DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

July 31, 2002

ALL COUNTY INFORMATION NOTICE NO I-57-02

TO: ALL COUNTY WELFARE DIRECTORS
ALL CalWORKs PROGRAM SPECIALISTS
ALL FOOD STAMP COORDINATORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

SUBJECT: TRANSMITTAL OF INSTRUCTIONS, FORMS AND NOTICES OF ACTION (NOAs) FOR USE WITH ELECTRONIC BENEFITS TRANSFER (EBT) IN THE CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) AND FOOD STAMP (FSP) PROGRAMS

This All County Information Notice (ACIN) transmits copies of forms, Notices of Action (NOAs), and their instructions (see attached), to be used in the California Work Opportunity and Responsibility to Kids (CalWORKs) and Food Stamp (FSP) programs Electronic Benefits Transfer (EBT) project.

Implementation

Counties should begin using these forms and NOAs as soon as your county begins using the EBT system. The Food Stamp Program's DFA 377.7C, 377.7E, 377.7 E1 and 377.7G have been revised (see attached copies). These forms were revised to replace the references to "coupons" with "benefits." This revision will allow counties participating in the EBT project to continue to use these forms.

Forms Designation and Modification of Forms

With the exception of the DFA 377.7C, 377.7E, 377.7E1 and 377.7G, the forms and NOAs transmitted with this ACIN are designated as "Required Form – Substitute Permitted." CWDs must obtain prior approval from the California Department of Social Services (CDSS) and/or the Department of Health Services (DHS) before implementing a modification or substitution to these and other "Substitute Permitted" forms. For CalWORKs and Food Stamp program changes, the procedures for submission of a change request are outlined in the Management and Office Procedures Regulations 23-400.2 and the Food Stamp Handbook Regulations 63-1250. The DFA 377.7C, 377.7E1 and 377.7G are designated as "Required Form-No Substitutes Permitted" and must not be modified or substituted in any way. The DFA 377.7E is designated as "Recommended." CWDs may modify forms in this category without prior CDSS approval or may choose to not use them.

Camera-Ready Copies and Translations

After you receive a copy of an English CalWORKs or Food Stamp form or message, please allow six to eight weeks for the forms and messages to be translated and mailed to your Forms Coordinator. Language Translation Services (LTS) will mail camera-ready copies of Spanish, Chinese, Vietnamese and Russian translations as soon as they become available. You do not

need to initially request forms or messages from LTS. To order additional camera-ready forms or messages in Spanish, Chinese, Vietnamese or Russian, FAX your request to LTS at (916) 657-3429 or e-mail it to LTS@dss.ca.gov.

For a camera-ready copy and/or an additional copy of an English form, please call the Forms Management Unit (FMU) at (916) 657-1907. If your office has Internet access, you may obtain various forms (not including NOA messages) from the CDSS web page at: www.dss.cahwnet.gov. FMU is currently in the process of making forms available on the Internet. If the name, mailing address or e-mail address of your CalWORKs or Food Stamp Forms Coordinator changes, please contact FMU by telephone at (916) 654-1282 or by e-mail to fmu@dss.ca.gov. For additional copies of NOA messages in English, please contact Shawn Bradley at (916) 653-8675, or by e-mail at: shawn.bradley@dss.ca.gov.

Your Forms Coordinator is to distribute translated forms and messages to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited English proficient populations as required by the Dymally Alatorre Bilingual Services Act (Government Code Section 7290 et seq.) and by State regulations in Manual of Policies and Procedures (MPP) Division 21, Civil Rights Nondiscrimination, Section 115.

Stock

State produced stock of forms may be ordered from the CDSS Warehouse upon receipt of the Notice of Form Change (GEN 127), in accordance with the procedures in the County Forms Catalog.

Contacts

If you have any questions or need further information regarding this letter, CalWORKs forms, NOAs and attachments, please contact Shawn Bradley at shawn.bradley@dss.ca.gov, or by calling (916) 653-8675/CALNET 453-8675. For questions relating to the FSP forms please contact Sandra Pierce at sandra.pierce@dss.ca.gov, or by calling (916) 653-5208/ CALNET 453-5208.

