STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

August 27, 1993

ALL-COUNTY INFORMATION NOTICE I-32-93

TO: ALL COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[X] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

SUBJECT: TREATMENT OF COMBINED AFDC-FG/U CASES

REFERENCE: ALL COUNTY LETTER NO. 92-98
MPP SECTION 89-301 - ELIMINATION OF THE 100-HOUR LIMIT

The purpose of this letter is to provide counties with guidelines for processing cases when an assistance unit (AU) is receiving aid based on absent (FG) and Unemployed (U) parent deprivation and is affected by mandatory inclusion and the waiver of the 100-hour limit. When such an AU would be discontinued due to the family's income exceeding financial eligibility standards for their AU size, the county must determine if some members are eligible to receive aid based on AFDC-FG deprivation.

In addition, we have been asked to provide Notice of Action (NOA) language to properly notify recipients when these situations occur.

COMBINED AFDC-FG/U CASES

For AFDC-U members, once AFDC-U deprivation is established, the AFDC-U family remains aided under that basis of deprivation regardless of the number of hours the principal earner (PE) subsequently works. Because of mandatory inclusion the U and FG cases must be combined and the siblings and half siblings must be put into one AU with their parents. In these situations waiver of the 100-hour limit applies to the entire AU and the family receives aid until it becomes income ineligible.

EXAMPLE::

A family consists of a mother and her two children, the unmarried father and a common child. The mother has been receiving AFDC-FG for herself and her two children. The father was determined to be the PE and was also employed full time (waiver of the 100 hours applies only to recipients); therefore, he and the common child were excluded from the AU since there was no basis of deprivation for the common child.

He becomes unemployed. Due to mandatory inclusion, the father and the common child must now be added to the AU. Two months later the father becomes employed full time, i.e., working more than 100 hours per month. Since the 100 hour limit applies only to applicants, AFDC eligibility continues and the father and common child must remain in the AU. The family continues on aid until they become income ineligible.

CONTINUING FINANCIAL ELIGIBILITY

In the above example, the case is not discontinued until the family's income exceeds financial eligibility standards for an AU of five. When the five-person AU becomes income ineligible and discontinuance is considered, the mother and her two children may remain eligible to receive AFDC-FG since absent parent deprivation still exists for her two children. The father and the common child would continue to be ineligible as long as he is employed full time, i.e. working more than 100 hours a month.

ASSESSMENT OF AFDC-FG/ACTION(S) REQUIRED

When a county determines that part of an AU will be ineligible for aid on the first of the month and that other members of that AU may be eligible for continuing aid, the county should automatically assess eligibility for AFDC. In the above example, the assessment would be for AFDC-FG for mom and her two children and should be done concurrent with action to discontinue the father and the common child. If the new AU, comprised of the mother and two children is otherwise eligible no break-in-aid should occur.

In order to simplify the process of informing recipients of the action the county intends to take, one NOA should delete ineligible members, change the continuing grant, and inform the remaining AU members of continuing aid, if otherwise eligible. The NOA would have to meet the adequate and timely requirements of MPP 22-001a.(1) and 22-001t.(1).

NOTICE OF ACTION LANGUAGE

See Attachment 1 for NOA language and instructions.
Also attached is the Spanish version of the M44-207K1.

If you have any further questions on this issue, please contact Henry Puga at (916) 654-1068 or CALNET 464-1068. For questions related to the NOA language/form, please contact John Honeycutt at (916) 654-1077 or CALNET 464-1077.

Sincerely,

MICHAEL C. GENEST
Deputy Director
Welfare Programs Division

Attachment

State of California
Department of Social Services

Manual Msg. No.: M44-207K1 1 of 5
Action : Change
Issue: Income Eligibility
Title: Discontinue Part of AU

Auto ID No. :

Form No. : Page 1 - NA 200
Page 2 - NA 270
Page 3 - NA 274C
Page 4 - NA 275

Flow Chart No. :
Source : County Request
Effective Date : 06/01/93
Revision Date :
Regulation Cite: 41-440.1 44-100, 44-207.2 & .3

PAGE 1, LEFT SIDE OF NA 200 - MESSAGE:

As of _____, the County is changing your monthly cash aid from $ _____ to $ _____. Cash aid for _____ is being stopped.

