NOTICE OF FORM CHANGE NO. 05-132

DATE: 10/6/2005

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: SSP 17
Notice of Hearing and Right to Request a State Hearing on Interim Assistance

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☐ Revised	DATE OF FORM: 4/99	REPLACES	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted
REQUIRED FORM-
☐ 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
Master only, use up supply of stock.

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.

NOTICE OF ACTION AND RIGHT TO REQUEST A STATE HEARING ON INTERIM ASSISTANCE

State No.:
County No.:
Worker No.:
District:
Date:
Case Name:
Interpreter Needed: _____ (Language) _____ (Dialect)

This office received on _____ a Supplemental Security Income/State Supplementary Program (SSI/SSP) payment for you in the amount of $ _____ , for the period _____ through _____. As per your agreement, we are sending you the balance of $_____ after deducting the amount of $_____ , to repay the amount of assistance you received from Interim Assistance for that same period while Social Security Administration (SSA) completed the work on your eligibility determination for SSI/SSP benefits.

SSI/SSP PAYMENT

If you disagree with the amount of the SSI/SSP payment of $_____, contact your local Social Security Office. The amount of the total SSI/SSP payment is subject to the SSA appeal process. A request for reconsideration must be filed within 60 days after the date the notice of the initial determination is received.

INTERIM ASSISTANCE PAYMENT

If you disagree with the amount of Interim Assistance withheld from your SSI/SSP payment or you contend that we did not send you the balance, if any, as shown above within the 10 working days, please contact the State Department of Social Services. This action is subject to the state fair hearing provision described on the reverse side of this form.

COMMENTS:

The law and/or regulations governing this action are:

Department of Social Services Eligibility and Assistance Standards Manual Section 46-337

If you have any questions please contact me.

County/State Representative		Agency
Telephone	Date:	

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.

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

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

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

Other Information

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 State Hearing Officer. You have a right to examine the materials that make up the file. Any information you provide may be shared with the departments whose action you are appealing and the U.S. Department of Health and Human Services. Authority: W&IC 10950.

I will bring this person to the hearing to help me
(name and address, if known):

_____

_____

_____

I need an interpreter at no cost
to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature: _____

Date: _____

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to :

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by_____
about the interim assistance said department deducted from my SSI/SSP payment.

Here's why: _____

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