Sincerely,
Original signed by
Maria Hernandez for Charr Lee Metsker on
July 31, 2002
CHARR LEE METSKER, Chief
Employment and Eligibility Branch

Attachments

c: CSAC
CWDA

INSTRUCTIONS FOR EBT FORMS AND NOAs

CalWORKs NOA Messages	Instructions
M16-105 (EBT Immediate Need Approval)	Use this message when immediate need is approved. Enter the amount that will be available to the recipient.
M16-120A (EBT Dormant Account)	Use this message to inform the recipient that he/she needs to use the EBT card before the date indicated or the account will become dormant. Enter the date that the recipient must use the EBT card to stop the action. This should be the day before access to the account is stopped.
M16-120B (EBT Dormant Account/Suspend)	Use this message to inform the recipient that access to the EBT account has been stopped because the account had not been accessed within the 90-day required period. Enter the date access to the account was stopped.
M16-120C (EBT Dormant Account/reactivate)	Use this message to inform the recipient that the county has reactivated the EBT Account. Enter the date the account was made accessible.
M16-215 (EBT Cash Aid Availability)	Use this message when the applicant is approved for cash aid. Enter the amount of the cash aid and the date the funds will be available each month. Check the appropriate box indicating the method in which the applicant/recipient will/did receive their EBT card.
M16-325A (EBT Exemption Approval)	Use this message when an applicant/recipient's request to be exempt from EBT has been approved. Enter the date in which the cash aid will be sent in the form of a check or deposited via direct deposit.
M16-325B (EBT Exemption/Additional Facts)	Use this message when the applicant/recipient has applied for EBT exemption but has not given the county enough information or facts to make the determination. Enter the information or

	other facts that the applicant/recipient must provide.
M16-325C (EBT Exemption Denial)	Use this message to inform applicant/recipient that the request for EBT exemption has been denied. Check the appropriate box indicating the reason or enter the reason on the "other" line.
M16-505A (Approve requested DAC)	Use this message to inform recipient that the person chosen to be the Designated Alternate Cardholder (DAC) has been approved. Enter the name of the DAC.
M16-505B (DAC/Additional Facts)	Use this message when a recipient has requested a DAC and has not provided enough information for the county to approve the request. Enter the date the recipient made the request and the information that the recipient must provide.
M16-505D (DAC request Denial)	Use this message when a recipient's request to make someone the DAC has been denied. Enter the name of the denied DAC, check the box under "HERE'S WHY" and enter the existing DAC's name or check "Other" and give reason.
M16-701 (EBT Adjustment Advice)	Use this message to inform recipient that an adjustment is being made to the EBT account due to a system error. Enter the date the adjustment will be made and the amount that will be removed from the account. Under "HERE'S WHY" enter the information regarding the transaction. Mail this message to the client NO LATER THAN 15 calendar days before the adjustment will take place. This message should be printed on the NA 1233 and used with the NA Back 9.
<u>Forms</u>	<u>Instructions</u>
TEMP 2201 (Request for DAC/AR)	Cash Aid and Food Stamps-this form is to be filled out by recipient when requesting a DAC or Authorized Representative. Both the recipient and the requested DAC or Authorized Representative must sign the form.
TEMP 2202 (EBT Service Request)	Cash Aid and Food Stamps-this form is to be filled out by the recipient, DAC or AR

	when coming to the counter/window to request a service relating to the EBT account.
TEMP 2203 (EBT Exemption Request)	Cash Aid-this form is to be filled out by the recipient when requesting exemption from participating in EBT.
TEMP 2205 (EBT Client Claim)	Cash Aid and Food Stamps-this form is to be filled out by the recipient if an error is noticed in a transaction or a debit has been made to the recipient's account in error.
TEMP 2215 (EBT Important Information)	Cash Aid and Food Stamps-this form is to be signed by the client to certify that they understand the responsibilities associated with the EBT card. One copy is to be given to the client and the original should be placed in the case file.
NA 1233 (EBT Adjustment Advice Template)	Cash Aid-this form is used to transmit NOA message M16-701 when an adjustment is being made to a recipient's EBT account due to a system error (see instructions for message M16-701 for time constraints). Use with the NA Back 9.
TEMP NA 1232 (Food Stamp EBT Notice)	Food Stamps-this is a multi-purpose form to be used by the county to notify the recipient of the following circumstances: • Access to the recipient's Food Stamp EBT will be stopped if the EBT card is not used before the 90-day period has expired. Enter the date that the recipient must use their card by in order to stop the action. • Notification that the county has stopped access to the Food Stamp EBT because the account has not been accessed within the 90-day period. Enter the date of the action. • Access to the Food Stamp EBT has been reactivated. Enter the date that the account was reactivated. • The Food Stamp EBT balance will be adjusted due to a system error. Enter the information regarding the transaction (date, time, location, amount, etc.). Must be used with the NA Back 9.

State of California
Department of Social Services

Noa Msg Doc No.: M16.105
Action : Approve
Issue: EBT Setup-Expedited Service or Immediate Need
Title: EBT Expedited Availability

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.105

Use Form No. : NA 290
Original Date : 07/01/02 (new)
Revision Date :

MESSAGE:

The County has approved your request for Expedited Service or Immediate Need.

