NOTICE OF ACTION

APPROVED RELATIVE CAREGIVER (ARC) OVERPAYMENT

COUNTY OF

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

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

(ADDRESSEE)

For Approved Relative Caregivers participating in the Approved Relative Caregiver Funding Option Program (ARC Program):

This is to inform you that you were overpaid ARC Program benefits for _____ (NAME OF CHILD)

for the month(s) of _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

Total amount you received: $ _____

Total amount you should have received: $ _____

Total amount of Overpayment: $ _____

Date of Discovery: _____ (MM/DD/YYYY)

(Collection is permitted if demand is made within one year of discovery.)

You are required to repay the overpayment amount of $_____.

Reason for the overpayment:

- ☐ From _____ (date) the child/youth was not residing in your home, and you failed to report that to your county social worker and you received payments for him/her that you were not entitled to.
- ☐ Other: _____

By law, we can collect ARC Program overpayments if the approved relative caregiver caused the overpayment. We cannot require you to repay the overpayment if you meet an **exception.** Exceptions to repayment are:

- The overpayment was caused by county administrative error, OR
- Neither the county nor the approved relative caregiver knew of or contributed to the cause of the overpayment.
- The minor's absence was temporary and the funds were used to maintain the home for his/her return or used to support his/her needs.

If you disagree with the reason for the overpayment or the amount of the overpayment, you may request a hearing. Please see the following page for hearing instructions.

If you agree with the reason for the overpayment and the amount of the overpayment, you must do **one of the following** within 90 calendar days from the day the county gave or mailed you this notice:

1) Make a one-time payment of the total amount.
Please pay by check or money order, made payable to:

Send to:

2) Sign a written repayment agreement. You must contact the worker at the top of this form to discuss the terms of a written payment agreement..

If you have any questions regarding the overpayment computation or repayment arrangements, please contact the case worker at the top of this form.

Relevant Law: Welfare and Institutions Code sections 11461.3 and 11466.24; MPP sections 22-009, 45-304, 45-305, and 45-306.

Insert overpayment calculations and substantiation of time periods by month as required in regulation. See Manual of Policies and Procedures (MPP) section 45-305. Attach a page if additional space is needed.

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 have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, 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 CalFresh benefits 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, CalFresh 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 ☐ CalFresh
☐ 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 ☐ CalFresh ☐ 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