

**NOTICE OF FORM CHANGE NO. 04-031**

DATE

02-06-2004

**TO:**  
County Welfare Director  
Supply Clerk / Forms Coordinator

**FROM:**  
Forms Management Unit  
(916) 657-1907

- Community Care Licensing District Offices  
 Private and Public Adoption Agencies

- District Attorney  
 Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE NA 991 (10/03) English and Spanish

Notice Of Action - Refugee Cash Assistance/Entrant Cash Assistance Time Expiration

ORDER UNIT <b>MASTER ONLY</b>	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 10/03	REPLACES 5/03	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input type="checkbox"/> No Change Permitted	REQUIRED FORM- <input checked="" type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: <b>Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788</b>		<input type="checkbox"/> Other:	

**FORMS DISPOSITION AND SPECIAL INSTRUCTIONS**

DISPOSITION OF OLD SUPPLY

- Use until exhausted  Destroy

USE NEW FORM

- When supply available in DSS Warehouse  Use new form effective 10/03

USE FORM IN ACCORDANCE WITH

- All County Letter No.  
 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Print form: 8 1/2 x 11, two sided, NA BACK 9.

Check on the internet to see if forms are available at [www.dss.cahwnet.gov](http://www.dss.cahwnet.gov)

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov). Contact Language Services for other languages at (916) 445-6778 or by electronic mail at [LTS@dss.ca.gov](mailto:LTS@dss.ca.gov).

# Notice of Action

## Refugee Cash Assistance (RCA)/Entrant Cash Assistance (ECA) MC-Decrease/Expiration (Time-Expiration)

If you have questions or want more information about this notice, please contact your worker.

Case Name:  
Case Number:  
Worker:  
Phone:  
Date:

Your monthly aid payment received under the Refugee Resettlement Program or Cuban/Haitian Entrant Program will be decreased from \$\_\_\_\_\_ to \$\_\_\_\_\_ on the effective date shown below. Your aid payment is based on the number of persons in your household, and the following persons will be discontinued from cash aid and cash-based Medi-Cal effective \_\_\_\_\_  
Persons: \_\_\_\_\_

		Net Nonexempt Income Computation		Name	Name	Name
Total Earned Income						
Disability Unearned Income		-				
225+ 50% Disregard		-				
Subtotal		=				
Other Unearned Income _____		+				
		+				
		+				
Net Nonexempt Income		-	<b>• Net Nonexempt Income</b>	=		
Total Grant		=				
Overpayment Adjustment (see page _____)		-	or			
Monthly Aid Payment		=	<b>• Net Nonexempt Income Total (columns 1 + 2 + 3)</b>			

### Computation Of Monthly Aid Payment

Maximum Aid Payment for \_\_\_\_\_ Persons \_\_\_\_\_  
Special Needs (Specify) \_\_\_\_\_ + \_\_\_\_\_  
\_\_\_\_\_ + \_\_\_\_\_  
Net Nonexempt Income - \_\_\_\_\_  
Total Grant = \_\_\_\_\_  
Overpayment Adjustment (see page \_\_\_\_\_) - \_\_\_\_\_  
Monthly Aid Payment = \_\_\_\_\_

- Your monthly aid payment and cash-based Medi-Cal received under the Refugee Resettlement Program or Cuban/Haitian Entrant Program will be discontinued effective \_\_\_\_\_.
- You will receive a separate Notice of Medi-Cal-Only eligibility.
- Other Medi-Cal Action: \_\_\_\_\_

### Reason:

These changes are required by Federal regulations which limit refugee/entrant aid payments and cash-based Medi-Cal eligibility to 8 months from the person's month and year of entry into the United States as a refugee, the date asylum was granted, or the date of certification as a trafficking victim. It has been determined from a review of immigration documents that you or the persons named above will have exceeded this period of eligibility on the effective date shown above.

### Laws requiring this action:

Section 412 of the Refugee Act of 1980 (Public Law 96-212) or Section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-422), as implemented by 45 CFR parts 400 and 401; 45 CFR 205.10; California Code of Regulations, Title 22, Sections 50183(a)(3) and 50227.

### Comments:

You or the persons discontinued may be eligible for further cash aid through other aid programs. Please contact your County Welfare Department for more information. Refugees/Entrants receiving aid payments under the CalWORKs Program are not affected by this notice or the 8-month eligibility time limit.

State welfare regulations are available for review at the local office of the County Welfare Department.

Information about family planning services is available from the County Welfare Department on request.