$_____ can be used **now** with cash aid Electronic Benefit Transfer-EBT.

You will get another notice telling you more about your cash aid.

You will get a separate notice for Food Stamps and Medi-Cal benefits.

State of California
Department of Social Services

Action : Inform
Issue: EBT Account Aging
Title: EBT Dormant Account

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.120

Use Form No. : NA 290
Original Date : 07/01/02
Revision Date :

MESSAGE:

Our records tell us that you have not used your cash aid Electronic Benefit Transfer – EBT card for over 45 days.

If you do not use your cash aid EBT card by _____, the County will stop access to your EBT cash aid.

You can stop this action by using your cash aid EBT card.

If you have lost your card call the toll free number (1-877-328-9677). If you need help using your EBT card, call your County Worker.

This notice:

- does not change your eligibility to get cash aid;
- does not change your responsibility to report changes that affect your eligibility;
- does not change the unused cash aid benefit in your EBT account.
- does not change your Food Stamp or Medi-Cal benefits. If these benefits change, you will get a separate notice.

State of California
Department of Social Services

Action : Suspend
Issue: EBT Account Aging
Title: EBT Dormant Account: Suspend

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.120

Use Form No. : NA 290
Original Date : 07/01/02 (new)
Revision Date :

MESSAGE:

On _____, the County stopped access to your cash aid Electronic Benefit Transfer – EBT.

HERE'S WHY:

You have not used your cash aid EBT card for 90 days.

Call your County Worker to access your cash aid EBT.

If you have lost your card call the toll free number (1-877-328-9677). If you need help using EBT, call your County Worker.

This notice:

- does not change your eligibility to get cash aid;
- does not change your responsibility to report changes that affect your eligibility;
- does not change the unused cash aid benefit in your EBT.
- does not change your Food Stamp or Medi-Cal benefits. If these benefits change, you will get a separate notice.

State of California
Department of Social Services

Action : Reactivate
Issue: EBT Account Aging
Title: EBT Dormant Account: Reactivate

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.120

Use Form No. : NA 290
Original Date : 07/01/02
Revision Date :

MESSAGE:

On _____, the County started access to your cash aid Electronic Benefit Transfer – EBT.

This notice:

- does not change your eligibility to get cash aid;
- does not change your responsibility to report changes that affect your eligibility;
- does not change the unused cash aid benefit in your EBT.
- does not change your Food Stamp or Medi-Cal benefits. If these benefits change, you will get a separate notice.

State of California
Department of Social Services

Noa Msg Doc No.: M16.215
Action : Approve
Issue: EBT Setup
Title: EBT Availability

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.215

Use Form No. : NA 290
Original Date : 07/01/02 (new)
Revision Date :

MESSAGE:

The County has approved your cash aid for $_____.

Your cash aid will be available through Electronic Benefit Transfer-**EBT** the _____of each month.

❒You have already received your EBT card.

❒Your EBT card will be **mailed** to you.

❒**Pick up** your EBT card from your County Worker.

State of California
Department of Social Services

Noa Msg Doc No.: M16.325A Page 1 of1
Action : Approval
Issue: EBT Exemption
Title: EBT Exemption Request

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.325

Use Form No. : NA 290
Original Date : 07/01/02
Revision Date :

MESSAGE:

The County has approved your request for Exemption from cash aid Electronic Benefit Transfer-EBT.

On _____ you will get cash aid by:

❒ CHECK.

❒ DIRECT DEPOSIT to your bank account.

If you would like to set up direct deposit to your bank account, call your County Worker to see if it available in your County.

This notice does not change your Food Stamp or Medi-Cal benefits. If these benefits change, you will get a separate notice.

State of California
Department of Social Services

Action : Partial Approve
Issue: EBT Exemption: Incomplete Doc
Title: EBT Exemption: Need Addl Facts

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.325

Use Form No. : NA 290
Original Date : 07/01/02 (new)
Revision Date :

MESSAGE:

The County has received your request for Exemption from cash aid Electronic Benefit Transfer - EBT. We cannot process your request. Here's why:

We need more facts.

TELL US:

_____

_____

_____

This notice does not change your Food Stamp or Medi-Cal Benefits. If these benefits change, you will get a separate notice.

State of California
Department of Social Services

Action : Deny
Issue: EBT Exemption: Deny
Title: EBT Exemption: Deny

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.325

Use Form No. : NA 290
Original Date : 07/01/02 (new)
Revision Date :

MESSAGE:

The County has denied your request for Exemption from cash aid Electronic Benefit Transfer - EBT. You will get your cash aid by EBT.

