

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



March 4, 1999

ALL-COUNTY LETTER NO. 99-11

TO: ALL-COUNTY WELFARE DIRECTORS
 ALL COUNTY FISCAL OFFICERS
 ALL COUNTY AUDITOR CONTROLLERS
 ALL COUNTY PROBATION OFFICERS

Reason For This Transmittal

- State Law Change
- Federal Law or Regulation Change
- Court Order or Settlement Agreement
- Clarification Requested by one or More Counties
- Initiated by CDSS

SUBJECT: CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI)
 STATE INTERIM ASSISTANCE REIMBURSEMENT

REFERENCE: AB 2779, ACL 98-82

BACKGROUND

The purpose of this letter is to provide authorization for counties to claim interim assistance reimbursement (IAR) from the state in certain situations when CAPI benefits are awarded retroactively. The state IAR program for CAPI will operate in a manner similar to the federal IAR program for the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program currently used by the Social Security Administration (SSA). Except as otherwise provided in this ACL or future instructions, the federal regulations governing the federal IAR program for SSI/SSP (20 Code of Federal Regulations [CFR] 416.1901 through 416.1922) will also govern the state IAR program for CAPI. There is no need for a separate interim assistance agreement between the state and the counties as indicated in 20 CFR 416.1910. Instead, counties must follow all instructions found in this and any subsequent ACL or future regulations in order to claim state IAR.

DEFINITION

Interim assistance, for purposes of state reimbursement, means any financial assistance the county provides to the CAPI applicant during the period beginning with the first month of CAPI eligibility, and ending with, and including, the month that the individual's CAPI payments begin. Interim assistance can be paid during the time an individual's initial application is pending, or during a period of CAPI payment suspension prior to reinstatement. December 1, 1998 is the earliest beginning date for which counties can claim state IAR. Counties will be reimbursed for interim assistance costs incurred beginning with the recipient's first month of CAPI eligibility. The interim financial assistance will typically be county-funded General Assistance (GA) or General Relief (GR), and does not include any payments financed wholly or partly with federal or state funds.

COUNTY AND CONSORTIUM RESPONSIBILITIES

County That Is Not Part Of A Consortium

In order for a county to receive state IAR, the county must do all of the following:

- Obtain a signed IAR Authorization (SOC 455 attached) from the GA applicant.
- Submit the signed SOC 455 to the county agency or unit responsible for determining CAPI eligibility and benefit amount (CAPI unit).
- After determining CAPI eligibility and payment amount, the CAPI unit must obtain the amount of interim assistance paid.
- The CAPI unit will then issue, or request issuance of, a net retroactive CAPI payment (after withholding the IAR owed to the county) directly to the recipient within 10 days of the date CAPI eligibility and payment amount have been determined.¹
- Not delay issuance of a CAPI check solely to obtain a signed SOC 455.
- Include the IAR paragraphs shown below (under Notice of Action) on the approval notice to the applicant or recipient.

County That Is Part Of A Consortium.

The county requesting IAR must:

- Obtain a signed IAR Authorization (SOC 455 attached) from the GA applicant.
- Submit the signed form to the consortium.
- Furnish the amount of interim assistance to the consortium in a timely manner.

The consortium must:

- Notify the county requesting IAR as soon as CAPI eligibility is determined, and obtain the amount of the interim assistance.
- Notify the county requesting IAR of CAPI ineligibility when an application is denied.
- Issue, or request issuance of, the net retroactive CAPI payment (after withholding the IAR owed to the county) directly to the recipient within 10 days of the date CAPI eligibility and payment amount have been determined.¹
- Not delay issuance of a CAPI check solely to obtain a signed SOC 455.
- Include the IAR paragraphs shown below (under Notice of Action) on the approval notice to the applicant or recipient.
- Ensure that the county requesting IAR that has met its responsibilities as outlined above is reimbursed for the interim assistance it provide to the applicant or recipient.

¹ The county or consortium may issue its own CAPI payment or request the state to issue them on its behalf. In either case, the signed IAR form should be sent to the county department or consortium responsible for determining CAPI eligibility and payment amount.

