

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814



February 23, 1999

ALL COUNTY INFORMATION NO. I-19-99

TO: ALL COUNTY WELFARE DIRECTORS
ALL CalWORKs PROGRAM SPECIALISTS

REASON FOR THIS TRANSMITTAL

- ☐ State Law Change
☐ Federal Law or Regulation
Change
☐ Court Order
☐ Clarification Requested by
One or More Counties
☒ Initiated by CDSS

SUBJECT: TEMP CW 101, CW TEMP 101A, AND NA FORMS: NA 213, NA 274E, NA 300,
AND NA 301

REFERENCE: ALL COUNTY LETTERS 98-35 AND 97-70

This notice transmits copies of the following:

- | | |
|----------------|--|
| • TEMP CW 101 | Immunization Rules Informing Stuffer |
| • TEMP CW 101A | Recommended Immunization Schedules |
| • NA 213 | Deny - Financial Eligibility |
| • NA 274E | Continuation Page – Overpayment Computations |
| • NA 300 | Continuation Page – Recipient Financial Eligibility Test |
| • NA 301 | Continuation Page – Applicant Financial Eligibility Test |

The TEMP CW 101, TEMP CW 101A, and NA forms are provided to the counties to facilitate the continued implementation of the California Work Opportunity and Responsibility to Kids (CalWORKs) Program. Attachment A provides an outline of the attachments and instructions for obtaining camera-ready copies and translations. Attachments B and C contain copies of the above forms and NA forms, as well as forms-specific information, including an outline of the changes. Attachment D contains instructions for the NA forms.

If you have any questions or need further information regarding the forms-related issues in this letter, please contact the following staff regarding the specific program areas:

- This letter and the TEMP CW 101 and TEMP CW 101A: Jackie Shelley at (916) 654-1061 or CALNET 464-1061;
- NA forms: Jill Sevaaetasi at (916) 654-2130 or CALNET 464-2130;
- Asian/Spanish translations: Shirley LuKung at (916) 654-1277 or CALNET at 464-1277.

Sincerely,
***Original document signed by
Charr Lee Metsker on 2/23/99***
CHARR LEE METSKER, Chief
Employment and Eligibility Branch

Attachments

c: CWDA
CSAC

ATTACHMENT A

LIST OF ATTACHMENTS

<u>Attachment</u>	<u>Form Number</u>	<u>Form Name</u>
B	TEMP CW 101	Immunization Rules
	TEMP CW 101A	Recommended Immunization Schedules
C	NA FORMS	Form-Related Information, Outline of Changes, and NA
	Forms:	
	NA 213	Deny - Financial Eligibility
	NA 274E	Continuation Page - Overpayment Computations
	NA 300	Continuation Page - Recipient Financial Eligibility Test
	NA 301	Continuation Page - Applicant Financial Eligibility Test
D	NA FORMS	Instructions

FORMS RELATED INFORMATION

Camera-Ready Copies and Translations

No state-produced stock will be made of any of the materials transmitted in this letter. For camera-ready copies of the English and Spanish versions of the TEMP CW 101, TEMP CW 101A, and the NA forms, counties should call the Forms Management Unit (FMU) at (916) 657-1907 or CALNET 437-1907. If your office has Internet access, you may obtain copies of various forms and Notice of Form Change (GEN 127) from the CDSS web page at <http://www.dss.cahwnet.gov>. To accommodate agencies without Internet access, copies will be available by contacting FMU.

Translations will be available in approximately 30 days. For Chinese, Cambodian, Vietnamese, and Russian versions of the forms, call Language Translation Services (LTS) at (916) 654-1282 or CALNET 464-1282. If you need several forms, please fax your request to (916) 657-3429 or e-mail your request to isu@dss.ca.gov. If your county is on the LTS mailing list, your Forms Coordinator now receives all translations as soon as they become available. Once you have established an e-mail address, please contact FMU by telephone or e-mail at fmu@dss.ca.gov.

IMMUNIZATION STUFFERS:

TEMP CW 101 (1/99), CalWORKs IMMUNIZATION RULES

TEMP CW 101A (1/99), RECOMMENDED IMMUNIZATION SCHEDULES

Overview

- Counties are required to provide information concerning immunization requirements to recipients at recertification and applicants as soon as administratively feasible. For this purpose, the TEMP CW 101 is recommended and the TEMP CW 101A is Required - No Substitute Permitted.
- The TEMP CW 101 is updated and edited slightly to make it more user-friendly for the applicant/recipient.
- The TEMP CW 101A is a new stuffer that is an attachment to the TEMP CW 101. Except for minor format and wording modifications, page 1 of the TEMP CW 101A essentially duplicates the chart in Eligibility and Assistance Standards (EAS) Handbook Section 40-105.

