User Centered CalFresh Client Communications

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CalFresh Overissuance Notice for IHE Pre-Redesign

Notice generally outdated.

So many reasons this may have happened.

Too much text and generally limited white space. Layout is not intuitive.

COUNTY OF

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

CALFRESH OVERISSUANCE NOTICE FOR INADVERTENT HOUSEHOLD ERRORS (IHE) ONLY

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

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing unless you already had a hearing on the amount you owe. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

Too many CalFresh benefits were issued to:
☐ the household.
☐ the household, whom you sponsored.

Here's why:

☐ The unreported earned income does not qualify for the 20% deduction.

You must repay the extra CalFresh benefits.
_________ in extra CalFresh benefits were issued for the period ______________________________.

The household received $ __________ in CalFresh benefits.

The household should have received $ _________ in CalFresh benefits. $__________ (extra CalFresh benefits) is what you received minus what you should have received.

☐ This amount was reduced by $ __________ because we owed the household benefits from past months or we received repayment of part of the amount owed. You now owe $ __________.

See how we figured the extra amount you got on the worksheet that came with this notice.

- You do not have to use any SSI benefits you get to repay this overissuance.
- You may ask for a hearing if you feel you received extra CalFresh benefits because the County Welfare Department made a mistake.
- Collection will be from all adults in the household when the overissuance occurred.

YOU MUST EITHER:

Pay for the extra CalFresh benefits in full, or complete, sign and return the enclosed Repayment Agreement (CF 377.7C) form and pay as agreed.

PROGRAM ACTIONS:

- Your repayment agreement will be based on your current ability to pay as figured by the county. Any changes in your ability to pay may change your monthly payments.
- If you do not sign and return the agreement within 30 days after the date of this notice, the amount of CalFresh benefits you get will be reduced by _________ % beginning __________.
- If you do not repay, the county may use other ways of collecting the amount owed, such as through the courts, other collection agency methods and by a federal government collection action.
- If this error is later reviewed by the court or hearing and determined to be your fault, penalties will apply even if you agree to repay what you owe.
- If the claim becomes delinquent or the household is sued, you may be subject to additional processing charges or court costs.
- If you do not repay the amount owed, the county may take your state/federal income tax refund and/or ask the court to attach your wages or any property you own.

Warning: If you believe this overissuance is wrong, this is your last chance to ask for a hearing. If you stay on CalFresh, the county can lower your CalFresh benefits to collect the overissuance. If you go off CalFresh before the overissuance is paid back, the county may take what you owe out of your income tax refund.

Rules: These rules apply: MPP 63-801.21, Duarte v. Saenz.

You may review them at your welfare office.

CF 377.7B (2/14) - REQUIRED FORM - NO SUBSTITUTE PERMITTED

Desired client action is not front and center.

Notes and warnings are mixed throughout.

CalFresh Overissuance Notice for IHE New & Improved

Clear numbering makes the notice easy to follow and indicates the order in which the client should read the notice.

A key factor, whether or not you are still receiving CalFresh, is highlighted to lead you to options specific to your circumstances.

Small icons are used as an alternative visual queue.

CALFRESH OVERISSUANCE NOTICE
INADVERTENT HOUSEHOLD ERROR (IHE)

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 disagree with us, you can ask for a hearing. If you ask for a hearing before [DATE] your benefits will not be changed before the hearing. See the back of this page for more information.

1. We paid you too much CalFresh

You may need to pay back the [$XXX] we "overissued" to your household between [MONTH] to [MONTH]. Please see below for your options to repay.

2. Here's why this happened

3. Your options to repay

YES ⇩ — Are you still receiving CalFresh? — NO ⇩

YES	NO
1. Join the 10% or $10 repayment plan If you don't respond, we'll assume you agree to a 10% or $10 per month reduction (whichever is more) in your CalFresh benefits until your balance is paid off. This will start on [DATE] OR **2. Agree to another repayment plan** Fill out and return the included repayment form by [DATE+30]. OR **3. Ask for a state hearing** If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by [DATE+90].	**1. Agree to a repayment plan** Fill out and return the included repayment form by [DATE+30]. OR **2. Ask for a state hearing** If you disagree with us, ask for a state hearing by filling out the back of this page and returning it by [DATE+90]. If you are NO LONGER receiving CalFresh, we **MUST** hear from you. If we do not hear from you by [DATE], we may take your federal income tax refund, offset certain federal benefits, or use other ways of collecting the amount owed.

