STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-2214

July 31, 1984

ALL-COUNTY LETTER NO. 84-81

TO: ALL-COUNTY WELFARE DIRECTORS

SUBJECT: REVISED MODIFICATION POLICY FOR FOOD STAMP REPAYMENT FORMS

REFERENCE: ACL 84-37, DATED MARCH 19, 1984

The purpose of this letter is to provide a revised policy for county modification of the recently implemented Food Stamp Repayment forms (DFA 377.7B and DFA 377.7C). This policy has been revised in response to counties expressing a need to modify the forms which were previously designated as no substitutes.

The Food Stamp Policy Implementation Bureau has carefully reviewed the county modification requests and identified those modifications which can be permitted. Each suggestion was evaluated against the following criteria: the change would provide additional useful information to the household and would not reduce the amount or specificity of information provided to the household on the state forms; or would provide additional administrative flexibility to the CWD; and, is within the constraints and meets the intent of the regulations.

The allowable modifications provided in the attachment are not required changes to the forms, however, they are the only allowable changes at this time. A CWD is encouraged to make these changes if they will meet the specific needs of the individual CWD. Those CWDs with other needs and/or other suggestions should submit this information for our review. To the extent that these suggestions have statewide applicability, all CWDs will be advised of the approval of other modifications.

Suggestions should be accompanied with sufficient explanation to allow evaluation against the above described criteria and should be sent to:

George Christie, Chief
Food Stamp Policy Implementation Bureau
744 P Street - M.S. 15-52
Sacramento, CA 95814

We have determined that state revision of these forms is not necessary at this time. It is our intent to carefully review all county suggestions concerning the forms and the regulations which they reflect so that all necessary changes can be made in one future revision.

Please note that All County Letter 84-47, dated April 19, 1984, transmitted additional information concerning notice requirements when the amount of allotment reduction changes. Essentially, the amount of reduction changes only if the amount of the allotment changes. MPP Section 63-504.26 prescribes that a Notice of Change (DFA 377.4) shall be provided whenever a household's benefits change during the certification period. The revised instructions for the DFA 377.4 (provided with ACL 84-47) therefore include the following instructions for notice of allotment change: If the household is repaying a claim through allotment reduction (intentional program violation or inadvertent household error) the amount entered should reflect the actual allotment the household will receive. The explanation for the change should include the reasons for the change in benefits as well as the effect on the amount of allotment reduction.

Should you have any questions please contact Chris Gomez, Food Stamp Policy Implementation Bureau at (916) 445-6907.

Robert Lestich

KYLE S. McKINSEY
Deputy Director

Attachment

cc: CWDA

# Revised Modification Policy
# DFA 377.7B (3/84), DFA 377.7C (3/84)

Modification may be made to the DFA 377.7B (3/84) and DFA 377.7C (3/84) as described below. This policy will remain in effect until further notice.

## DFA 377.7B, Food Stamp Repayment Notice

The following sentence may be added to the form to clarify that the amount of benefit reduction is subject to change. The appropriate placement of this sentence is indicated on the attached form by the number 1.

1. This amount may change if you report a change in circumstances that affects your monthly allotment.

## DFA 377.7C, Food Stamp Repayment Agreement

The following items may be added to the form to promote appropriate completion of the form (2); to clarify that the amount of the benefit reduction is subject to change (3); and, to clarify that the ending date of repayment may change if the amount of benefit reduction changes (4).

2. Repayment by this method will be based on the terms checked below:

   /__/ At least 10% of your monthly allotment or $10 each month, whichever is greater.

   /__/ At least 20% of your monthly allotment or $10 each month, whichever is greater.

   /__/ Discussion with you about the amount to be repaid.

3. (based on the Terms and Conditions above)

4. ...., or until fully paid if the monthly amount of reduction changes.

In addition, under Terms and Conditions, number 3 Benefit Reduction, "At least" may be omitted from the two check-box statements. Based on additional clarification received from FNS, the formulas for benefit reduction represent maximums. If a household wishes to repay an amount each month greater than the formula provides, an additional repayment method, such as installments, will have to be used. Elimination of these words from the form is not critical as long as each CWD correctly applies the policy in this area.

To further reinforce that the initial amount of benefit reduction specified in number 3 of the Agreement is subject to change based on the Terms and Conditions of benefit reduction, the words "each month" may be deleted from the benefit reduction statement in the Agreement section (see attached sample).

# FOOD STAMP REPAYMENT NOTICE

Case Name:
Case Number:
District:
Worker:
Phone:
Date of Notice:

## EXTRA FOOD STAMPS WERE ISSUED

☐ After reviewing your food stamp file, we found you received more food stamps than you were entitled to receive.

☐ After reviewing the food stamp file for ______________________________, whom you sponsor, we found he/she received more food stamps than he/she was entitled to receive.

The extra food stamps were issued because:

## THIS IS WHAT YOU OWE

$ ____________ in extra food stamps were issued for the period ______________________________________.
This amount was reduced by $ ____________ because we owed the household benefits from past months or we received repayment of part of the amount owed. You now owe $ ____________.

