NOTICE OF FORM CHANGE NO. 04-162

DATE: 06/16/2004

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices ☐ District Attorney
☐ Private and Public Adoption Agencies ☐ 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: SOC 451 (8/02) Cash Assistance Program For Immigrants Interim Assistance Reimbursement Authorization

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☐ Revised	DATE OF FORM: 8/02	REPLACES	☐ Obsolete

REQUIRED FORM-
☐ No Change Permitted ☒ Substitute Permitted With Prior DSS Approval ☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ 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 _____

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE
Attached is a Reproducible Copy

Due to low usage this will now be a Master Only form.

Check on the internet to see if forms are available at 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. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

CASH ASSISTANCE PROGRAM FOR IMMIGRANTS
INTERIM ASSISTANCE REIMBURSEMENT AUTHORIZATION

NAME	SOCIAL SECURITY NUMBER

I understand that the state-funded, Cash Assistance for Immigrants (CAPI), assistance authorized or paid to me, or on my behalf,

by_____County (DPSS) is considered interim assistance if it is paid during the period of time that my Supplemental Security Income/State Supplementary payment (SSI/SSP) eligibility is being determined. (Assistance financed wholly or partly with Federal Funds shall not be considered interim assistance.)

In consideration of such interim assistance paid to me, or on my behalf, I authorize the Commissioner of the Social Security Administration (SSA) to send the first payment of any SSI/SSP benefits, for which I may be determined eligible to the above agency.

I authorize the above agency to retain from that payment an amount equal to the sum of CAPI assistance payments the above agency and other California Interim Agencies paid to me, or on my behalf, to meet my basic needs both before and after the date of this authorization, but limited to the period of my SSI/SSP eligibility.

☐ Initial Claim — beginning with the month for which I am found eligible for an SSI/SSP payment and ending with the month my SSI/SSP payments begin;

or

☐ Post Eligibility — beginning with the month for which my SSI/SSP payments are reinstated after a period of suspension or termination and ending with the month my payments resume.

I understand that, after making the above deduction from my SSI/SSP payments, the above agency shall pay to me the balance, if any, no later than ten (10) working days from the day the above agency receives my payment from SSA.

I understand that, if I feel that the amount deducted from my SSI/SSP retroactive payments is more than the amount of CAPI | assistance paid to me, or on my behalf by the agency, or I feel the above agency failed to pay me the excess within the ten (10) day period, I have a right to request a fair hearing from the State Department of Social Services. This request must be filed within ninety (90) days of the date the above agency notifies me of the receipt and disbursement of the payment.

I understand that if I file an initial claim for SSI/SSP benefits at a Social Security office within 60 days of the date the above agency receives this signed form, my eligibility for SSI/SSP benefits may begin as early as the date the above agency receives this signed form.

I understand that this authorization is effective from the date the above agency receives this signed form and that it will cease to have effect:

☐ Initial Claim — at the end of one(1) year from the date the above agency receives this signed form, unless I file for SSI/SSP 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:

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

or

☐ Post Eligibility — at the end of one (1) year from the date the above agency 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 SSI/SSP 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 United States of America and 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
SIGNATURE OF IA AGENCY REPRESENTATIVE	**PHONE**	**DATE SIGNED**