. If there is a change in your Medi-Cal benefits, you will receive another notice. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply; you may review them at your welfare office: MPP 49-001 through 49-070

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 <u>before</u> 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:

<u>Welfare to Work</u>:

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.

<u>Cal-Learn</u>:

- 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 <u>can be</u> a friend or relative but cannot interpret for you.)**

Name		Phone Number	
Street Address	City	State	Zip Code