STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

WILL LIGHTBOURNE
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

June 3, 2015

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

ALL COUNTY LETTER (ACL) NO. 15-07

TO: ALL COUNTY WELFARE DIRECTORS
ALL CHIEF PROBATION OFFICERS
ALL COUNTY ADOPTION AGENCIES
ALL ADOPTION DISTRICT OFFICES
ALL COUNTY FISCAL OFFICERS
ALL GROUP HOME PROVIDERS
ALL FOSTER FAMILY AGENCIES
ALL TITLE IV-E AGREEMENT TRIBES

SUBJECT: NOTICE OF FORMS AND INSTRUCTIONS FOR FOSTER CARE OVERPAYMENTS

REFERENCE: WELFARE AND INSTITUTIONS CODE (WIC) SECTIONS 11466.23, 11466.235(a) AND 11466.24; MANUAL OF POLICIES AND PROCEDURES (MPP) SECTION 45-304, 45-305, 45-306; ACL NO. 09-64, DATED DECEMBER 17, 2009, COUNTY FISCAL LETTER (CFL) NO. 13/14-30, DATED NOVEMBER 20, 2013

The purpose of this ACL is to direct counties and providers on the proper use of the new and revised overpayment Notice of Action (NA) forms. The California Department of Social Services (CDSS) has updated the NA 1261 form addressing overpayments paid to Group Homes (GHs) and Foster Family Agencies (FFAs) and has developed the new NA 1261A form for overpayments paid to licensed, approved family homes and Non-Minor Dependents (NMDs) residing in a Supervised Independent Living Setting (SILS). The newly developed NA 1261B form is to be used for addressing overpayments paid to Kinship-Guardianship Assistance Payment (Kin-GAP) guardians. These approved Foster Family Homes (FFHs) are defined for the purpose of overpayment collection as including an approved relative home, an approved home of a Non-Relative Extended Family Member (NREFM) and an approved home of a Non-Relative Legal Guardian (NRLG). The new and revised forms and their instructions are enclosed.

The CDSS is advising counties to refrain from sending out the SOC 841 form which had previously been used to request repayment of overpayments in situations where a licensed or approved FFH provider, as specified, is not legally obligated to repay it. Also, included are NMDs residing in a SILS, who are the recipient of the foster care maintenance payment, as well as a host family or other locations certified for placement of NMDs by a Transitional Housing Placement-Plus Foster Care (THP+FC) provider. Not included are the transitional housing placement providers operating the THP+FC Program. Counties must use the revised NA 1261 or NA 1261A forms when seeking remittance of overpaid Aid to Families with Dependent Children-Foster Care (AFDC-FC) funds and the NA 1261B form when seeking remittance of Kin-GAP funds. The NA 1261A and the NA 1261B forms specify/identify circumstances under which counties cannot require the repayment of an overpayment.

The county must seek to collect overpayments from FFHs, approved homes, and SILS where a NMD is residing, as specified, and Kin-GAP guardians that occurred because payments were made when the child was no longer placed in the home unless specified conditions exist. The conditions under which overpayments shall not be collected from licensed FFHs, approved relatives, Kin-GAP guardians, approved NREFMs, approved NRLGs and a SILS where NMDs resides are set forth in WIC section 11466.24.

Collection from these providers as identified in WIC section 11466.24 is prohibited if one of the following conditions applies:

(1) The cost of collection exceeds the amount of the overpayment that is likely to be recovered by the county. The cost of collecting the overpayment and the likelihood of collection shall be documented by the county. Costs that the county shall consider when determining the cost-effectiveness to collect are totally administrative, personnel, legal filing fee, and investigative costs, and any other applicable costs.
(2) The child was temporarily removed from the home and payment was owed to the provider to maintain the child's placement, or the child was temporarily absent from the provider's home, or on runaway status and subsequently returned, and payment was made to the provider to meet the child's needs.
(3) The overpayment was exclusively the result of a county administrative error or both the county welfare department and the provider were unaware of the information that would establish that the foster child was not eligible for foster care benefits.
(4) The provider did not have knowledge of and did not contribute to the cause of the overpayment.

For further clarification of what constitutes a temporary absence please refer to MPP section 45-302.231

As business entities, GHs and FFAs have a greater liability for overpayments. The CDSS has therefore developed one set of forms for family homes/approved relative homes, SILS and another set of forms for GHs/FFAs to reflect the different collection provisions.

Description of the Forms

NA 1261

The NA 1261 form is *only* to be used when demanding a mandatory repayment of AFDC-FC funds from a GH and FFA and is not to be used when seeking repayment of an overpayment from an individual provider.