HERE'S WHY:

❒ The temporary or permanent condition you told us about does not keep you from using EBT.

❒ The temporary or permanent condition you told us about was not supported by your doctor.

❒ Other

This notice does not change your Food Stamp or Medi-Cal Benefits. If these benefits change, you will get a separate notice.

State of California
Department of Social Services

Noa Msg Doc No.: M16.505A Page 1 of 1
Action : Approve
Issue: Designated Alternate Cardholder
Title: Designated Alternate Cardholder

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.505.31

Use Form No. : NA 290
Original Date : 07/01/02
Revision Date :

MESSAGE:

The County has approved your request to make_____ the Designated Alternate Cardholder for your cash aid Electronic Benefit Transfer-EBT.

Call your County Worker to get an additional cash aid EBT card and Personal Identification Number-PIN for your Designated Alternate Cardholder.

If this is wrong, or you want to stop your request to make this change, call your County Worker.

REMINDER!
It is your responsibility to call the toll free number (1-877-328-9677) to terminate another household member's, Designated Alternate Cardholder's or Authorized Representative's access to your EBT account.

This notice does not change your Food Stamp or Medi-Cal benefits. If these benefits change, you will get a separate notice.

State of California
Department of Social Services

Noa Msg Doc No.: M16.505B Page 1 of1
Action : Partial Approval
Issue: Incomplete Facts-Designated Alternate Cardholder Request
Title: Designated Alternate Cardholder Request: need additional facts

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.505.31

Use Form No. : NA 290
Original Date : 07/01/02 (new)
Revision Date :

MESSAGE:

On _____you asked to add/change/stop your Designated Alternate Cardholder for cash aid Electronic Benefits Transfer-EBT. We cannot process your request. Here's why:

We need more facts.

TELL US:

_____

_____

_____

_____

This notice does not change your Food Stamp or Medi-Cal benefits. If these benefits change, you will get a separate notice.

REMINDER!
It is your responsibility to call the toll free number (1-877-328-9677) to terminate another household member's, Designated Alternate Cardholder's or Authorized Representative's access to your EBT account.

State of California
Department of Social Services

Noa Msg Doc No.: M16.505D Page 1 of 1
Action : Deny
Issue: Designated Alternate Cardholder
Title: Designated Alternate Cardholder: Deny

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.505.31

Use Form No. : NA 290
Original Date : 07/01/02
Revision Date :

MESSAGE:

The County has denied your request to make _____ the Designated Alternate Cardholder for your cash aid Electronic Benefit Transfer-EBT.

HERE'S WHY:

❒You already made _____your Designated Alternate Cardholder for cash aid EBT.

If this is wrong, or you want to make a change, call your County Worker.

❒Other:

This notice does not change your Food Stamp or Medi-Cal benefits. If these benefits change, you will get a separate notice.

REMINDER!
It is your responsibility to call the toll free number (1-877-328-9677) to terminate another household member's, Designated Alternate Cardholder's or Authorized Representative's access to your EBT account.

State of California
Department of Social Services

Action : EBT Adjustment
Issue: EBT System Error Resolution
Title: EBT Adjustment Advice

Auto ID No.:
Source :
Issued by :
Reg Cite : 16.XXX, 16.XXX

Use Form No. : NA 2
Original Date : 07/01/02 (new)
Revision Date :

MESSAGE:

On _____, your cash aid Electronic Benefit Transfer –EBT will have $_____ removed from your balance.

HERE'S WHY:

A system error happened when using your cash aid EBT:
Date:
Time:
Location:
Amount:

Other:

If you do not have enough money in your EBT cash account to repay the amount of the error, we will take it out of your next month's benefit.

This notice does not change your Food Stamp or Medi-Cal Benefits. If these benefits change, you will get a separate notice.

CASH AID/FOOD STAMP ELECTRONIC BENEFIT TRANSFER - EBT
REQUEST FOR A DESIGNATED ALTERNATE CARD HOLDER/AUTHORIZED REPRESENTATIVE

CASE NAME:	WORKER NAME
CASE NUMBER:	DATE:

INSTRUCTIONS:
A Designated Alternate Card Holder/Authorized Representative is a responsible person that you trust. A Designated Alternate Card Holder/Authorized Representative will have an EBT card issued in their name and the card holder/authorized representative, you choose will have access to all your cash aid or food stamp EBT.

