

EMERGENCY ASSISTANCE APPLICATION FOR PROBATION

COUNTY NAME _____

Primary Application Supplemental Application Date of Removal (*Effective Date*) _____

INFORMATION REQUIRED FOR ELIGIBILITY DETERMINATION

Child at Risk	NAME (LAST, FIRST, M.I.)	AKA NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
	NAME (LAST, FIRST, M.I.)		DATE OF BIRTH	SOCIAL SECURITY NUMBER
Related Head of Household	STREET ADDRESS		Telephone Number ()	
	CITY, STATE, ZIP CODE		Child's Case ID Info	CWS Case Name (Last, First, M.I.)
	MAILING ADDRESS IF DIFFERENT THAN ABOVE (ADDRESS, CITY, STATE, ZIP CODE)			CWS CASE NUMBER

CERTIFICATION SECTION (Place an "X" in each applicable box.)

1. Does the emergency meet the definition of Emergency Assistance because of a child's behavior that resulted in the child's removal from the home and a judicial determination that the child must remain in out-of-home care for more than seventy-two (72) hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this application on behalf of a child under age 21 living with, or within the past six months having lived with, a parent/relative? (specify relative) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did the emergency arise because an adult family member refused, without good cause, to accept employment or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the total family income equal to or less than 200% of California's median income for the current state fiscal year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is this application being made by a county worker on behalf of a child whose parents or relatives are unavailable or unwilling to apply for emergency assistance for this child? ..	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Comments _____	

PARENT/RELATIVE SIGNATURE (IF NONE, STATE REASON)	RELATIONSHIP TO CHILD	DATE
COUNTY WORKER SIGNATURE (REQUIRED)	OFFICE	TELEPHONE NUMBER ()
		DATE

ELIGIBILITY WORKER SECTION (Place an "X" or a "Date" in each applicable box.)

7. Reviewed signed application and County Worker certification of emergency

8. The emergency did not arise because an adult family member refused, without good cause, to accept employment or training as certified in Item 3 above

9. This family meets the income criteria for Emergency Assistance as certified by the applicant

10. Emergency Assistance database queried and response received

11. I authorize that from the date of removal stated above, until the case is closed, or for a period not to exceed twelve months from the date of authorization, this family is eligible for all probation assistance and services covered under the California State Plan for Title IV-A Emergency Assistance, as determined to be appropriate and necessary to meet the needs of the family

a. Date services were authorized (*If based on presumptive eligibility, place an "X" in the box*) _____

b. Date of final eligibility determination if authorization in Item 11a was based on presumptive eligibility _____

c. Last date services can be provided under this authorization (*Not To Exceed Date*) _____

12. Date Emergency Assistance was denied (*Specify reason(s) below*) _____

13. Comments _____

ELIGIBILITY WORKER SIGNATURE (REQUIRED)	DATE	SUPERVISOR SIGNATURE AND DATE (OPTIONAL)
OFFICE NAME AND ADDRESS (OPTIONAL)		TELEPHONE NUMBER (OPTIONAL) ()

HOW TO FILE AN APPEAL AND REQUEST A HEARING

The Emergency Assistance (EA) program is a federally funded program under Title IV-A of the Social Security Act which provides funding for assistance and services which can be offered to families in crisis.

Receipt of this form shall constitute a Notice of Action to the parent/relative of the child noted on the reverse side of this form that EA has been applied for and, upon eligibility worker determination, will be authorized or denied.

A copy of the EA application will be mailed to you within thirty (30) calendar days from the date EA is requested. The copy of the application mailed to you will indicate whether EA was authorized or denied for your child. If you as a parent/relative disagrees with the eligibility determination on the application, you may file a request for a hearing with your County Welfare Department (in Los Angeles County, the Department of Children's Services) within fourteen (14) calendar days of the date the EA application (Notice of Action) is received. Upon filling of a request for hearing, the intended action shall be suspended until the review is complete, the appeal process has been exhausted or you abandon the appeal process.

If you want to request a hearing because you are in disagreement with the proposed actions of the County Welfare Department regarding EA requested on behalf of your child, send a copy of the EA application that you disagree with along with a written request for a hearing to your County Welfare Department at:

The hearing will be conducted by an administrative staff person at a level higher in authority than the county worker who made the contested decision. You or your authorized representative are required to attend the hearing. If you or your authorized representative fail to appear at the hearing, you will be deemed to have abandoned your appeal. Only persons directly affected by the hearing will be allowed to attend.

Within ten (10) calendar days following the receipt of your request for a hearing, the County Welfare Department Appeals Section staff will notify you of the time and place of the hearing. The time and place of the hearing shall, to the extent possible, be convenient for you.

The county will arrange for the presence of an interpreter at the hearing, if one is requested by you.

At the hearing the legal, regulatory, or policy basis for the intended action will be explained to you. During the hearing, you will have an opportunity to explain the reason(s) you believe the County Welfare Department's decision is incorrect. The County Welfare Department's staff will present any material facts omitted by you. A written decision will be mailed or delivered to you within ten (10) calendar days after the hearing.

If you disagree with the written hearing decision received from the County Welfare Department, you have fourteen (14) calendar days in which to submit a written appeal to the California Department of Social Services at 744 "P" Street, Mail Station 19-37, Sacramento, CA, 95814. If you do not submit an appeal request within fourteen (14) calendar days, your appeal process shall be deemed abandoned and the County Welfare Department will implement the intended action.

Upon receipt of an appeal request, the California Department of Social Services may request copies of the basic data file and other relevant materials from the County Welfare Department. The California Department of Social Services may also conduct any investigations, interviews or mediation necessary to resolve the appeal. The decision of the California Department of Social Services will be mailed or delivered to you and to the County Welfare Department within ninety (90) calendar days after receipt of the appeal request.