Changes to the TEMP CW 101 include:

- The spelling for the form title is corrected from “CALWORKS” to “CalWORKs.” The first sentence in the “IMMUNIZATION RULES” paragraph is revised to delete the January 1, 1998, start up date, clarify that these rules are required “for cash aid under the California Work Opportunity and Responsibility to Kids (CalWORKs) Program,” and delete the parentheses from the word “immunization(s).” Narrative is added to the last sentence in this paragraph: “...and see the attached page for the recommended immunization schedules.”
- In the “PROOF” section, the first sentence in paragraph 2 is revised to read “...you must submit proof within 45 days after the county notifies you that proof of immunization is required.”
- In the “EXEMPTIONS” section, bullet 2 narrative is revised in the last line to read “...immunizations are against his/her beliefs.”
- In the “FAILURE TO COOPERATE” section, the reference to “pre-school age child(ren)” is changed to “all children under the age of 6.”
- In column 2, the title “MEDICALLY RECOMMENDED IMMUNIZATIONS” replaces the prior title “IMMUNIZATIONS” to parallel narrative in the first paragraph of column 1 that references this list. The abbreviation “DTaP” is added to the second bullet to be consistent with other references.
- In the lower left corner, the title of the form is revised to “(Immunization Rules).”

The TEMP CW 101A

- Narrative is “Required-No Substitute Permitted.”
- Page 1 contains a three-column chart for the “IMMUNIZATIONS CURRENTLY RECOMMENDED FOR CHILDREN UNDER THE AGE OF SIX.”
- Page 2 contains a three-column chart for the “RECOMMENDED IMMUNIZATION SCHEDULE FOR CHILDREN NOT IMMUNIZED IN THE FIRST YEAR OF LIFE.”

ATTACHMENT C

NA FORMS

- NA 213 (1/99) Deny - Financial Eligibility
- NA 274E (1/99) Continuation Page - Overpayment Computations, (for 1-1-98 and after)
- NA 300 (1/99) Continuation Page - Recipient Financial Eligibility Test
- NA 301 (1/99) Continuation Page - Applicant Financial Eligibility Test

EFFECTIVE DATES

All of the forms are effective immediately, subject to availability.

FOR HOLDERS OF THE AFDC NOTICE OF ACTION HANDBOOK

File the English language NA forms and instructions in Section 5 of your AFDC NOA Handbook.
Remove the earlier versions.

DESCRIPTION OF CHANGES

NA 213 (1/99) Deny - Financial Eligibility

- Modified second paragraph to include "Non-Assistance Unit Members" on "Special Needs" line.

NA 274E (1/99) Continuation Page - Overpayment Computations (for 1-1-98 and after)

- Modified computation to remove "Part A Family Gross Income," which deletes the "185% of Needs" test.

NA 300 (1/99) Continuation Page - Recipient Financial Eligibility Test

- Modified computation to remove "Total Gross Income," which deletes the "185% of Needs" test.

NA 301 (1/99) Continuation Page - Applicant Financial Eligibility Test

- Modified second paragraph to include "Non-Assistance Unit Members" on "Special Needs" line.

INSTRUCTIONS FOR NA FORMS

NA 213 (1/99) Deny - Financial Eligibility

Manual form, first page (must be preprinted with the current NA Back).

Use to deny eligibility when income for the family [Assistance Unit (AU)+ Non-Assistance Unit Members] exceeds the basic need standard (AU + Non-AU Members).

The \$90 disregard is per each employed person. In cases where the \$90 disregard is applied to one person's income that is less than \$90, the excess disregard does not carry over to another family member's income.

Complete the entire computation section.

NA 274E (1/99) Continuation Page - Overpayment Computations (for 1-1-98 and after)

Manual form, continuation page, cannot be used alone. This form is used only for overpayments that occurred from 1-1-98 through the present. Use as a second page to the NA 200 to first notify a current recipient of an overpayment. Use as a second page to the NA 290 to first notify a former recipient of an overpayment.

The entire computation must be completed for each month of the overpayment. Attach additional NA 274 Es as needed to show all the months for the same overpayment. A separate NA 274 E must be used each time a subsequent overpayment is discovered and a notice sent.