NA 1261A

The newly developed NA 1261A must be used in circumstances in which a demand of compulsory repayment from a Relative Caregiver, NREFM, FFH, NRLG or the SILS where the NMD resides is mandated by WIC section 11466.24 and the provider does not qualify for any of the exemptions listed in WIC section 11466.24. Counties must document the underlying information that supports its determination that a Relative Caregiver, NREFM, FFH, NRLG, or SILS where the NMD resides knowingly contributed to or caused the overpayment, and that the overpayment is based upon the child not being in the home, or other collectible reasons before sending the NA 1261A.

NA 1261B

The NA 1261B parallels the NA 1261A, but shall be used solely for Kin-GAP providers. The newly developed NA 1261B must be used in circumstances in which a demand of compulsory repayment from a Kin-GAP guardian is mandated by WIC section 11466.24 and the provider does not qualify for any of the exemptions listed in WIC section 11466.24. Counties must document the underlying information that supports its determination that a Kin-GAP guardian knowingly contributed to or caused the overpayment and that the overpayment is based upon the child not being in the home before sending the NA 1261B.

Fraud

In addition to the proper collection and documentation of evidence supporting the issuance of the NA 1261A or NA 1261B, counties should consult with local County Counsel on whether that evidence supports a determination that the provider engaged in fraudulent activities and, if so, whether further actions in addition to overpayment collection such as criminal prosecution are warranted.

Assistance Claiming Instructions

Refer to CFL No. 13/14-30 for information on claiming instructions, questions may be sent via email to assistance.claims@dss.ca.gov.

Inquiries

Any questions regarding this ACL can be directed to the Foster Care Rates Bureau, Rates Policy Unit, at (916) 651-9152.

Sincerely,

Original Document Signed By:

GREGORY E. ROSE
Deputy Director
Children and Family Services Division

Enclosures

NOTICE OF ACTION

COUNTY OF

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

FORM AND INSTRUCTIONS - FOR GROUP HOMES AND FOSTER FAMILY AGENCIES ONLY

(1) Name:
(2) Address:
(3) City, State Zip:

(4) Notice Date: _____
(5) Case Name: _____
(6) Case Worker Number: _____
(7) Case Worker Name: _____
(8) Case Number: _____
(9) Telephone: _____
(10) Address: _____

Questions? Ask your Worker.

For Group Homes and Foster Family Agencies

This is to inform you that you were overpaid AFDC-Foster Care benefits

(11) for _____ (NAME OF CHILD) for

(12) the period of _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

(13) Total amount you received: $ _____

(14) Total amount you should have received: $ _____

(15) Total amount of Overpayment: $ _____

(16) Date of Discovery: _____ (DATE)

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

(18) Reason for the overpayment:

(A) Child/Youth left your Group Home or Foster Family Agency on _____ (DATE)
and you were not entitled to payments for him/her on or after this date; or

(B) Other:

(19) Insert overpayment calculations and substantiation of time periods by month as required in regulation. See MPP Section 45-305. Attach a page if adtional space is needed.

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

If you agree with the overpayment amount, 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 or sign a written voluntary grant offset. Please contact the worker at the top of this form to discuss the terms for these options.

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

Relevant Law: Welfare and Institutions Code sections 11466.23, 11466.235, Manual of Policies and Procedures (MPP) sections 22-009, 45-304, 45-305, and 45-306.

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.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

To request a Hearing:

If you think this action is wrong, you can ask for either an informal hearing provided by the County or a formal State hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

In order to request an informal hearing, your request must be made no later than 30 calendar days after this notice was mailed to you. You may send your request by any of the following methods.

In writing:

Email requests:

Address

Address

Phone requests:

Your request should state why you want the informal hearing and if you will need a free interpreter. If so, please indicate what language or dialect you speak.

You may appeal the informal hearing decision at a formal State hearing. You may request the formal State hearing within 90 calendar days after the informal hearing decision is mailed to you. If the informal hearing is requested but not held, the 90 days will begin 31 calendar days from the date of this notice.

If you choose a formal State hearing, please note that you must request that State hearing within 90 calendar days of the receipt of this notice.

If you have any questions, contact the worker at the top of the first page of this form.

TDD - For Hearing Impaired

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:

Overpayment _____

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 can be a friend or relative but cannot interpret for you.)