Note:

- You do not have to use your SSI benefits to pay back the overissuance.
- Collection will be from all adults in the household when the overissuance occurred.
- If you stop receiving CalFresh before the overissuance is paid back, we may take what you owe out of your federal income tax refund or offset certain federal benefits.
- If you do not pay back the overissuance, agree to a payment plan, or have your benefits reduced, the county may use other ways of collecting the amount owed, such as through the courts (by wages or property), collection agency methods, or a federal government collection action.
- If the claim becomes delinquent or the household is sued, you may be subject to additional processing charges or court costs.

These rules apply: MPP 63-801; MPP 63-804. You may review them online at cdss.ca.gov or at your local county office.
CF 377.7B - REQUIRED FORM - NO SUBSTITUTE PERMITTED

Bolded text is used selectively.

Notes and warnings, are organized together.

Up Next: Semi-Annual Reporting Form (SAR 7)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

WORK PAYS

SAR 7 ELIGIBILITY STATUS REPORT

REPORT MONTH ____________

TO KEEP YOUR BENEFITS COMING ON TIME, PLEASE SIGN THE FORM AFTER ________ 1st AND RETURN IT BY ________ 5th
(SUBMIT MONTH) (SUBMIT MONTH)

CASE NUMBER HERE

NEED HELP? *(County Specific instructions w/county url)*
Worker Name:
Worker Phone:
County:
Street address:
City, State, Zip Code
BAR CODE:
[DIST. ID HERE]

Check the box if you would like to STOP getting any of the following: ☐ STOP my CalWORKs ☐ STOP my CalFresh ☐ STOP my Medi-Cal

1. Has anyone moved into or out of your home (including newborns) or did you move in with someone else since you last reported? ☐ Yes ☐ No (If yes, complete the section below)

Date of Move (mm/dd/yy)	Name (First, Middle, Last)	Date Of Birth	Relationship To You	Regularly Purchase And Prepare Food Together?
☐ In ☐ Out / /		/ /		☐ YES ☐ NO
☐ In ☐ Out / /		/ /		☐ YES ☐ NO
☐ In ☐ Out / /		/ /		☐ YES ☐ NO

2. Have there been any changes to your address since you last reported? ☐ Yes ☐ No (If yes, complete the section below)
New Address: ____________ Date Moved: ________
Mailing Address (if different than above) ____________

3. If you have moved since you last reported please fill out the section below:
Your rent or mortgage per month now? $ | If paid separately, your property taxes and home insurance per month now? $
Do you have utility costs that are not included in your rent or mortgage payment? If so, check which ones:
☐ Phone ☐ Trash ☐ Water ☐ Electric/Gas ☐ Other heating or cooling costs

4. CalWORKs only: Is anyone in your home:
A. Running from an outstanding warrant?
B. Found by a court to be in violation of probation or parole?
☐ Yes ☐ No (If yes, complete the section below)

Name of person	A or B from above	In what state was the warrant issued, or did violation happen?	Date of warrant or violation

5. Medical Costs: If anyone who gets CalFresh and is 60 years old or older, or disabled, had an increase in medical costs please complete the section below and attach proof:
Who had the change? | Amount of increase: $

6. Child Support: Did anyone who gets CalFresh have a change in the amount of child support they have to pay since they last reported? ☐ Yes ☐ No If yes, complete the section below and attach proof.
What was the amount paid in the Report Month? $________
Who paid support?________

7. Dependent Care: If anyone who gets CalFresh and either works, is looking for work, or is going to school, had an increase in out-of-pocket dependent care costs since they last reported, please complete the section below and attach proof:
What was the amount paid out-of-pocket in the Report Month? $________
Who paid: ________ List dependent(s): ________

8. Did anyone: Get, buy, sell, trade or give away any property, land, homes, cars, bank accounts, money, payments (such as lottery/casino winnings, back benefits from social security), or other property items since last reported?
☐ Yes ☐ No (If yes, complete the section below and attach proof. If you need more space, attach a separate piece of paper).

Who?	Type of Property?	When?	Amount/Value?	
				☐ Bought ☐ Sold ☐ Gave Away ☐ Spent ☐ Got as a gift ☐ Traded ☐ Won ☐ Other

9. Did anyone get income from employment in the Report Month? ☐ Yes ☐ No (If yes, complete the section below and attach proof). The Report Month is listed at the top of the first page. List each job for each person who works. If you need more space attach a separate piece of paper. Examples include babysitting, salary, self-employment, sick pay, tips, etc. If you lost your job, attach proof.

