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

January 29, 1996

ALL-COUNTY INFORMATION NOTICE NO. I-05-96

TO: ALL COUNTY WELFARE DIRECTORS
ALL IAR AGENCY PROGRAM CONTACTS
ALL IAR AGENCY FISCAL CONTACTS

REASON FOR THIS TRANSMITTAL

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

SUBJECT: TRANSMITTAL OF NEW SSP 17 FORM FOR SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP) DRUG ADDICTS AND ALCOHOLICS (DA&A)

The purpose of this letter is to inform you of the new form "Notice of Action and Right to Request a State Hearing on Interim Assistance for DA&A Recipients" (Form SSP 17(DA&A)). This Interim Assistance Reimbursement (IAR) Program form must be used for all SSI/SSP recipients whose drug addiction or alcoholism is material to their disability. The development of this form was necessitated by a change in the way the Social Security Administration (SSA) processes the repayment of interim assistance provided to these recipients (see ACL 95-05). The regular Form SSP 17 is to be used for all other SSI/SSP recipients.

The SSP 17(DA&A) differs from the regular SSP 17 by informing the recipient of the IAR amount owed to the IAR agency. Additionally, it informs the recipient that SSA will forward any balance to his or her representative payee.

This form is now available from the California Department of Social Services' (CDSS) Warehouse in pads of 100. Please address supply requests as follows:

CDSS Warehouse
P.O.Box 22429
Sacramento, CA 95822

Phone: (916) 322-6250

A copy of the new form is attached for your information. Please direct any questions regarding this form to Ms. Terrie Marks, SSI/SSP Unit, at (916) 229-4041.

CAROL R. WIDEMON
Deputy Director
Adult Services Division

Attachment

NOTICE OF ACTION AND RIGHT TO REQUEST A STATE HEARING ON INTERIM ASSISTANCE FOR DA&A RECIPIENTS

State No.:
County No.:
Worker No.:
District:
Date:
Case Name:
Interpreter Needed: _____ (Language) _____ (Dialect)

This office was notified of your initial SSI/SSP payment in the amount of $_____, for the period_____through_____. As per your agreement, we billed the Social Security Administration (SSA) in the amount of $_____to repay the Interim Assistance you received for that same period while SSA completed your application for Supplemental Security Income payments. This leaves a balance owed you of $_____for this period. The balance will be forwarded to your representative payee by SSA.

SSI/SSP PAYMENT

If you disagree with the amount of the initial SSI/SSP payment of $_____, contact your local Social Security Office. The amount of the initial SSI/SSP payment is subject to the SSA appeal process. Request for reconsideration must be filed within 60 days after the date the notice of the initial determination is received by you.

INTERIM ASSISTANCE PAYMENT

If you disagree with the balance owed you for this period, please contact the California Department of Social Services. This action is subject to the state hearing provision described on the reverse side of this form.

COMMENTS:

The law and/or regulations governing this action are:

Department of Social Services Eligibility Assistance Standards Manual Section (EAS) 46-337
Public Law 103-296, Section 201(b)
42 U.S. Code, Section 1383(g)
20 CFR 416.1910

If you have any questions please contact me.

COUNTY/STATE REPRESENTATIVE		AGENCY
TELEPHONE	DATE:	

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office of welfare rights group.

Other Information

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the State Hearing Officer. You have a right to examine the materials that make up the file. Any information you provide may be shared with the departments whose action you are appealing and the U.S. Department of Health and Human Services. Authority: W&IC 10950.

I will bring this person to the hearing to help me (name and address, if known):

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature: _____

Date: _____

HOW TO AS FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to :

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by_____ about the balance of my initial SSI/SSP payment that was forwarded by the SSA.

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____