- Tell us the name and birthdate of the person you want to be a Designated Alternate Card Holder/Authorized Representative
- Sign and complete this form
- Send or bring in the form to your County Office

☐ Designated Alternate Card Holder ☐ Authorized Representative

☐ New ☐ Change ☐ Remove

NAME OF REQUESTED DESIGNATED ALTERNATE CARDHOLDER/AUTHORIZED REPRESENTATIVE	BIRTHDATE

CERTIFICATION:

I understand the person I make Designated Alternate Card Holder/Authorized Representative will have access to ALL of my cash aid and/or food stamp EBT. The County is not responsible for lost or stolen benefits. I can change who can access my cash aid or food stamps by calling my County Worker.

SIGNATURE	PHONE	DATE

To be signed by Designated Alternate Card Holder/Authorized Representative

I agree to be a Designated Alternate Card Holder/Authorized Representative. By using this card, I agree to the terms of the cash aid/food stamp Electronic Benefit Transfer - EBT program.

DESIGNATED ALTERNATE CARD HOLDER/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

Report lost or stolen card IMMEDIATELY by calling toll free 1-877-328-9677.

REMINDER
It is **YOUR** responsibility to call the toll-free customer service telephone number (1-877-328-9677) to terminate another household member's, Designated Alternate Cardholder's, or Authorized Representative's access to your EBT account.

CASH AID/FOOD STAMP ELECTRONIC BENEFIT TRANSFER - EBT SERVICE REQUEST

DATE

CLIENT NAME	CASE NUMBER

County Service Counter Request

☐ Request Designated Alternate Card Holder ☐ Request Authorized Representative

☐ Reactivate

☐ Replace ☐ Card ☐ PIN

Explain_____

_____

_____

_____

If you are here to report a lost or stolen EBT Card, call toll free 1-877-328-9677 IMMEDIATELY.

☐ Other *(Explain)*_____

_____

_____

_____

I have received a copy of this service request.

CLIENT OR DESIGNATED ALTERNATE CARD HOLDER/AUTHORIZED REPRESENTATIVE	PHONE	DATE

			Date
Issued Card	☐ Yes	☐ No	_____
Issued PIN	☐ Yes	☐ No	_____
Reactivate Account	☐ Yes	☐ No	_____
Worker Initials	_____		

REQUEST FOR CASH AID ELECTRONIC BENEFIT TRANSFER - EBT EXEMPTION

DATE	
CLIENT NAME	CASE NUMBER

The County will look at the facts I give to decide how my cash aid will be given to me.

I do not want to get cash aid by EBT because:

☐ I have a Temporary Condition that prevents me from using EBT. *

☐ I have a Permanent Condition that prevents me from using EBT. *

*You need to get written verification from your medical provider unless you have a condition that is readily apparent or has been previously documented within sixty (60) days from this request that says what the condition is that prevents you from using EBT and the expected duration of the condition.

☐ Other *(Explain)*:_____

_____

_____

_____

_____

_____

_____

Verification provided? ☐ Yes ☐ No ☐ Not needed

Exemption granted? ☐ Yes ☐ No, continue EBT

If Yes, alternate method to be used:

☐ Direct Deposit ☐ Warrant

CLIENT SIGNATURE	PHONE
DATE CLIENT NOTIFIED	WORKER'S INITIALS
WORKER'S NAME:	WORKER'S NUMBER

ELECTRONIC BENEFITS TRANSFER - EBT

Client Claim

DATE

CLIENT NAME

CASE NUMBER

Date :_____ Time: _____ Amount: $_____

Location:_____

Please include EBT receipt or other proof.

☐ Cash Aid ☐ Food Stamps

☐ Wrong amount credit

☐ Wrong amount debit

☐ No transaction made on date indicated

☐ Other *(Explain)*:_____

Tell us the facts: _____

I know the facts I give will be checked out by the county. I will be notified of the county decision. Any amount owed to me will be put into my EBT account. Any amount I owe will come out of my balance, and if not enough, my next month's benefit will be used.

CLIENT SIGNATURE

DATE

ELECTRONIC BENEFIT TRANSFER (EBT) IMPORTANT INFORMATION

CASE NAME
CASE NUMBER

- It is important that I keep my Electronic Benefit Transfer (EBT) card and Personal Identification Number (PIN) safe. Any EBT transaction made by me, a Designated Alternate Cardholder/Authorized Representative, or any person I voluntarily give my EBT card and PIN will be considered a valid transaction and any benefits taken from the account will **NOT** be replaced.
- If my EBT card is lost or stolen, I will report it by calling the customer service center **IMMEDIATELY** at 1-877-328-9677. I can do this 24 hours a day, 7 days a week. Any benefits taken from my account before I report it to customer service will **NOT** be replaced.
- If I think someone may know my PIN number that I don't want to use my benefits, I will have my PIN number changed (I can do this by calling the toll-free customer service center at 1-877-328-9677). If I don't change my PIN number, benefits used by another person will not be replaced.
- I will be sure all authorized cardholders, including my Designated Alternate Cardholder/Authorized Representative know to report a lost or stolen EBT card or PIN number as soon as possible so I won't lose any benefits.