	Job #1	Job #2	Job #3
Name of person who got income:			
Source of income/Employer name:	Self-employed, check here ☐	Self-employed, check here ☐	Self-employed, check here ☐
How often paid:	☐ Weekly ☐ Biweekly ☐ Other ☐ Monthly ☐ Twice monthly	☐ Weekly ☐ Biweekly ☐ Other ☐ Monthly ☐ Twice monthly	☐ Weekly ☐ Biweekly ☐ Other ☐ Monthly ☐ Twice monthly
Gross amount of income they got in the report month:	$ DATE(S) RECEIVED:	$ DATE(S) RECEIVED:	$ DATE(S) RECEIVED:
Hours worked per month:			

10. Will there be any changes to your income from employment in the next six months (including income listed in #9)? ☐ Yes ☐ No (If yes, explain here and attach proof). Examples: Stopping or starting a job; increase or decrease of income; changes in hours; quitting a job or going on strike; change in how often you are paid.

11. Did anyone get money from any other source in the Report Month: ☐ Yes ☐ No (If yes, complete the section below and attach proof.) The Report Month is listed at the top of the first page. Examples include: Social Security, Unemployment Compensation, Veteran's Benefits, State Disability Insurance (SDI), Child/Spousal Support, Worker's Compensation, Loans/Gifts, Earned/Unearned Housing, Utilities, Food, etc. If you no longer get money from a source you previously reported, attach proof.

Name	Source of income	One time payment or monthly	How much
			$
			$
			$

12. Will there be any changes to money received from any other source in the next six months (including money listed in #11)? ☐ Yes ☐ No (If yes, explain here and attach proof). Examples of changes: An increase or decrease in income or benefits, or if you will start or stop getting income or benefits.

13. CalWORKs only: Have any of the following happened to anyone in your home since you last reported? ☐ Yes ☐ No
(If yes, check below and attach proof):
- ☐ Family Change (Married, divorced, separated, entered into a California Registered Domestic Partnership (RDP), have a non-California Domestic Partnership (DP), ended a DP or RDP, became pregnant, or is no longer pregnant?)
- ☐ Job/Employment (Start, stop, quit a job, started a business or went on strike?)
- ☐ Disability (Became disabled or recovered from a disability or major illness?)
- ☐ Immigration (Citizenship or immigration status change, or got a new card, form, or letter from USCIS (INS)?)
- ☐ Insurance (Started, stopped, or changed health, dental, or life insurance benefits, including MEDICARE?)
- ☐ Custody (Any change in the amount of time you care for/have custody of your children?)
- ☐ In-Home Support Services (Started or stopped getting services?)
- ☐ School Attendance For Age 18 or older student - started or stopped school/college? (You may be able to claim costs for books, school transportation, etc.)
- ☐ Someone paid for all of my housing, food, clothing or utility costs. (please explain) ________
- ☐ Other________

Please read carefully, sign, and date.

By signing this form:
- I understand and certify, under penalty of perjury, that all my answers on this report are correct and complete to the best of my knowledge.
- I understand the penalties for fraud are as follows: I may be sent to prison for up to 20 years and fined up to $250,000. I may have to pay back benefits if I was not eligible to them. The first time I break the rules on purpose I will not be able to get CalFresh for one year; the second time two years; and after the third time I will not be able to get CalFresh again.
- I understand and agree to give copies of all documents needed to complete my semi-annual report.
- I understand that in some instances, I may be asked to give consent to the County to make whatever contacts are necessary to determine eligibility.

CERTIFICATION - FRAUD WARNING

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be legally prosecuted. I may also be charged with committing a felony if more than $950 in Cash Aid, and/or CalFresh is wrongly paid out as a result of such an action. I have received a copy of the Instructions and Penalties for the SAR 7 Eligibility Status Report for Cash Aid and CalFresh.

YOU MUST SIGN AND DATE THIS REPORT AFTER THE LAST DAY OF THE REPORT MONTH OR IT WILL BE CONSIDERED INCOMPLETE.
I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW: For Cash Aid: You and your aided spouse, registered domestic partner, or the other parent (of cash-aided children) if living in the home. For CalFresh: The head of household, a responsible household member, or the household's authorized representative.

SIGNATURE OR MARK	DATE SIGNED	HOME PHONE ( )	CONTACT/CELL PHONE ( )
SIGNATURE OF SPOUSE, REGISTERED DOMESTIC PARTNER, OR OTHER PARENT OF CASH AIDED CHILD(REN)	DATE SIGNED	SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE SIGNED