NAME	PHONE NUMBER	
STREET ADDRESS		
CITY	STATE	ZIP CODE

NA 1261 FORM AND INSTRUCTIONS
FOR GROUP HOMES AND FOSTER FAMILY AGENCIES ONLY

Welfare and Institutions Code sections 11466.23 and 11466.235 and Manual of Policies and Procedures (MPP) sections 45-304 and 45-305 require county welfare agencies to recoup Aid to Families with Dependent Children-Foster Care (AFDC-FC) overpayments with certain exceptions.

1. **Name**: Use this line to report the name of the foster care provider.
2. **Address**: Use this line to report the address of the foster care provider.
3. **City, State, Zip**: Use this line to report the city, state and zip code of the foster care provider.
4. **Notice Date**: Use this line to report the date the letter is drafted.
5. **Case Name**: Use this line to report the name of the child/youth.
6. **Case Worker Number**: Use this line to report the case worker's identification number.
7. **Case Worker Name**: Use this line to report the case worker's name.
8. **Case Number**: Use this line to report the case number associated with the child/youth.
9. **Telephone Number**: Use this line to report the case worker's telephone number.
10. **Address**: Use this line to report the case worker's address.
11. Name of child AFDC-FC benefits were provided for.
12. Beginning date and ending date AFDC-FC benefits were provided for each identified overpayment period. If more than one period is in contention, then a separate NA 1261 form needs to be completed.
13. Total amount of AFDC-FC funds the provider received.
14. Total amount of AFDC-FC funds the provider should have received.
15. Total amount of AFDC-FC funds overpaid.
16. Date overpayment was discovered and statement that the NOA is being sent within 1 year of discovery.
17. Total amount of AFDC-FC overpayment funds to be repaid.
18. Reason for the overpayment. Check the appropriate box(es).

    A. Child/youth left your Group Home or Foster Family Agency on_____and you were not entitled to payments for him/her after this date.

    B. Other: (Describe). If you use this you must give a full description of the overpayment.

If you have checked A or B, you must give a full description of how the overpayment was established. You may use the blank area of the right side of the form.

19. This section of the NA 1261 is left blank and should be used by counties to identify time periods for overpayments. This section can also be used to provide documentation and substantiation of time periods and mathematical calculations for verification of the overpayment. If you need additional space, attach a page and entitle it.

The purpose for any attachments submitted by the county pursuant to the instructions in #18 or #19 is for counties to provide clear and complete details of the reasons identified on the front page so that providers understand the basis for the establishment of the overpayment and the demand for repayment.

NOTICE OF ACTION

FORM AND INSTRUCTIONS -

For Approved Relatives, Non-Relative Extended Family Members, Foster Family Homes, Non-Related Legal Guardians or Non-Minor Dependents Residing In A Supervised Independent Living Setting:

COUNTY OF

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

(4) Notice Date: _____
(5) Case Name: _____
(6) Case Worker Number: _____
(7) Case Worker Name: _____
(8) Case Number: _____
(9) Telephone: _____
(10) Address: _____

(1) Name:
(2) Address:
(3) City, State Zip:

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

This is to inform you that you were overpaid AFDC-Foster Care benefits

(11) for _____ for
(NAME OF CHILD)

(12) the period of _____ to _____
(MM/DD/YYYY) (MM/DD/YYYY)

(13) Total amount you received: $ _____

(14) Total amount you should have received: $ _____

(15) Total amount of Overpayment: $ _____

(16) Date of Discovery: _____ Collection is permitted if demand is made within one year of discovery.

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

(18) Reason for the overpayment:

(A) 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.

(B) Other: _____

By law we can collect foster care overpayments if the adult caretaker caused the overpayment. We cannot require you to repay the overpayment if you meet an **exception.** Exceptions to repayment are:

- The overpayment was exclusively caused by county administrative error, or
- Both the county and the foster care provider did not know of or contribute to the cause of the overpayment.
- The minor's absence was temporary and the funds were used to maintain the home for their return or used to support their needs.

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

If you agree with the reason for overpayment and the overpayment amount, 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 payment agreement. You must contact the worker at the top of this page to discuss the terms of a written payment agreement.

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

Relevant Law: Welfare and Institutions Code section 11466.24, Manual of Policies and Procedures (MPP) sections 22-009, 45-304, 45-305, and 45-306.

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.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

To request a Hearing:

If you think this action is wrong, you can ask for either an informal hearing provided by the County or a formal State hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

In order to request an informal hearing, your request must be made no later than 30 calendar days after this notice was mailed to you. You may send your request by any of the following methods.

In writing:

Address

Address

Email requests:

Phone requests:

Your request should state why you want the informal hearing and if you will need a free interpreter. If so, please indicate what language or dialect you speak.