Section A - Net Countable Income

Subtract either a 40% deduction or actual expenses from the total business income for self-employed recipients. The remainder will be entered further down in the net countable income calculation. The income of both AU and Non-AU members is used when computing the net countable income. Subtract \$225 from the Unearned Disability-Based Income and enter the remainder in the next line titled "Nonexempt Unearned Disability-Based Income." When the \$225 disregard is greater than the Unearned Disability-Based Income, carry the amount down to the second line entitled "Unused Amount of \$225 Disregard." These amounts will be used further in the net countable income calculation.

Section B - Correct Cash Aid Payment

The first computation with "Maximum Aid Payment (MAP) persons and amount" factors in all family members: AU and Non-AU. This also applies to Special Needs (SN). In the comparison, the second MAP and SN only consider the AU members.

Section C - Overpayment

Subtract the correct cash aid amount from the cash aid paid. Then subtract the support payment amount from the cash aid paid and the overpayment is the lesser of the two subtotals.

NA 300 (1/99) Continuation Page - Recipient Financial Eligibility Test

Use as a continuation of a "Page 1" NOA to show how the recipient family's income (AU + Non-AU Members) exceeds eligibility requirements.

Complete the entire computation section. Compare the figure calculated for total net countable income to the figure calculated for Maximum Aid Payment.

Fill in the page number and the number of pages at the bottom of the page.

NA 301 (1/99) Continuation Page - Applicant Financial Eligibility Test

Use as a continuation of a "Page 1" NOA to show how the applicant family's income (AU + Non-AU Unit Members) exceeds eligibility requirements.

The \$90 disregard is per each employed person. In cases where the \$90 disregard is applied to one person's income that is less than \$90, the excess disregard does not carry over to another family member's income.

Complete the entire computation section. Compare the figure calculated for net countable income to the figure calculated for family needs.

Fill in the page number and the number of pages at the bottom of the page.

CalWORKs IMMUNIZATION RULES

IMMUNIZATION RULES

If you are getting cash aid under the California Work Opportunity and Responsibility to Kids (CalWORKs) Program, you must give the county proof that the child(ren) in your family under the age of 6 has received age-appropriate immunizations (shots). See Column 2 for a list of medically recommended immunizations and see the attached page for the recommended immunization schedules.

PROOF

If you are an applicant for CalWORKs, you must provide proof of immunization within 30 days of approval of Medi-Cal or within 45 days from date of application for CalWORKs if you are already getting Medi-Cal.

If you are a current recipient of CalWORKs, you must submit proof within 45 days after the county notifies you that proof of immunization is required. For each child under the age of 6 added to the assistance unit, you must submit proof of immunization within 30 days of the child's approval for Medi-Cal.

If you have a problem getting immunizations for your child(ren), contact your worker immediately.

EXEMPTIONS

A child(ren) is exempt from these immunization regulations if the parent or caretaker relative submits a:

- Written statement that certifies the child(ren) should not be immunized because of medical reasons. The statement must be from their doctor or a health care professional, who works under the supervision of a doctor, and must give the medical condition and if the condition is temporary or permanent.
- Sworn statement that immunizations are against his/her beliefs.

FAILURE TO COOPERATE

If you do not submit proof of immunization for all children under the age of 6 in the assistance unit, your cash aid will be lowered by an amount equal to the share of the cash aid for the parent(s) or caretaker relative(s). Once proof is submitted, the share of cash aid will be restored for the parent(s)/caretaker relative(s).

MEDICALLY RECOMMENDED IMMUNIZATIONS

The Advisory Committee on Immunization Practices, American Academy of Pediatrics, and American Academy of Family Physicians currently recommend the following immunizations for children under age 6:

- Polio
- Diphtheria, tetanus, and pertussis (DTaP or DTP)
- Measles, mumps, and rubella (MMR)
- Varicella Virus Vaccine* (for Chicken Pox)
- Hepatitis B
- Hemophilus influenza type b (for meningitis)

WHERE TO GET IMMUNIZATIONS

- A provider that accepts Medi-Cal
- Your assigned physician in your Medi-Cal managed care plan
- A county public health clinic
- Any other source within your county offering free or low cost immunizations
- A "Child Health and Disability Prevention (CHDP)" provider

HOW TO GET MORE FACTS ABOUT IMMUNIZATIONS

You can call:

- The National Immunization Information Hotline sponsored by the Center for Disease Control (CDC) and the American Social Health Association. Call Monday through Friday between 5 AM and 8 PM:
 - English 1-800-232-2522
 - Spanish 1-800-232-0233
- Your local health department's Immunization Service Program or the CHDP Program (depending on the county) is:

* The vaccination for chicken pox may not be available from all physicians.