*If you believe that the amount you owe is wrong, you may request a state hearing, unless you already had a hearing on the amount you owe.*

## THIS IS WHAT YOU MUST DO

☐ You must repay the extra food stamp benefits. Please complete the attached Repayment Agreement, sign and return it to the County Welfare Department.

☐ If you do not return an acceptable Repayment Agreement within 30 days after the date of this notice, your household's food stamp benefits will be reduced to $ ____________ effective ____________________.

## YOU DID NOT REPAY AS AGREED

☐ You must contact us to explain why you did not repay food stamp benefits as you agreed. If you can no longer afford to pay the amount due as agreed, you may ask to renegotiate your agreement.

☐ If we do not hear from you within 10 days of the date of this notice, your household's food stamp benefits will be reduced to $ ____________ effective ____________________.

The above action is required by the following Food Stamp Manual Section(s):

| | | |
|---|---|---|
| If you have any questions, please contact me: | Name | Phone Number |

You have the right to request a state hearing if you believe this action is wrong. See the back of this notice for a state hearing request.

# Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county or adoption worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

**FOOD STAMPS AND CASH AID†: If this action stops or reduces your food stamps or cash aid and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.**

### Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

### How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

**Office of the Chief Referee**
**State Department of Social Services**
**744 P Street, Mail Station 6-100**
**Sacramento, CA 95814**

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

**Public Inquiry and Response (Public Information)**

**Toll-Free Number: (800) 952-5253***

For the Deaf Only TDD (800) 952-8349*

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

## Request for a State Hearing

Name ____________________ Phone number ( )

Address ____________ City ____________ State ____________ Zip Code ____________

I am requesting a state hearing because of an action by the welfare department of ____________ county related to my family's: ☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Adoption Assistance Program Payments

Reasons for my request:

____________________

____________________

____________________

____________________

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language ____________ Dialect ____________

†If you request a state hearing and your benefits continue unchanged, the county can recover as an overpayment the cash aid and value of food stamps the hearing decision finds you were not eligible for. If you remain eligible to receive cash aid after the hearing, and you have no other income or resources, your grant will be reduced by 10% each month until the full amount of such overpayment is collected. If you do have other income or available property, the amount your grant will be reduced each month will be greater.

Check here if you want your benefits reduced or discontinued now, as described in this Notice of Action.

☐ Cash Aid ☐ Food Stamps

If you checked the box(es) and the hearing decision is in your favor, any lost benefits will be made up.

Signature ____________________ Date ____________

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority W&IC 10950.



88746-880 3-84 50M OSP

# FOOD STAMP REPAYMENT AGREEMENT

| | |
|---|---|
| Case Number | |
| Worker | |
| Case Name | |

Name ______________________

Address ______________________

## TERMS AND CONDITIONS

You must repay extra food stamp benefits in one or a combination of the methods described below:

1. Lump Sum Payment — You may repay all or part of the amount owed at one time with cash and/or coupons, including returning coupons already received.
2. Installments — You may repay all or part of the amount owed in monthly installments with cash and/or coupons, including returning coupons already received. 2
3. Benefit Reduction — If you are currently receiving food stamps, you may repay by having your household's benefits reduced for all or part of the amount owed. Repayment by this method will be based on the terms checked below:
   - ☐ ~~At least~~ 10% of your monthly allotment or $10 each month, whichever is greater.
   - ☐ ~~At least~~ 20% of your monthly allotment or $10 each month, whichever is greater.
   - ☐ Discussion with you about the amount to be reduced.
4. Court-Ordered Repayment
   - ☐ The court ordered that you repay as indicated below. These repayment terms cannot be changed by you or by the County.

If we have not already contacted you to discuss the terms of this Agreement, or if you have any questions about this form, please contact me: ______________________ at (phone number) ______________

## AGREEMENT

I, ______________________, the undersigned, understand this Agreement is entered into between me and ______________________ County because extra food stamps in the amount of $ ____________ were issued. I agree to repay this amount to the County by the method(s) checked below:

1. Lump Sum Payment
   - ☐ Repay by a lump sum cash payment of $ __________ due on ______________.
   - ☐ Repay by a lump sum coupon payment of $ __________ due on ______________.
2. Installments
   - ☐ Repay by monthly cash payments of $ __________ due on the __________ day of each month beginning ______________ through ______________.
   - ☐ Repay by monthly coupon payments of $ __________ due on the __________ day of each month beginning ______________ through ______________.
3. Benefit Reduction 3
   - ☐ Repay by having my household's benefits reduced by $ __________ ~~each month~~, beginning __________ through ______________. 4

I understand that if my circumstances change, I may ask the County to reconsider the terms checked above. I understand that if I cannot reach an agreement with the County, I may ask for a state hearing.

Signed by ______________________ on ______________ at
(Date)

______________________ County, California.

After completing and signing this Agreement, return all copies to the County Welfare Department in the envelope provided. Do not send cash or coupons through the mail with this Agreement. When accepted by the County, a signed copy of this Agreement will be sent to you. A request for a State Hearing is on the back of the Food Stamp Repayment Notice sent to you with this Agreement.

### COUNTY USE ONLY

The above signed Agreement has been accepted by ______________________ on ______________
(Date)

for ______________ County. Payments should be made at:

______________________
(Signature of Authorized County Official)