You may appeal the informal hearing decision at a formal State hearing. You may request the formal State hearing within 90 calendar days after the informal hearing decision is mailed to you. If the informal hearing is requested but not held, the 90 days will begin 31 calendar days from the date of this notice.

If you choose a formal State hearing, please note that you must request that State hearing within 90 calendar days of the receipt of this notice.

If you have any questions, contact the worker at the top of the first page of this form.

TDD - For Hearing Impaired

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:

Overpayment _____

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 can be a friend or relative but cannot interpret for you.)

NAME	PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

NA 1261A FORM AND INSTRUCTIONS

Welfare and Institutions Code (WIC) section 11466.24 and Manual of Policies and Procedures sections 45-304 and 45-305 require county welfare agencies to recoup Aid to Families with Dependent Children-Foster Care (AFDC-FC) overpayments with certain exceptions. **Do not** use this form if overpayment was to one of the listed providers BUT they meet an exception.

In an effort to clarify instances when an overpayment is legally collectible from Approved Relatives, NREFMs, FFHs, NRLGs or NMDs residing in a SILS, California Department of Social Services has developed the NA 1261A form and instructions. This newly developed form has specific language for Approved Relatives, NREFMs, FFHs, and NRLGs who are assessed an overpayment and do **NOT** qualify for one of the exceptions identified in WIC section 11466.24 because they knowingly contributed to or caused the overpayment.

1. **Name**: Use this line to report the name of the foster care provider.
2. **Address**: Use this line to report the address of the foster care provider.
3. **City, State, Zip**: Use this line to report the city, state and zip code of the foster care provider.
4. **Notice Date**: Use this line to report the date the letter is drafted.
5. **Case Name**: Use this line to report the name of the child/youth (or foster care recipient).
6. **Case Worker Number**: Use this line to report the case worker's identification number.
7. **Case Worker Name**: Use this line to report the case worker's name.
8. **Case Number**: Use this line to report the case number associated with the child/youth (or foster care recipient).
9. **Telephone Number**: Use this line to report the case worker's telephone number.
10. **Address**: Use this line to report the case worker's address.
11. Name of child/youth (or foster care recipient) for which AFDC-FC benefits were provided for.
12. Beginning date and ending date AFDC-FC benefits were provided for each identified overpayment period. If more than one period is in contention, then a separate NA 1261A form needs to be completed.
13. Total amount of AFDC-FC funds the provider received.
14. Total amount of AFDC-FC funds the provider should have received.
15. Total amount of AFDC-FC funds overpaid.
16. Date overpayment was discovered.
17. Total amount of AFDC-FC overpayment funds to be repaid.
18. Reason for the overpayment. Check the appropriate box(es).

    A. You knowingly failed to report the child/youth left your home on_____and you received payments for him/her that you were not entitled to after this date; or

    B. Other: Use additional page for detailed explanation that fully describes the reason why an overpayment exists for a period when the child/youth was not in the home that is excluded under WIC section 11466.24. The reason **must** be one of the listed reasons for collecting an overpayment.

19. This section of the NA 1261A is left blank and should be used by counties to identify time periods for overpayments. This section can also be used to provide documentation and substantiation of time periods and mathematical calculations for verification of the overpayment.

The purpose for any attachments submitted by the county pursuant to the instructions in #18 or #19 is for counties to provide clear and complete details of the reasons identified on the front page so that providers understand the basis for the establishment of the overpayment and the demand for repayment.

NOTICE OF ACTION

COUNTY OF

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

FORM AND INSTRUCTIONS - FOR KINSHIP-GUARIDANS ONLY

(4) Notice Date: _____
(5) Case Name: _____
(6) Case Worker Number: _____
(7) Case Worker Name: _____
(8) Case Number: _____
(9) Telephone: _____
(10) Address: _____

(1) Name:
(2) Address:
(3) City, State Zip:

FOR KINSHIP-GUARDIANSHIP ASSISTANCE PAYMENT (KIN-GAP) GUARDIANS ONLY:

This is to inform you that you were overpaid Kin-GAP benefits

(11) for _____
(NAME OF CHILD)

(12) for the month(s) of _____

(13) Total amount you received: $_____

(14) Total amount you should have received: $ _____

(15) Total amount of Overpayment: $_____

(16) Date of Discovery:_____Collections is permitted if demand is made within one year of discovery.

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

(18) Reason for the overpayment:

(A) In the month of_____(date) the child/youth was not residing in your home and you failed to report to your county social worker and you received payments for him/her that you were not entitled to.