**State Hearing. If you are dissatisfied with this action, your aid may continue unchanged if you ask for a State Hearing before the effective date of the action. Read the back for important information about your right to appeal this action.**

## YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got.

To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop:  Cash Aid  Food Stamps  Child Care

While You Wait for a Hearing Decision for:

### Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

### Cal-Learn:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

**Medi-Cal Managed Care Plan Members:** The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but 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 Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

## TO ASK FOR A HEARING:

- Fill out this page.
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- Send or take this page to:

OR

- Call toll free: 1-800-952-5253 or for hearing or speech impaired who use TDD, 1-800-952-8349.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

### HEARING REQUEST

I want a hearing due to an action by the Welfare Department of \_\_\_\_\_ County about my:

Cash Aid  Food Stamps  Medi-Cal

Other (list) \_\_\_\_\_

Here's Why: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you need more space, check here and add a page.

I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: \_\_\_\_\_

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

SIGNATURE

DATE

NAME OF PERSON COMPLETING THIS FORM

PHONE NUMBER

I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

# Notificación de acción

## Reducción/Descontinuación de beneficios por vencimiento del período de elegibilidad para el Programa de Asistencia Monetaria para Refugiados (RCA)/Asistencia Monetaria para Entrantes (ECA) y el Programa de Asistencia Médica de California (Medi-Cal)

Si usted tiene preguntas o desea más información acerca de esta notificación, por favor, comuníquese con su trabajador.

Nombre del caso:  
 Número del caso:  
 Trabajador:  
 Teléfono:  
 Fecha:

Su pago mensual de asistencia proveniente del Programa para Relocalizar a Refugiados o del Programa para Entrantes Cubanos/ Haitianos se reducirá de \$\_\_\_\_\_ a \$\_\_\_\_\_ a partir de la fecha que aparece abajo. Su pago de asistencia está basado en el número de personas en su hogar, y a las siguientes personas se les discontinuará la asistencia monetaria y el Medi-Cal basado en asistencia monetaria a partir de\_\_\_\_\_. Personas:\_\_\_\_\_

Cálculo del pago mensual de asistencia		Cálculo de los ingresos netos no exentos			
			Nombre	Nombre	Nombre
Pago máximo de asistencia para _____ personas	_____	Total de ingresos ganados			
Necesidades especiales (especifique) _____	+ _____	Ingresos por incapacidad/discapacidad no ganados	-		
	_____	Deducción de \$225 + 50%	-		
Ingresos netos no exentos	- _____	Subtotal	=		
Total del pago mensual	= _____	Otros ingresos no ganados _____	+		
Ajuste por pago excesivo (vea la página _____)	- _____		+		
Pago mensual de asistencia	= _____	<b>• Ingresos netos no exentos</b>	=		
		o			
		<b>• Total de ingresos netos no exentos (Columnas 1 + 2 + 3)</b>			_____

- Su pago mensual de asistencia y su Medi-Cal basado en asistencia monetaria provenientes del Programa para Relocalizar a Refugiados o del Programa para Entrantes Cubanos/Haitianos se discontinuará a partir de \_\_\_\_\_.
- Usted recibirá por separado una notificación de elegibilidad solamente para Medi-Cal.
- Otra acción respecto a Medi-Cal: \_\_\_\_\_

**Razón:**  
 Estos cambios se requieren por ordenamientos federales que limitan los pagos de asistencia a refugiados/entrantes, así como la elegibilidad para Medi-Cal basado en asistencia monetaria, a 8 meses a partir del mes y año de entrada de la persona a los Estados Unidos como refugiado, la fecha en que se le otorgó el asilo, o la fecha de certificación como una víctima de traficantes. Se ha determinado, por medio de una revisión de documentos de inmigración, que usted o las personas indicadas arriba habrán excedido este período de elegibilidad empezando en la fecha que aparece arriba.

**Leyes que requieren esta acción:**  
 La Sección 412 del Decreto sobre Refugiados de 1980 (Ley Pública 96-212) o la Sección 501 del Decreto sobre la Asistencia Educacional para Refugiados de 1980 (Ley Pública 96-422), de la manera puesta en vigor por las partes 400 y 401 del Código de Ordenamientos Federales (CFR) 45 y 205.10 del CFR 45; Secciones 50183(a)(3) y 50227 del Título 22 del Código de Ordenamientos de California.

**Comentarios:**  
 Es posible que usted o las personas discontinuadas reúnan los requisitos para más asistencia monetaria a través de otros programas de asistencia. Para más información, por favor, comuníquese con el departamento de bienestar público del condado. Los refugiados/entrantes que reciben pagos de asistencia bajo el Programa de CalWORKs (Programa de California de Oportunidades de Trabajo y Responsabilidad hacia los Niños) no son afectados por esta notificación ni por el límite de elegibilidad de 8 meses.  
 Los ordenamientos de bienestar público del Estado están disponibles para revisión en la oficina local del departamento de bienestar público del condado.

Hay información disponible respecto a los servicios de planificación familiar en el departamento de bienestar público del condado si usted la pide.  
**Audiencia con el Estado: Si usted no está satisfecho con esta acción, es posible que su asistencia continúe sin cambio si pide una audiencia con el Estado antes de que la acción entre en vigor. Lea la siguiente página para más información importante sobre su derecho a apelar esta acción.**