[ ] If this box is checked, you were overpaid. The amount is $_____. See Page 3.

Here's why cash aid is changing:

You have been getting cash aid for a family group of __ persons. This group is not eligible for cash aid next month because the recent change in your income raised the income above the limit for families of this size.

Your cash aid for next month was figured for a new group of __ persons made up of those who now get cash aid MINUS those whose aid is being stopped. The income for the new group is NOT above the limit for families of this size.

Here's how your new cash aid was figured:

FIRST, we figured income eligibility for next month for the group now getting cash aid. See the right side of Page 2.

NEXT, we figured aid for the persons in the new (smaller) eligible family group. See the right side of this page.

LAST, if you were overpaid, we figured your overpayment starting on the left side of Page 2.

[ ] You will get another notice about Medi-Cal.

PAGE 2, LEFT SIDE OF NA 270 - MESSAGE:

If Page 1 Says You Were Overpaid ...

Here's why:

Your cash aid was paid for a family group of __ persons. This group was not eligible for cash aid in the month(s) of

_____

because of the change in this group's income. You were eligible for cash aid for the smaller group of __ persons described on Page 1.

Your monthly aid will be reduced until the amount you owe is paid back. We will take less money out of your monthly aid payment when an overpayment is caused by a county mistake. We have decided your overpayment was:

[ ] Caused by the county.
[ ] Not caused by the county

If cash aid stops before your overpayment is paid back, the county can take action to collect.

You do not have to use any Social Security or SSI benefits you get to repay this overpayment.

Page 3 shows how much cash aid you should have got for each month you were overpaid and the total amount of your overpayment. Page 4 shows how much will be taken out of next month's aid amount and the amount you still owe after that amount is taken out.

WARNING: If you think this overpayment is wrong, this is your last chance to ask for a hearing. The back of Page 1 tells how. As long as you still get cash aid, the County can collect an AFDC overpayment by lowering your monthly grant. If your cash aid stops before the overpayment is paid back, the County may take what you owe out of your state income tax refund.

PAGE 2, RIGHT SIDE OF NA 270 - COMPUTATION:

Income Eligibility for Next Month _____

Section A. 185% Income Limit

[ ] You are ineligible because expected total income, Line 5, is more than 185% of total needs, Line 10.

Expected Gross Income

1.	_____	$_____
2.	_____	+_____
3.	_____	+_____
4.	_____	+_____
5.	Total Expected Gross Income.....	=_____

Family Needs

6.	Basic Need, _____ Person.....	$_____
7.	Special Needs.....	+_____
8.	Total Needs.....	=_____
9.	Multiplier.....	x 1.85
10.	185% of Total Needs.....	=_____

Section B. Financial Eligibility

[ ] You are ineligible because expected countable income, Line 18, is not less than total needs, Line 21.

Expected Countable Income

11.	Total Earned Income.....	$_____
12.	Work Expense Disregard.....	-_____
13.	$30 and 1/3 Disregard.....	-_____
14.	Dependent Care Disregard.....	-_____
15.	Other Countable Income:	
	_____	+_____
	_____	+_____
16.	Child Support County Collects...	+_____
17.	Court Ordered Support You Pay...	-_____
18.	Total Expected Countable Income.	=_____

Family Needs

19.	Basic Need, _____ Person.....	$_____
20.	Special Needs.....	+_____
21.	Total Needs.....	=_____

INSTRUCTIONS

This noa is used to reduce the grant when a family's income increases, making them ineligible as a group, but - when aid is stopped for some family members - others remain eligible.

Provision is made for informing the client about an overpayment.

If there is no overpayment, the noa consists of Pages 1 and 2. If there is an overpayment, the noa consists of these pages plus NA 274C and NA 275, making a 4 page noa.

PAGE 1, LEFT SIDE OF NA 200 - MESSAGE:

- Fill in the effective DATE and the old and new AMOUNTS.
- Fill in the NAMES of the person(s) whose aid is being stopped.
- IF there is an OVERPAYMENT:
  - Check the BOX.
  - Fill in the total AMOUNT of the overpayment from Page 3.
  - Prepare to attach a completed NA 274C as Page 3.
  - Prepare to attach a completed NA 275 as Page 4.
- Under "Here's why ..." fill in
  - The NUMBER of persons CURRENTLY aided.
  - The NUMBER of persons in the NEW group.
- Check the MEDI-CAL box if appropriate.
- Enter the REG CITES into the rules section of the NA 200.