If you have any questions, call your worker.

MMUNIZATIONS CURRENTLY RECOMMENDED FOR CHILDREN UNDER THE AGE OF SIX

TYPE OF SHOT	DOSE	RECOMMENDED AT AGE
Polio (or DPV, TOPV, IPV, Sabin, Salk)	1st 2nd 3rd 4th	2 months 4 months 6-18 months Before starting school (4-6 years)
DTaP (DTP) (diphtheria, tetanus, and pertussis)	1st 2nd 3rd 4th 5th	2 months 4 months 6 months 15-18 months Before starting school (4-6 years)
MMR (measles, mumps, and rubella)	1st 2nd	12-15 months Before starting school (4-6 years)
Varicella Virus Vaccine* (or VAR, VZV)(chicken pox)	1st	12-18 months
Hepatitis B	1st 2nd 3rd	At birth - 3 months 1-5 months 6-18 months
Hemophilus Influenzae type b (or Hib)	1st 2nd 3rd 3rd or 4th	2 months 4 months 6 months (<i>may not be required</i>) 12-18 months

Recommended Childhood Immunization Schedule (United States), approved (January, 1998) by the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics, and the American Academy of Family Physicians (AAFP).

(*The varicella virus vaccine is only required for susceptible children, i.e., those who have not had the chickenpox. This vaccine may not be universally available at the present time.)

RECOMMENDED IMMUNIZATION SCHEDULE FOR CHILDREN NOT IMMUNIZED IN THE FIRST YEAR OF LIFE

- This schedule is recommended for children who have not received any immunizations in the first year of life.
- If the child has received some but not all of the recommended immunizations by his or her first birthday, the recommended schedule will depend on which immunizations the child is missing and the child's age.
- A health care provider should be consulted to determine the appropriate immunizations.

VISIT	WHEN	VACCINES WHICH MIGHT BE GIVEN
First Visit		<ul style="list-style-type: none"> • Hepatitis B • DTaP (or DTP) • Hib • Polio (or DPV, TOPV, IPV, Sabin, Salk) • MMR • Varicella (or VAR, VZV) (chicken pox)
Second Visit	1 - 2 months after 1st visit	<ul style="list-style-type: none"> • Hepatitis B • DTaP (or DTP) • Hib • Polio (or DPV, TOPV, IPV, Sabin, Salk)
Third Visit	1 - 2 months after 2nd visit	<ul style="list-style-type: none"> • DTaP (or DTP) • Polio (or DPV, TOPV, IPV, Sabin, Salk)
Fourth Visit	6 months after 3rd visit	<ul style="list-style-type: none"> • Hepatitis B • DTaP (or DTP)

This schedule is approved by the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics, and the American Academy of Family Physicians (AAFP). This schedule will be updated when necessary by the California Department of Health Services, Immunization Branch. (Note: Delays between doses does not require repeating doses or re-starting series. Hib schedules vary by age when series started.)

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

DENY - FINANCIAL ELIGIBILITY

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

Family's Total Earned Income

(Assistance Unit + Non-Assistance Unit Members) . \$ _____

\$90 Disregard for each employed person - _____

Other Nonexempt Income (Assistance Unit + Non-Assistance Unit Members) + _____

(A) Net Countable Income = _____

Family Needs

Basic Need for _____ Persons

(Assistance Unit + Non-Assistance Unit Members) . \$ _____

Special Needs (Assistance Unit + Non-Assistance Unit Members) + _____

(B) Family Needs = _____

Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply; you may review them at your welfare office: MPP 44-207.1.

YOUR HEARING RIGHTS

To Ask For a State Hearing

- You only have 90 days to ask for a hearing. The 90 days started the day after we gave or mailed you this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- Your CalWORKs Child Care benefits will **not** stay the same until your hearing.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child and/or Medical Support: The District Attorney's office will help you collect support even if you are not on cash aid. There is no cost for this help. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They 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 Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950).

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then, send or take this page to:

Your worker will get you a copy of this page if you ask. Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call: 1-800-952-8349.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Child Care

☐ Other (list) _____

Here's why: _____

☐ Check here and add a page if you need more space.

