



DAVID MAXWELL-JOLLY
Director

State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

April 29, 2009

TO: ALL COUNTY WELFARE DIRECTORS Letter No. : 09-22
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALIST/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: INCOME EXEMPTION FOR THE INCREASE TO BOTH REGULAR AND
EXTENDED UNEMPLOYMENT COMPENSATION BENEFITS

The purpose of this letter is to inform counties that the American Recovery and Reinvestment Act of 2009, Division B, Title II, Section 2002 (h) provides for a Federal Stimulus increase to both regular and extended Unemployment Benefits by \$25 a week. The increases will begin with the week of February 22, 2009, for both new and existing claims. The monthly equivalent to the \$25 weekly increase shall be exempt income and, as such, shall not be considered for purposes of determining Medi-Cal eligibility or share-of-cost (SOC).

To be eligible for the additional Unemployment Compensation Benefit payments an individual must:

- Have a regular Unemployment Compensation Benefits claim, Disaster Unemployment Assistance (DUA) claim, or federal extension claim that began on or before December 20, 2009, or
- Submit a continued claim form for a week or weeks beginning on or after February 22, 2009 and;
- Be eligible for at least \$1 in Unemployment Compensation Benefits, and
- Meet all other criteria.

Any individuals who have a claim effective December 20, 2009, and have not exhausted all rights to regular compensation can receive the additional \$25 weekly benefit up to June 30, 2010.

Effective immediately, applicants/beneficiaries or representatives who report the receipt of the \$25 Federal Stimulus increase in their Unemployment Compensation Benefit as described above, shall be required to provide verification sufficient to identify the nature of the increase in order to receive the income exemption. (See enclosed sample).

Counties shall rescind any discontinuance, denial or SOC notice of action (NOA) issued as they become aware of any case that was adversely affected as a result of the delay in implementing this provision of the ARRA. Counties shall then retroactively re-determine eligibility and SOC as appropriate and reissue NOAs.

If you have questions regarding this issue, please call Mr. Craig Yagi, of my staff, at (916) 552-9522.

Original Signed By

Vivian Auble, Chief
Medi-Cal Eligibility Division

Enclosure

160522

CLAIM EXPIRES

SSA# [REDACTED] / WEEK PAID
03-13-10 [REDACTED]04-04-09 \$450.00
04-11-09 \$450.00

YOUR CLAIM BALANCE AFTER THIS PAYMENT IS \$10350.00
UNEMPLOYMENT COMPENSATION IS TAXABLE. A QUESTION ON THE CLAIM FORM ALLOWS YOU TO REQUEST
FEDERAL INCOME TAX WITHHOLDING AT 10% OF YOUR PAYABLE AMOUNT. YOU MAKE A NEW WITHHOLDING
CHOICE ON EACH CLAIM FORM YOU SUBMIT.
THE ATTACHED CHECK INCLUDES A FEDERAL STIMULUS PAYMENT.

Regular
Benefit

* Sec check below.

ALLOW 10 DAYS FOR DELIVERY OF CHECK.

DETACH THIS STUB FOR YOUR RECORD

486985C

CONTINUED
CLAIM

03-15-09

A A

ANSWER ALL QUESTIONS. SEE SECTION A. ON BACK FOR EXAMPLES
OF HOW TO COMPLETE YOUR ANSWERS. Each question is explained
in your booklet, A Guide to Benefits and Employment Services.

COMPLETE AND MAIL THIS FORM ON 04-26-09

1. Were you too sick or injured to work? ☐ YES ☐ NO ☐ YES ☐ NO
If yes, enter the number of days (1 through 7) you were unable to work. ☐ (1-7) ☐ (1-7)
2. Was there any reason (other than sickness or injury) that you could not have
accepted full time work each workday? ☐ YES ☐ NO ☐ YES ☐ NO
3. Did you look for work? ☐ YES ☐ NO ☐ YES ☐ NO
☐ IF MARKED 'X', YOU MUST COMPLETE SEC. B., WORK-SEARCH RECORD, ON REVERSE.
4. Did you refuse any work? ☐ YES ☐ NO ☐ YES ☐ NO
5. Did you attend any kind of school or training? ☐ YES ☐ NO ☐ YES ☐ NO
6. Do you work or earn money, WHETHER FULL TIME OR PART TIME, OR NOT?
If yes, you MUST complete items a. and b.
Enter earnings before deductions here \$
Enter employment information here \$

LAST WEEK	TOTAL WEEKS WORKED	EMPLOYER NAME AND MAILING ADDRESS - INCLUDE ZIP CODE	REASON NO LONGER WORKING (OR WRITE "STILL WORKING")
1ST WEEK			
2ND WEEK			

7. If you want federal income tax withheld for the week(s) shown above,
mark this block ☐
8. If you had a change of mailing address or phone number,
mark this block and complete Sec. D on reverse ☐

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NORCAL AUTHORIZATION CENTER
PO BOX 989057
WEST SACRAMENTO CA 95798-9057

I understand the questions on this form. I know the law provides penalties
I make false statements or withhold facts to receive benefits; my answers
true and correct. I declare under penalty of perjury that I am a U.S. citizen
national; or an alien in satisfactory immigration status and permitted to work
USCIS. I signed this form after the latest date for which I am claiming ben

X

(your signature is required)

DE 4581-CKOC Rev. 6 (2-09) FLASH CU-PA862

VERIFY THE AUTHENTICITY OF THIS TRI-COLOR SECURITY DOCUMENT THIS IS A WATERMARKED PAPER. HOLD TO LIGHT TO VERIFY

SOCAL AUTHORIZATION CENTER U160522
PO BOX 19007
SAN BERNARDINO CA 92423-9007

PERIOD ENDING U4869850
7508 04-11-09 827 1211

STATE OF CALIFORNIA
BILL LOCKYER, TREASURER



03-15-09 A 04-15-09
EMPLOYMENT DEVELOPMENT DEPARTMENT
VOID IF OVER \$950, OR IF NOT CASHED
WITHIN 1 YEAR FROM DATE ISSUED

PAY TO THE ORDER OF: **\$5000**
CITY OF LOS ANGELES

PAY TO
THE ORDER OF:

NINE HUNDRED FIFTY DOLLARS

\$950.00**

SAMPLE

DIRECTOR
UNEMPLOYMENT INSURANCE ACCOUNT

110072 1211111111 486985068