PAGE 1, RIGHT SIDE - COMPUTATION

Use this side to show the computation of the grant for the NEW family group.

- Fill in all applicable blanks according to the instructions for the NA 200.

PAGE 2, LEFT SIDE OF NA 270 - MESSAGE:

Use this message only if the action carries an OVERPAYMENT with it.

- Fill in the blanks as appropriate.

PAGE 2, RIGHT SIDE - COMPUTATION:

Use this computation to show how the current AU was determined to be ineligible due to the increased income.

- Check either the BOX at the top of Section A or Section B, as appropriate.

- Fill in the COMPUTATION for the selected section.

file: wpjhone/l.m.docs/m44207k1 - 4.27.93
(wipla)

header - 132/12/8/40/
p1 - ../75
p2 - ../80
p3 - ../77

NOTIFICACION DE ACCION

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación : _____
Nombre del caso : _____
Número : _____
Nombre del trabajador(a) : _____
Número : _____
Teléfono : _____
Dirección : _____

(ADDRESSEE)

¿Tiene preguntas? Comuníquese con su trabajador.

Audiencia con el estado. Si usted cree que esta acción está equivocada, puede solicitar una audiencia. En el reverso de esta hoja se le explica cómo hacerlo. Es posible que sus beneficios no cambien si usted solicita una audiencia antes que esta acción entre en vigor.

A partir de _____, el condado cambiará su asistencia monetaria mensual de $ _____ a $ _____. Parará la asistencia monetaria para _____.

☐ Si esta casilla está marcada, usted recibió un pago excesivo. La cantidad es $ _____. Vea la página 3.

La razón para el cambio es la siguiente:

Usted ha estado recibiendo asistencia monetaria para un grupo familiar compuesto de _____ personas. Este grupo no reúne los requisitos para recibir asistencia monetaria el próximo mes, porque con el aumento reciente en sus ingresos, se excedió el límite para las familias de este tamaño.

Se calculó su asistencia monetaria para el próximo mes para un grupo nuevo de _____ personas, compuesto por las personas que reciben ahora asistencia monetaria MENOS las personas cuya asistencia monetaria ha parado. Los ingresos para el grupo nuevo NO se pasan del límite para familias de este tamaño.

Enseguida explicamos la manera en que se calculó su nueva asistencia monetaria:

PRIMERO, calculamos la elegibilidad tomando en consideración los ingresos para el siguiente mes, para el grupo que recibe asistencia monetaria ahora. Vea el lado derecho de la página 2.

ENSEGUIDA, calculamos la asistencia para las personas en el grupo familiar nuevo (más pequeño) que reúne los requisitos. Vea el lado derecho de esta página.

POR ULTIMO, si se le hizo un pago excesivo, hemos calculado su pago excesivo comenzando en el lado izquierdo de la página 2.

☐ Usted recibirá otra notificación acerca de su Medi-Cal.

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP 41-440.1, 44-100, 44-207.2 & .3

Cantidad de la asistencia monetaria mensual

Sección A. Ingresos contables en el mes de _____

Total de ingresos ganados	$	
Deducción por gastos de trabajo	-	
Deducción de $30 y 1/3	-	
Deducción por cuidado de personas a su cargo	-	
Otros ingresos contables (enumere las fuentes)		
_____	+	
_____	+	
Mantenimiento pagado ordenado por la corte	-	
Ingresos contables netos	=	

Sección B. Su asist. monetaria en el mes de _____

1. Necesidades básicas, _____ personas	$	
2. Necesidades especiales	+	
3. Ingresos contables netos de la Sección A	-	
4. Subtotal de necesidades básicas	=	
5. Asistencia máxima, _____ personas	$	
6. Necesidades especiales	+	
7. Subtotal de asistencia máxima	=	
8. **Subtotal de asist. del mes completo** (Cant. menor en el renglón 4, 7, o 14)	=	
9. Renglón 8 prorrateado para parte del mes	=	
10. Ajuste para cobrar el pago excesivo	-	
11. **Cant. de la asistencia monetaria mensual** (Renglón 8 o 9 menos el renglón 10)	=	
12. MAP del estado anterior, _____ personas.	$	
13. Necesidades especiales (California)	+	
14. Subtotal del estado anterior	=	

NOTIFICACION DE ACCION
(Continuación)

CONDADO DE

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Fecha de la notificación: _____
Nombre del caso: _____
Número: _____

Si la página 1 indica que usted recibió un pago excesivo ...

