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 Underpayment

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 underpaid you $ _____ in Cash Assistance Program for Immigrants (CAPI) benefits. The underpayment happened from _____ (MONTH/YEAR) through _____ (MONTH/YEAR) . You were underpaid because:

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

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

Total amount of underpayment: $ _____

We will send you a check to repay you the CAPI benefits we owe you for the amount and the period shown above. Contact your worker if you do not receive the check within two weeks.

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, Part 6, Chapter 10.3, Sections 18937 through 18944; 20 CFR 416.558 and 20 CFR 416.536

The form originally included with this letter is outdated and has been removed. To access a more current version, please visit the NA BACK 9.