NOTE: For CAPI applications filed prior to the issuance of this letter, counties were required to obtain both: 1) the SSP 14 or replacement form authorizing SSA to reimburse from the individual's SSI/SSP check to the county for GA expenditures made during the SSI/SSP eligibility period, and 2) the IAR part of CAPI form SOC 451 authorizing SSA to reimburse from the individual's SSI/SSP check to the county, on behalf of the state, for CAPI expenditures made during the SSI/SSP eligibility period. This was an interim process that is now obsolete.

CLAIMING INSTRUCTIONS

County Fiscal Letter 98/99-53 will be released in the near future which will provide instructions for claiming the IAR payment.

NOTICE OF ACTION (Approval Language)

The following paragraphs are to be used as part of the approval notice when the county or consortium is authorizing IAR withholding from a retroactive CAPI payment:

“You have been found eligible for CAPI benefits in the amount of \$ _____ for the period _____ through _____. Out of this amount, we have withheld \$ _____ for the months of _____ through _____ to repay (name of county). You agreed in writing to have all or part of your first retroactive CAPI payment sent to that county because they paid you for the months of _____ while you were waiting for CAPI benefits. You will therefore receive an initial net CAPI payment of \$ _____. After this initial payment, your continuing CAPI payment will be \$ _____ per month.

If you believe that (county) paid you less than \$(amount of CAPI benefit withheld) for that period, please contact that county.”

Any questions regarding this information should be directed to your Operations Analyst in the Adult Programs Management Bureau, at (916) 229-4000.

Sincerely,

**Original Document Signed by
Donna L. Mandelstam on 3/4/99**

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

CASH ASSISTANCE PROGRAM FOR IMMIGRANTS STATE INTERIM ASSISTANCE REIMBURSEMENT AUTHORIZATION

NAME (PLEASE PRINT)

SOCIAL SECURITY NUMBER

I have applied for public assistance in _____ County. I understand that if I apply for benefits under the Cash Assistance Program for Immigrants (CAPI), any public assistance paid on my behalf by the county after I file a CAPI application and while my eligibility for CAPI benefits is being determined is considered interim assistance. (Assistance financed in any part with federal or state funds will not be considered interim assistance.)

In consideration of any interim assistance paid on my behalf, I authorize the entity responsible for determining CAPI eligibility and benefit amounts to reimburse the county by deducting from my first CAPI payment the amount of interim assistance paid on my behalf during my CAPI eligibility period. The amount to be reimbursed to the county shall be deducted from my first CAPI payment and shall not exceed the amount of that payment.

Initial Claim beginning with the month for which I am found eligible for a CAPI payment and ending with the month my CAPI payments begin;

or

Post Eligibility beginning with the month for which my CAPI payments are reinstated after a period of suspension or termination and ending with the month my payments resume.

I understand that after deducting the amount of the reimbursement to the county, the entity responsible for determining CAPI eligibility and benefit amounts will issue, or request issuance of, a payment for any balance due on my behalf immediately. The responsible entity will issue, or request issuance of, this CAPI payment no later than ten (10) working days from the date it makes the determination of my CAPI eligibility and benefit amount.

I understand that if I feel that the amount deducted from my CAPI retroactive payments is more than the amount of public assistance paid on my behalf by _____ county, I have a right to request a fair hearing from the California Department of Social Services. If I desire a fair hearing, I must file a request for a fair hearing within ninety (90) days after the date my initial Notice of Approval was issued.

I understand that this authorization is effective immediately and that it will cease to have effect:

Initial Claim at the end of one (1) year from the date the entity responsible for determining CAPI eligibility and benefit amounts receives this signed form, unless I file for CAPI within that time, or one of the events listed below occurs earlier, in which case the authorization will cease to have effect as of the date of such event:

- The State makes an initial payment or reinstates payment on my claim;
- The State denies my claim and I do not file a timely appeal of that determination;
- The county and I agree to terminate this agreement.

or

Post Eligibility at the end of one (1) year from the date the entity responsible for determining CAPI eligibility and benefit amounts receives this signed form or at the end of the maximum period within which to request review of the determination to suspend or terminate my CAPI payments, whichever period of time is longer, unless I file a timely request for review, or one of the events listed above occurs in which case the authorization will cease to have effect as of the date of such event.

I declare under penalty of perjury under the laws of the State of California that the information I have given on this form is true, correct, and complete.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE

DATE SIGNED