NOTICE OF ACTION
IN-HOME SUPPORTIVE SERVICES (IHSS)
OVERPAYMENT - ADVANCE PAY

(ADDRESSE)

County of: ____________________________

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

Questions? Contact your worker.

NOTE: This notice ONLY relates to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. **KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.**

OVERPAYMENT INFORMATION:

This notice is to inform you that you were overpaid for authorized In-Home Supportive Services (IHSS) for the period of _________ to _________, totaling ____ months. During this period your monthly IHSS payment amount was ________________. Thus, the amount of the overpayment is $______, or _____ months x $_______ per month.

You are required to repay the total overpayment amount of **$**______________, (amount unreconciled).

REASON FOR OVERPAYMENT:

The reason you were overpaid is because you failed to submit signed timesheets for reconciliation within 45 days from the date you were issued your advance payment. (MPP §30-768.213)

METHOD OF REPAYMENT:

Consistent with State law, your monthly IHSS Advance Pay payment will be adjusted resulting in a reduction of **10%** until the overpayment is repaid. At the current pay rate, your IHSS Advance Pay payment amount will be reduced by $_______________. The reduction will take effect ______________ through______________. You must continue to pay your Individual provider(s) in full for all Authorized IHSS services provided.

You also have the option of repaying the full amount, or making additional payments in addition to the reduction described above to shorten the repayment time. If you choose either of these options, please make checks/money orders payable to:

(COUNTY DEPARTMENT)

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ADDITIONAL INFORMATION:

Please note, if Advance Pay timesheets are not submitted for reconciliation 90 days from the date you were last issued payment, the county may change your Advance Payment method to payment in arrears. This means your IHSS provider(s) will be paid directly by the state (instead of by you) after you approve each timesheet. (MPP § 30-767.133(b) and 30-769.737)

You must immediately report any changes that might affect your eligibility or need for IHSS such as changes in income, property, living arrangement, medical condition or ability to work. If you have any questions or think additional facts should be considered regarding this overpayment, contact your social worker.

LAWS AND RULES:

These laws and rules apply: Welfare and Institutions Code §10950, 12300(a),12303.4, 12304 and California Department of Social Services' Manual of Policies and Procedures (MPP) § 30-767.133, 30-767.133(a) and (b), 30-768.213, 30-769.737, you may review them at your county welfare office.

STATE HEARING: YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS.

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YOUR HEARING RIGHTS

1. You have the right to ask for a conference with the county to talk about this action. At the conference you can speak for yourself, or someone else (a lawyer, relative, friend, or other person) can speak for you. If you want a conference, contact the county.

2. Whether or not you ask for a conference, you also 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.

3. If you ask for a hearing before an action on your In-Home Supportive Services (IHSS) takes place, your services will continue until the hearing. If you make your request in good faith, you will not have to repay any money you receive for services you get pending the hearing, even if the hearing decision says the county's action was right.

4. You can ask for a hearing in person or in writing. You have to say that you want a hearing and tell the reason(s) you want one.

5. You can ask for a hearing on your own or you can ask the county for assistance. Either way, you should tell your worker as soon as possible.

6. At a hearing, you can speak for yourself, or someone else (a lawyer, relative, friend, or other person) can speak for you. You can get free legal help at your local legal aid or welfare rights office. For a legal aid referral, call the toll-free number listed on this page.

7. If you do not want to go to the hearing alone, you can bring a relative, friend, or other person with you.

8. You can review the regulations about hearings at your local IHSS office.

9. Information Practices: The information you give to ask for a hearing is required to process your request according to state law. A case file will be made up for the hearing and you have the right to look at the information in the file. Any information you give may be shared with the county or the United States Department of Health and Human Services.

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 this page to:

California Department of Social Services
State Hearings Division
P.O. Box 944243
Mail Station 8-16-50
Sacramento, CA 94244-2430

OR Call toll free:
1-800-952-5253 or for hearing or speech impaired who use TDD, 1-800-952-8349.

REQUEST FOR HEARING:

I want a hearing because I disagree with the action of the county regarding my social services. Here's why:

____
____
____
____

☐ If you need more space, check box 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:

____

PERSON WHOSE SOCIAL SERVICES WERE DENIED, CHANGED OR STOPPED

Telephone | Birthdate

Street Address

City | State | Zip Code

Signature | Date

NAME OF PERSON COMPLETING THIS FORM

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records and/or go to the hearing for me. (This person can be a friend or relative but this person cannot interpret for you.)

Name

Telephone

Street Address

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City State Zip Code

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