I certify that I have read this notice or have had it read to me and that I understand this important information about my EBT card.

SIGNATURE OF CLIENT	DATE

NOTICE OF ACTION

COUNTY OF

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

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 how. Your benefits may not be changed if you ask for a hearing before this action takes place.

Electronic Benefit Transfer

EBT Adjustment Advice

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: MPP

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

FOOD STAMP NOTICE - EBT ACCOUNT

COUNTY OF

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

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 how. Your benefits may not be changed if you ask for a hearing before this action takes place.

ACCOUNT DEACTIVATED

OUR RECORDS SHOW THAT YOU HAVE NOT USED YOUR FOOD STAMP ELECTRONIC BENEFIT ACCOUNT FOR OVER 45 DAYS.

☐ If you do not use your food stamp benefit card by _____ , the county will stop access to your electronic food stamp benefits. You can stop this action by using your food stamp benefit card.

OUR RECORDS SHOW THAT YOU HAVE NOT USED YOUR FOOD STAMP ELECTRONIC BENEFIT ACCOUNT FOR OVER 90 DAYS.

☐ On _____, the county stopped access to your food stamp benefits. Call your County Worker to activate your electronic food stamp benefit account again.

IF YOU HAVE NOT USED YOUR FOOD STAMP ELECTRONIC BENEFIT ACCOUNT FOR NINE MONTHS, YOUR BENEFITS WILL BE REMOVED AND CAN NOT BE RESTORED.

ACCOUNT REACTIVATED

☐ On _____, the county started access to your food stamp electronic benefit account.

If you have lost your card call 1 - 877 - 328-9677. If you need help using your EBT card, call your county worker.

ACCOUNT ADJUSTED

☐ On_____, your electronic food stamp benefit account will have $ _____ removed from your balance.

HERE'S WHY:

A system error happened when using your electronic food stamp benefit account:

Date:
Time:
Location:
Amount:
Other:

If you do not have enough benefits in your account to repay the amount of the error, we will take it out of your next month's benefits.

This Notice:

- does not change your eligibility to benefits;
- does not change your responsibility to report changes that affect your eligibility; and
- does not change your cash aid or Medi-Cal benefits--you will get a separate notice.

Rules: These rules apply: You may review them at your welfare office. MPP 16-210, MPP 16-300, and MPP 16-710.

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

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP REPAYMENT AGREEMENT FOR INADVERTENT HOUSEHOLD ERRORS ONLY

CASE NUMBER

WORKER

NAME

CASE NAME

ADDRESS

TERMS AND CONDITIONS

You or a member of your household made a mistake.
You must repay extra food stamp benefits by using one or more methods listed here:

1. **Lump Sum Payment** - You may repay in full the amount owed at one time with cash and/or food stamp benefits.
2. **Benefit Reduction** - If you are getting food stamp benefits now, you may repay by having your household's benefits reduced for all or part of the amount owed. Repayment by this method will be 10% of your monthly benefit or $10 each month, whichever is more.
3. **Installments** - You may repay the amount owed in monthly payments with cash and/or with food stamp benefits.
4. **Ordered Repayment**

   ☐ The court or Administrative Law Judge ordered that you repay as indicated below. These repayment terms cannot be changed by you or by the county.

If we have not already talked to you about the terms of this Agreement, or if you have any questions, call the welfare collector at _____.

After you complete and sign this Agreement, return all copies to the county in the envelope provided. Do not send cash or food stamp benefits through the mail with this Agreement. When approved by the county, a signed copy of this Agreement will be sent to you.

AGREEMENT

I, _____ , understand this Agreement is between me and _____ County because extra food stamps in the amount of $ _____ were issued. I agree to repay this amount by the method(s) checked below:

☐ Lump Sum Payment

- ☐ I will repay by a lump sum cash payment of $ _____due on_____ .
- ☐ I will repay by a lump sum food stamp benefit payment of $ _____ due on_____ .

☐ Benefit Reduction

- ☐ I will repay by having my household's benefits reduced by $_____ each month, beginning _____.

☐ Installments

- ☐ I will repay by monthly cash payments of $_____ due on the_____ day of each month beginning _____.
- ☐ I will repay by monthly food stamp benefit payments of $_____ due on the_____ day of each month beginning _____.

