

**DEPARTMENT OF SOCIAL SERVICES
IEVS/PAYMENT VERIFICATION SYSTEM**

COUNTY RESPONSE DOCUMENT

Please answer all applicable questions and return the form to the address below, only if the IEVS information impacted the Grant, Issuance Amount, Share-of-Cost, or Eligibility.

A. Case: Co. Case Number FBU
 _____ _____ _____ _____

B. Run Date: Mo. Day Year
 _____ _____ _____ _____
 (From Abstract)

1. What program(s) was affected and what was the actual amount of the overpayment/overissuance or monthly share of cost increase?

List Whole Dollars Only	C. CalWORKs	\$	
	D. FS	\$	
	E. MCO	\$	
	F. Other	\$	

2. What type(s) of unreported income was the reason for the actual overpayment/overissuance or monthly share-of-cost increase?

"X" all that apply:

- G. UI 1
- H. DI 2
- I. RSDI 3

3. Did the IEVS Match information result in the case being discontinued?

"X" one:

- J. Yes..... 1
- K. No 2

4. Completed By:

Name

Worker Number

Date

When response Document is complete, mail the original* form to:

California Department of Social Services
 Fraud Bureau
 744 P Street, MS 19-26
 Sacramento, CA 95814

*File copy in the case.