IM-19 STATE APPORTIONMENT NOTICE FORM
NOTICE OF SSI BENEFITS RECEIVED BY COUNTY

To	Client Name	First and Last Name
	Client Address	Client Address
	Client Phone Number	Client Phone Number
	Social Security Number	SSN
From	County Technician Name	Worker's First and Last Name
	County Department	County Department
	Address	County Address
	Telephone Number	Worker's Phone Number
Date:		***DATE FORM WAS MAILED***

This is to inform you that the County Department of Social/Human Services listed above has received a check on your behalf from the Social Security Administration. This check is all or part of your retroactive Supplemental Security Income (SSI) payment.

Earlier you signed an authorization giving Social Security the authority to reimburse the State (or County Department of Social/Human Services) for assistance given to you under the State Aid to the Needy Disabled (AND) program (3.540, 9 CCR-2503-5) for meeting basic needs while waiting on a decision of SSI eligibility. This notice explains the distribution of the SSI retroactive check. (**Comment**: Home Care Allowance is not included in this figure since it is not reimbursable.)

We are sending you the excess amount due, if any.

1. Amount of retroactive SSI payment received on: ***DATE SSI LUMP SUM RECEIVED*		$ TOTAL SSI LUMP SUM RECEIVED
2. Minus amount of payment refunded to the State		$ TOTAL IAR AMOUNT
	Subtotal	The above amount is the total benefits paid to you beginning with the first month you received SSI and ending with (and including) the month SSI payments began.
(Calculation: 5 months x $ 189 per month)	$ 945	
(Calculation: months x $ per month)	$	
(Calculation: months x $ per month)	$	
(Calculation: months x $ per month)	$	
(Calculation: months x $ per month)	$	
(Calculation: months x $ per month)	$	
3. Amount of check, if any, being sent to you from the county Department of Human/Social Services.		$ TOTAL AMOUNT TO CLIENT (IF ANY)

APPEAL RIGHTS ON REVERSE SIDE

CLIENT APPEAL RIGHTS

If you think the action taken in this notice is wrong, you have the right to a hearing so that you can discuss why the action was taken. You can ask for a county-level hearing or a state-level hearing or both.

COUNTY HEARING: If you want a county hearing, you must call the telephone number listed on this form within the notice period which is ten (10) days from the date this notice was placed in the mail.

STATE HEARING: If you disagree with the county hearing decision, you may ask for the next level state hearing within fifteen (15) days after the county hearing decision. If you want a state appeal, you must write a letter to:

Division of Administration Hearings
1525 Sherman, 4th Floor
Denver, Colorado 80203

In the letter, say that you want to appeal and why. If you need help, you can ask anyone to help you or you may talk to a Legal Aid Office.

You may skip the county all together and have a state level hearing. You have 90 calendar days from the date this notice was placed in the mail to ask for a state level hearing. Write to the Division of Administrative Hearings at the above address to ask for such a hearing. If you do not request a hearing within the above time frame, you cannot request another hearing on this overpayment.

If you believe you have been discriminated against because of race, color, sex, age, religion, political belief, national origin, or handicap, you have a right to complain to:

US Department of Health and Human Services (HHS)
Director, Office for Civil Rights (OCR)
Room 506-F, 200 Independence Ave. S.W.
Washington, D.C. 20201
(202) 619-0403 (*voice*) or (202) 619- 3257 (*TDD*)