I also understand and agree that:

1. My repayment schedule is based on my current ability to pay as figured by the county. Any changes in my ability to pay may change my monthly payments.
2. If anything changes, I may ask the county to refigure the terms checked above.
3. If I do not pay as agreed and I do not get a new payment schedule, the county may ask that the total amount owed be paid now.
4. If I do not pay as agreed and the county sues me to collect the amount owed, I may also be required to pay collection costs, attorney fees, and court costs.
5. If I do not pay, the county may take my state/federal income tax refund and/or ask the court to attach my wages or any property I own.
6. I will be subject to involuntary collection action(s) if payment is not received by the due date and the claim becomes delinquent.
7. If this inadvertent household error is later found to be an intentional program violation, penalties will apply even if I pay back what I owe.

Signature | Date | County

To be completed by the county:

The above signed Agreement has been accepted by_____on _____
Date

for _____ County. Payments should be made at:

_____
(Signature of Authorized County Official)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP REPAYMENT AGREEMENT FOR ADMINISTRATIVE ERRORS ONLY

CASE NUMBER

WORKER

NAME

CASE NAME

ADDRESS

TERMS AND CONDITIONS – The County Welfare Department made a mistake in the amount of your food stamps. You do not have to agree to benefit reduction unless you want to repay this way. If you do, you must sign this agreement. See attached REPAYMENT NOTICE (DFA 377.7D).

You may repay extra food stamp benefits by using one or more methods listed here:

1. Lump Sum Payment - You may repay all or part of the amount owed at one time with cash and/or food stamp benefits.

2. Benefit Reduction - If you are getting food stamps now, you may repay by having your household's benefits reduced for all or part of the amount owed. You may wish to talk to us about the amount to be reduced.

3. Installments - You may repay all or part of the amount owed in monthly payments with cash and/or food stamp benefits.

4. Ordered Repayment

☐ The court or Administrative Law Judge ordered that you repay as indicated below.These repayment terms cannot be changed by you or by the county.

If we have not already talked to you about the terms of this Agreement, or if you have any questions, call the welfare collector at _____.

After you complete and sign this Agreement, return all copies to the county in the envelope provided. Do not send cash or food stamp benefits through the mail with this Agreement. When approved by the county, a signed copy of this Agreement will be sent to you.

AGREEMENT

I, _____ , understand this Agreement is between me and _____ County because extra food stamps in the amount of $ _____ were overissued due to the county's error. I agree to repay this amount by the method(s) checked below:

☐ Lump Sum Payment

- ☐ I will repay by a lump sum cash payment of $_____due on_____.
- ☐ I will repay by a lump sum food stamp benefit payment of $_____due on_____.

☐ Benefit Reduction

- ☐ I will repay by having my household's benefits reduced by $_____ each month, beginning _____.

☐ Installments

- ☐ I will repay by monthly cash payments of $_____ due on the_____ day of each month beginning _____.
- ☐ I will repay by monthly food stamp benefit payments of $_____ due on the_____ day of each month beginning _____.

I also understand and agree that:

1. My repayment schedule is based on my current ability to pay as figured by the county. Any changes in my ability to pay may change my monthly payments.
2. If anything changes I may ask the county to refigure the repayment terms checked above.
3. If I do not pay as agreed and I do not get a new payment schedule, the county may ask that the total amount owed be paid now.

Signature | Date | County

To be completed by the county:

The above signed Agreement has been accepted by_____on _____

for _____ County. Payments should be made at:

_____

(Signature of Authorized County Official)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP REPAYMENT AGREEMENT FOR ADMINISTRATIVE ERRORS ONLY

CASE NUMBER

WORKER

NAME

CASE NAME

ADDRESS

TERMS AND CONDITIONS – The County Welfare Department made a mistake in the amount of your food stamp benefits. You must repay extra food stamp benefits by using one or more methods listed here:

1. **Lump Sum Payment** - You may repay in full the amount owed at one time with cash and/or food stamp benefits.
2. **Benefit Reduction** - If you are getting food stamp benefits now, you may repay by having your household's benefits reduced for all or part of the amount owed. You may wish to talk to us about the amount to be reduced.
3. **Installments** - You may repay the amount owed in monthly payments with cash or with food stamp benefits.
4. **Ordered Repayment**

☐ The court or Administrative Law Judge ordered that you repay as indicated below. These repayment terms cannot be changed by you or by the county.

If we have not already talked to you about the terms of this Agreement, or if you have any questions, call the welfare collector at _____.