(B) Other:_____

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

By law we can collect Kin-GAP overpayments if the adult caretaker caused or contributed to 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
- Both the county and the foster care provider did not know of or contribute to the cause of the overpayment.
- The minor's absence was temporary and the funds were used to maintain the home for their return or used to support their needs.

If you disagree with the reason for overpayment or the amount of the overpayment, or if you think the exception applies, you may request a hearing. Please see following pages for hearing instructions.

If you agree with the reason for or 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 discuss the terms of a written payment agreement.

If you fail to make a one-time payment of the total amount or enter into a written payment agreement, you may be subject to a reduction in the payment for the child/youth identified at the top of this form or civil judgment.

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 11466.24, Manual of Policies and Procedures (MPP) sections 22-009, 45-304, 45-305, and 45-306.

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.

State Hearing: If you think this action is wrong, you can ask for a hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

To request a Hearing:

If you think this action is wrong, you can ask for either an informal hearing provided by the County or a formal State hearing. Your benefits may not be changed if you ask for a hearing before this action takes place.

In order to request an informal hearing, your request must be made no later than 30 calendar days after this notice was mailed to you. You may send your request by any of the following methods.

In writing:

Address

Address

Email requests:

Phone requests:

Your request should state why you want the informal hearing and if you will need a free interpreter. If so, please indicate what language or dialect you speak.

You may appeal the informal hearing decision at a formal State hearing. You may request the formal State hearing within 90 calendar days after the informal hearing decision is mailed to you. If the informal hearing is requested but not held, the 90 days will begin 31 calendar days from the date of this notice.

If you choose a formal State hearing, please note that you must request that State hearing within 90 calendar days of the receipt of this notice.

If you have any questions, contact the worker at the top of the first page of this form.

TDD - For Hearing Impaired

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:

Overpayment _____

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 can be a friend or relative but cannot interpret for you.)

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

NA 1261B FORM AND INSTRUCTIONS

Welfare and Institutions Code (WIC) section 11466.24 and Manual of Policies and Procedures sections 45-304 and 45-305 require county welfare agencies to recoup Kin-GAP overpayments with certain exceptions. **Do not** use this form if the Kin-GAP family meets one of the exceptions.

In an effort to clarify instances when an overpayment is legally collectible from Kin-GAP guardians, California Department of Social Services has developed the NA 1261B form and instructions. This newly developed form has specific language for Kin-GAP families who are assessed an overpayment and do **NOT** qualify for one of the exceptions identified in WIC section 11466.24 because they knowingly contributed to or caused the overpayment.

1. **Name**: Use this line to report the name of the Kin-GAP guardian.
2. **Address**: Use this line to report the address of the Kin-GAP guardian.
3. **City, State, Zip**: Use this line to report the city, state and zip code of the Kin-GAP guardian.
4. **Notice Date**: Use this line to report the date the letter is drafted.
5. **Case Name**: Use this line to report the name of the child/youth (or foster care recipient).
6. **Case Worker Number**: Use this line to report the case worker's identification number.
7. **Case Worker Name**: Use this line to report the case worker's name.
8. **Case Number**: Use this line to report the case number associated with the child/youth (or foster care recipient).
9. **Telephone Number**: Use this line to report the worker's telephone number.
10. **Address**: Use this line to report the worker's address.
11. Name of child/youth (or foster care recipient) for which Kin-GAP benefits were provided.
12. Month Kin-GAP benefits were provided for each identified overpayment period. If more than one period is in contention, then a separate NA 1261B form needs to be completed.
13. Total amount of Kin-GAP funds the provider received.
14. Total amount of Kin-GAP funds the provider should have received.
15. Total amount of Kin-GAP funds overpaid.
16. Date overpayment was discovered.
17. Total amount of Kin-GAP overpayment funds to be repaid.
18. Reason for the overpayment. Check the appropriate box(es).

    A. You failed to report the child/youth left your home on _____ and you received payments for him/her that you were not entitled to after this date; or

    B. Other: Use additional page for detailed explanation that fully describes the reason why an overpayment exists for a period when the child/youth was not in the home that is not excluded under WIC section 11466.24.

    The reason **must** be one of the listed reasons for collecting an overpayment.

19. This section of the NA 1261B is left blank and should be used by counties to identify time periods for overpayments. This section can also be used to provide documentation and substantiation of time periods and mathematical calculations for verification of the overpayment.

The purpose for any attachments submitted by the county pursuant to the instructions in #18 or #19 is for counties to provide clear and complete details of the reasons identified on the front page so that providers understand the basis for the establishment of the overpayment and the demand for repayment.