La razón es la siguiente:

Se pagó la asistencia monetaria para un grupo familiar de _____ personas. Este grupo no reunió los requisitos para recibir asistencia monetaria en el mes(es) de _____

_____

a causa del cambio en los ingresos de este grupo. Usted reunía los requisitos para recibir asistencia monetaria para el grupo más pequeño de _____ personas que se describe en la página 1.

Se reducirá su asistencia monetaria hasta que se termine de reembolsar la cantidad que usted debe. Deduciremos menos dinero de su pago mensual de asistencia, cuando el error sea del condado. Hemos decidido que su pago excesivo:

☐ Fue causado por el condado.

☐ No fue causado por el condado.

Si para la asistencia monetaria antes que se acabe de reembolsar su pago excesivo, el condado puede ejercitar una acción de cobranza.

No tiene que usar beneficios del Seguro Social o de SSI que usted reciba, para reembolsar este pago excesivo.

La página 3 muestra cuánta asistencia monetaria debió haber recibido en cada mes en que recibió un pago excesivo. La página 4 muestra cuánto se deducirá de la cantidad del siguiente mes, y la cantidad que todavía debe después que se haya deducido esa cantidad.

ADVERTENCIA: Si usted cree que este pago excesivo está equivocado, esta es su última oportunidad para pedir una audiencia. En el reverso de la página 1 se le explica cómo hacerlo. En tanto que usted reciba asistencia monetaria, el condado puede cobrar un pago excesivo de AFDC reduciendo su pago mensual. Si la asistencia monetaria para, antes de terminar de reembolsar el pago excesivo, el condado puede tomar lo que usted debe de su devolución de impuestos del estado sobre los ingresos.

Ingresos que determinarán si reúne los requisitos el próximo mes _____

Sección A. 185% del límite de ingresos

☐ Usted no reúne los requisitos a causa del total de los ingresos que se espera. La cantidad en el renglón 5 es superior al 185% del total de necesidades que aparece en el renglón 10.

Ingresos brutos que se esperan

1. _____	$	_____
2. _____	+	_____
3. _____	+	_____
4. _____	+	_____
5. total de ingresos que se esperan	=	_____

Necesidades de la Familia

6. Necesidades básicas, _____ personas.....	$	_____
7. Necesidades especiales	+	_____
8. Total de necesidades	=	_____
9. Multiplicador	x	1.85
10. 185% del total de necesidades	=	_____

Sección B. Situación financiera que determina si reúne los requisitos

☐ Usted no reúne los requisitos a causa de los ingresos contables que se esperan. La cantidad en el renglón 18 no es menor al total de las necesidades que aparece en el renglón 21.

Ingresos contables que se esperan

11. Total de ingresos ganados	$	_____
12. Deducción por gastos de trabajo	-	_____
13. Deducción de $30 y 1/3	-	_____
14. Deducción por cuidado de personas a su cargo.....	-	_____
15. Otros ingresos contables		
_____	+	_____
_____	+	_____
16. Mantenimiento de hijos que cobra el condado.....	+	_____
17. Mantenimiento ordenado por la corte que Ud. paga ..	-	_____
18. Total de ingresos contables que se esperan ...	=	_____

Necesidades de la familia

19. Necesidades básicas _____ personas	$	_____
20. Necesidades especiales	+	_____
21. Total de necesidades	=	_____

Reglamentos. Estos ordenamientos aplican; usted puede consultarlos en su oficina de bienestar: MPP 41-440.1, 44-100, 44-207.2 & .3

Audiencia con el estado: Si cree que esta acción está equivocada, puede pedir una audiencia. En el reverso de la página 1 se le explica cómo hacerlo.