After you complete and sign this Agreement, return all copies to the county in the envelope provided. Do not send cash or food stamp benefits through the mail with this Agreement form. When approved by the county, a signed copy of this Agreement will be sent to you.

AGREEMENT

I, _____ , understand this Agreement is between me and _____ County because extra food stamp benefits in the amount of $ _____ were overissued due to the county's error. I agree to repay this amount by the method(s) checked below:

☐ Lump Sum Payment

- ☐ I will repay by a lump sum cash payment of $_____due on_____.
- ☐ I will repay by a lump sum food stamp benefit payment of $_____due on_____.

☐ Benefit Reduction

- ☐ I will repay by having my household's benefits reduced by $_____ each month, beginning _____.

☐ Installments

- ☐ I will repay by monthly cash payments of $_____ due on the_____ day of each month beginning _____.
- ☐ I will repay by monthly food stamp benefit payments of $_____ due on the_____ day of each month beginning _____.

I also understand and agree that:

1. My repayment schedule is based on my current ability to pay as figured by the county. Any changes in my ability to pay may change my monthly payments.
2. If anything changes, I may ask the county to refigure the repayment terms checked above.
3. If I do not pay as agreed and I do not get a new payment schedule, the county may ask that the total amount owed be paid now.
4. If I do not pay as agreed and the county sues me to collect the amount owed, I may also be required to pay collection costs, attorney fees, and court costs.
5. If I do not pay, the county may take my state/federal income tax refund and/or ask the court to attach my wages or any property I own.
6. I will be subject to involuntary collection action(s) if payment is not received by the due date and the claim becomes delinquent.

SIGNATURE | DATE | COUNTY

To be completed by the county:

The above signed Agreement has been accepted by_____on _____

for _____ County. Payments should be made at:

_____

(Signature of Authorized County Official)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP REPAYMENT AGREEMENT FOR AN INTENTIONAL PROGRAM VIOLATION (IPV) ONLY

CASE NUMBER

WORKER

NAME

CASE NAME

ADDRESS

TERMS AND CONDITIONS

You or a member of your household broke a Food Stamp rule on purpose.
You must repay extra food stamp benefits by using one or more methods listed here:

1. **Lump Sum Payment** - You may repay in full the amount owed at one time with cash and/or with food stamp benefits.
2. **Benefit Reduction** - If you are getting food stamp benefits now, you may repay by having your household's benefits reduced for all or part of the amount owed. Repayment by this method will be 20% of your monthly benefit or $20 each month, whichever is more.
3. **Installments** - You may repay the amount owed in monthly payments with cash and/or with food stamp benefits.
4. **Ordered Repayment**

   ☐ The court or Administrative Law Judge ordered that you repay as indicated below. These repayment terms cannot be changed by you or by the county.

If we have not already talked to you about the terms of this Agreement, or if you have any questions, call the welfare collector at _____.

After you complete and sign this Agreement, return all copies to the county in the envelope provided. Do not send cash or food stamp benefits through the mail with this Agreement. When approved by the county, a signed copy of this Agreement will be sent to you.

AGREEMENT

I, _____ , understand this Agreement is between me and _____ County because extra food stamps in the amount of $ _____ were issued. I agree to repay this amount by the method(s) checked below:

☐ Lump Sum Payment

- ☐ I will repay by a lump sum cash payment of $_____ due on _____.
- ☐ I will repay by a lump sum food stamp benefit payment of $ _____ due on _____.

☐ Benefit Reduction

- ☐ I will repay by having my household's benefits reduced by $_____ each month, beginning _____.

☐ Installments

- ☐ I will repay by monthly cash payments of $_____ due on the_____ day of each month beginning _____.
- ☐ I will repay by monthly food stamp benefit payments of $_____ due on the_____ day of each month beginning _____.

I also understand and agree that:

1. My repayment schedule is based on my current ability to pay as figured by the county. Any changes in my ability to pay may change my monthly payments.
2. If anything changes, I may ask the county to refigure the terms checked above.
3. If I do not pay as agreed and I do not get a new payment schedule, the county may ask that the total amount owed be paid now.
4. If I do not pay as agreed and the county sues me to collect the amount owed, I may also be required to pay collection costs, attorney fees, and court costs.
5. If I do not pay, the county may take my state/federal income tax refund and/or ask the court to attach my wages or any property I own.
6. I will be subject to involuntary collection action(s) if payment is not received by the due date and the claim becomes delinquent.
7. Even if I agree to pay back what I owe, IPV penalties will apply.

Signature | Date | County

To be completed by the county:

The above signed Agreement has been accepted by_____on _____
Date

for _____ County. Payments should be made at:

_____
(Signature of Authorized County Official)