NOTICE OF ACTION AND RIGHT TO REQUEST A STATE HEARING ON INTERIM ASSISTANCE

State No.:
County No.:
Worker No.:
District:
Date:
Case Name:
Interpreter Needed: _____ (Language) _____ (Dialect)

This office was notified of your initial Supplemental Security Income/State Supplementary Payment (SSI/SSP) for the period_____through_____. As per your agreement, we billed the Social Security Administration (SSA) in the amount of $_____to repay the amount of Interim Assistance you received for that same period while SSA completed your application for Supplemental Security Income payments. SSA will notify you about how the remaining SSI money (if any) due you will be released by SSA.

SSI/SSP PAYMENT

If you disagree with the amount of SSI/SSP payment, contact your local Social Security Office. The amount of the initial SSI/SSP payment is subject to the SSA appeal process. Request for reconsideration must be filed within 60 days after the date the notice of the initial determination is received by you.

INTERIM ASSISTANCE PAYMENT

If you disagree with the amount billed to the SSA, please contact the California Department of Social Services. This action is subject to the state hearing provision described on the reverse side of this form.

COMMENTS:

The law and/or regulations governing this action are:

Department of Social Services/Eligibility Assistance Standards Manual Section (EAS) 46-337
42 U.S. Code, Section 1383(g)
20 CFR 416.1910

If you have any questions please contact me.

COUNTY/STATE REPRESENTATIVE		AGENCY
TELEPHONE	DATE:	