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

NAME _____

ADDRESS _____

☐ I need a free interpreter.
My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My case number: _____

My signature: _____

Date: _____

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES**(Continued)****Overpayment Amount Owed**
(For Overpayments Occurring on or after 1-1-98)Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____**Overpayment Month and Year:** _____

(A) Net Countable Income					
Total Business Income	\$				
Business Expenses					
A. 40% Standard	-				
OR					
B. Actual	-				
Net Earnings from Self Employment	=				
Total Disability-Based Unearned Income (Assistance Unit + Non Assistance Unit Members)	\$				
\$225 Disregard	-				
Nonexempt Unearned Disability-Based Income	=				
OR					
Unused Amount of \$225 Disregard	=				
Total Earned Income	\$				
Net Earnings from Self-Employment (from above)	+				
Subtotal	=				
Unused Amount of \$225 Disregard	-				
Earned Income Disregard 50%	-				
Nonexempt Unearned Disability-Based Income (from above)	+				
Other Nonexempt Income (Assistance Unit + Non-Assistance Unit Members)	+				
Net Countable Income	=				
(B) Correct Cash Aid Payment					
Maximum Aid Payment (# persons) \$ Amount (Assistance Unit + Non-Assistance Unit Members)	()	()	()	()	()
Special Needs (Assistance Unit + Non-Assistance Unit Members)	+				
Net Countable Income	-				
Subtotal A	=				
Maximum Aid Payment (MAP) (Assistance Unit Only)	\$				
Special Needs (Assistance Unit only)	+				
Subtotal B	=				
Correct Cash Aid Amount (Lesser of Subtotal A or B)	\$				
(C) Overpayment					
Cash Aid Paid to You	\$				
Correct Cash Aid Amount	-				
Subtotal C	=				
Cash Aid Paid to You	\$				
Support Payments Collected for You	-				
Subtotal D	=				
Amount of Overpayment for Each Month (Lesser of Subtotal C or D)	=				

Total Overpayment (All Months) \$ _____**Rules:** These rules apply; you may review them at your
Welfare Office: MPP 44-352.12**State Hearing:** If you think this action is wrong, you can ask for
a hearing. The back of Page 1 tells how.

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

(Continued)

RECIPIENT - FINANCIAL ELIGIBILITY TESTS

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

You are ineligible because your **Total Net Countable Income** is more than your **Maximum Aid Payment**.

Net Countable Income

Total Business Income \$ _____

Business Expenses:

a. 40% Standard - _____

OR

b. Actual - _____

Net Earnings from Self-Employment = _____

Total Disability-Based Unearned Income (Assistance

Unit + Non-Assistance Unit Members) \$ _____

\$225 Disregard - _____

Nonexempt Unearned Disability-Based Income = _____

OR

Unused Amount of \$225 Disregard = _____

Total Earned Income \$ _____

Net Earnings from Self-Employment (from above) + _____

Subtotal = _____

Unused Amount of \$225 Disregard - _____

Subtotal = _____

Earned Income Disregard 50% - _____

Subtotal = _____

Nonexempt Unearned Disability-Based Income

(from above) + _____

Other Nonexempt Income (Assistance Unit +

Non-Assistance Unit Members) _____ + _____

+ _____

Child Support collected by the County, Except for Maximum

Family Grant child (for financial eligibility only) + _____

Total Net Countable Income = _____

Maximum Aid Payment

Maximum Aid for _____ Persons (Assistance Unit + Non-

Assistance Unit Members) \$ _____

Special Needs (Assistance Unit + Non-Assistance Unit

Members) + _____

Maximum Aid Payment = _____

Rules: These rules apply; you may review them at your welfare office: MPP 44-207.2

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of page 1 tells how.

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES

(Continued)

APPLICANT - FINANCIAL ELIGIBILITY TEST

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

You are ineligible because your **Net Countable Income** is more than your **Family Needs**.

Family's Total Earned Income (Assistance Unit +
Non-Assistance Unit Members) \$ _____
\$90 Disregard for each employed person - _____
Other Nonexempt Income (Assistance Unit +
Non-Assistance Unit Members) + _____
Net Countable Income = _____

Family Needs

Basic Need for _____ Persons (Assistance Unit +
Non-Assistance Unit Members) \$ _____
Special Needs (Assistance Unit + Non-Assistance
Unit Members) + _____
Family Needs = _____

Rules: These rules apply; you may review them at your welfare office; MPP 44-207.1

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of page 1 tells how.