NOTICE OF FORM CHANGE NO. 06-133

DATE: 09/26/2006

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: NA 1217 - CAPI Notice of Overpayment

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 9/06	REPLACES: 7/00	☐ 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 9/06

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

ADDITIONAL INFORMATION REGARDING FORM CHANGE
Attached is a Reproducible Copy

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) 651-8876 or by electronic mail at LTS@dss.ca.gov.

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Cash Assistance Program For Immigrants
Notice of Overpayment

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

We have paid you $ _____ too much Cash Assistance Program for Immigrants (CAPI) benefits. The overpayment happened from _____ (MONTH/YEAR) through _____ (MONTH/YEAR) . You were overpaid because:

The following table shows the incorrect amount you received, the correct amount you should have received for each month, and the total amount to be repaid.

Month(s)/Year	Amount Paid Each Month	Correct Amount Each Month	Underpaid Amount	Overpaid Amount

Total amount of overpayment $ _____

You must pay us back unless we decide that recovery of your overpayment can be waived. If you think you should not have to pay us back or you disagree with the decision about the overpayment, you can ask for a waiver, a hearing, or both.

Repaying The Overpayment

There are two ways to repay the overpayment:

1. You can refund the full amount. Contact your worker to find out how.
2. If you are receiving CAPI now, or will receive CAPI in the future, we can withhold no more than 10 percent of your total income from your monthly CAPI check.

If you are still receiving CAPI, and we do not hear from you in the next 30 days, we will withhold $ _____ per month from your check beginning _____ . If you ask for a waiver or appeal in the next 30 days, we won't change your check until we decide your case.

If You Think You Should Not Have To Repay The Overpayment

Sometimes recovery of an overpayment can be waived, which means that you will not have to pay us back. Recovery of an overpayment can be waived if BOTH of the following are true:

- You were not at fault in connection with causing or accepting the overpayment

AND

- You could not pay your bills for food, clothing, housing, medical care, or other necessary expenses if you had to pay us back.

You can request a waiver by contacting your county worker who will send you the proper forms to fill out and return, or help you complete the forms.

Medi-Cal: This notice does NOT change or stop Medi-Cal benefits. If there is a change in your Medi-Cal benefits, you will receive another notice. **Keep your plastic Benefits Identification Card(s).**

Rules: These rules apply; you may review them at your welfare office: Welfare and Institutions Code Division 9, Part6, Chapter 10.3, Sections 18937 through 18944; 20 CFR 416.558, 20 CFR 416.537(a).

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 <u>before</u> 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:

<u>Welfare to Work</u>:

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.

<u>Cal-Learn</u>:

- 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 <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME	PHONE NUMBER

STREET ADDRESS

CITY	STATE	ZIP CODE