FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #10-114-OPE

(This Policy Bulletin Replaces PB #10-61-OPE)

RECOUPMENT FORMS M-328aa and M-328d

Date: November 19, 2010	**Subtopic:** Forms

This procedure can now be accessed on the FIAweb.

Revisions to original Policy Bulletin:

This policy bulletin is being revised to inform Job Center staff that the last paragraph in the Notice of Intent to Transfer Recoupment and Reduce Cash Assistance form (**M-328aa**) has been deleted. That paragraph read "*If your current household needs (pre-added, rent and miscellaneous allowance, if any) and the number of recoupments remain the same, recoupment will last for approximately ______issues.*"

Purpose:

The purpose of this policy bulletin is to inform all Job Center staff about two forms, the **M-328aa** and the Notice of Completed Recoupment form (**M-328d**).

Management Information Systems (MIS) will mail the appropriate form to participants who either completed a recoupment or whose cases are subject to a transferred recoupment action.

M-328aa:

The Timely Aid-Continuing Fair Hearing Language Insert (Form **M-328a/b/c**) is sent out with Form **M-328aa**.

This form informs the head of household that an existing recoupment for a household member, who previously had been a member of another case, will be transferred to the head of household's current case and that, as a result, their Cash Assistance (CA) benefits will be reduced.

MIS will insert the following language:

M-328aa language to be inserted by MIS

"While ______________ was an active member of case _________, that household received more cash assistance than it should have. We already told the head of household _____________ of that case about the overpayment(s), and HRA's right to recover the overpayment(s). Because either you are now the head of household or _____________ is now a member of your case, you must repay the following balances:

Your Cash Assistance (CA) grant will be reduced by 10 percent of your household needs. If you have an existing recoupment at the maximum rate, no further reduction in your grant will be made until the current recoupment is completed. If you are not receiving a CA grant, the reduction will start if you resume CA. If the recoupment presents a hardship, you may contact your Worker to ask for a hard ship determination."

The notice will also contain the overpayment amount, dates, and reason for each recoupment being transferred.

M-328d:

This form informs participants whose cases were subject to a recoupment action, that the amount that was owed has been fully recouped.

MIS will insert the following language:

M-328d language to be inserted by MIS

"We wish to inform you that recoupment activity on your case has been completed. The last overpayment on record has been repaid or otherwise resolved. An increase in your Cash Assistance (CA) grant will result in a decrease in your Food Stamp (FS) benefit. (Your FS benefit was increased when your CA grant was decreased for recoupment.)"

Samples of the forms are attached.

Effective Immediately

Attachments:

Please use Print on Demand to obtain copies of forms.

M-328aa	Notice of Intent to Transfer Recoupment and Reduce Cash Assistance (Rev. 11/19/10)
M-328aa (S)	Notice of Intent to Transfer Recoupment and Reduce Cash Assistance (Spanish) (Rev. 11/19/10)

M-328a/b/c Insert	Timely Aid-Continuing Fair Hearing Language Insert/ Conference and Fair Hearing Information (Rev.10/30/09)
M-328a/b/c (S) Insert	Timely Aid-Continuing Fair Hearing Language Insert/ Conference and Fair Hearing Information (Spanish) (Rev.10/30/09)
M-328d	Notice of Completed Recoupment (6/4/10)
M-328d (S)	Notice of Completed Recoupment (Spanish) (6/4/10)

Form M-328aa LLF Rev. 11/19/10

Date: ______________________________

Case Number: ______________________________

Case Name: ______________________________

Notice of Intent to Transfer Recoupment and Reduce Cash Assistance

The Human Resources Administration intends to reduce your Cash Assistance (CA) grant beginning ___________ to recover an outstanding overpayment(s) from a previous case.

SAMPLE

If a reduction is to take effect beginning with the first regular CA grant received after the date of the proposed reduction, you will be informed of the starting date and the amount of the first reduced grant. Thereafter, the amount recouped each cycle may vary as changes occur in your household needs and the number of recoupments on record, but it will not be affected by budgeted income.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION INSERT ON HOW TO APPEAL THIS DECISION

Human Resources Administration
Department of Social Services
Family Independence Administration

Form M-328aa (S) LLF Rev. 11/19/10

Fecha: ____________________________

Número del Caso: ____________________________

Nombre del Caso: ____________________________

Aviso de la Intención de Transferir Reembolso y de Reducir la Asistencia en Efectivo

La Administración de Recursos Humanos tiene la intención de reducir su concesión de Asistencia en Efectivo (CA) a partir del ________________ para recobrar un sobrepago(s) pendiente(s) de un caso anterior.

SAMPLE

Si después de proponerse, la reducción entra en vigor en la fecha de la primera concesión normal de Asistencia en Efectivo, usted será informado(a) de la fecha de comienzo y cantidad de la primera concesión reducida. Posteriormente, la cantidad reembolsada en cada ciclo puede variar conforme a cambios en las necesidades de su hogar y el número de reembolsos en su expediente, sin ser afectada por el ingreso presupuestado.

USTED TIENE EL DERECHO DE APELAR CONTRA ESTA DECISIÓN.
ASEGÚRESE DE LEER LA HOJA DE INFORMACIÓN SOBRE CONFERENCIAS Y AUDIENCIAS IMPARCIALES SOBRO CÓMO APELAR CONTRA ESTA DECISIÓN.

Timely Aid-Continuing Fair Hearing Language Insert
Conference and Fair Hearing Information

CONFERENCE
If you think our decision is wrong, or if you do not understand our decision, please call us to set up a conference (informal meeting with us). To do this, call or write to the Center that handles your case. Sometimes this is the fastest way to solve a problem you may have. We encourage you to do this even if you have asked for a Fair Hearing. If you ask for a conference, you are still entitled to a Fair Hearing.

STATE FAIR HEARING
How to Ask for a Fair Hearing: If this notice is telling you that you owe a Cash Assistance overpayment, and if you do not agree that you owe this overpayment, you must call for a Fair Hearing within 60 days of the date of this notice. If you do not call for a Fair Hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong. If you believe the decision(s) we are making is/are wrong, you may request a State Fair Hearing by telephone, writing, fax, in person or online.

(1) TELEPHONE: Call **(800) 342-3334**. (Please have this notice in hand when you call.)

(2) WRITE: Send a copy of the entire notice, with the "Fair Hearing Request" section completed, to:
Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201
(Please keep a copy for yourself.)

SAMPLE

(3) FAX: Fax a copy of the entire notice, with the "Fair Hearing Request" section completed, to:
(518) 473-6735

(4) IN PERSON: Bring a copy of the entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at either:
14 Boerum Place, Brooklyn or **330 West 34th Street, 3rd Floor, Manhattan**

(5) ONLINE: Complete an online request form at: **http://www.otda.state.ny.us/oah/forms.asp**

What to Expect at a Fair Hearing: The State will send you a notice that tells you when and where the Fair Hearing will be held. At the hearing, you will have a chance to explain why you think our decision is wrong. To help explain your case, you can bring a lawyer and/or witnesses such as a relative or a friend to the hearing, and/or give the Hearing Officer any written documentation related to your case such as: pay stubs, leases, receipts, bills and/or doctor's statements, etc. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give that person a letter to show the Hearing Officer that you want that person to represent you. At the hearing, you, your lawyer or your representative can also ask questions of witnesses whom we bring, or you bring, to explain the case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the Yellow Pages under "Lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case files. If you call, write or fax us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax us, we will send you free copies of specific documents from your files which you think you may need to prepare for your Fair Hearing. To ask for documents or to find out how to look at your file, call **(718) 722-5012**, fax **(718) 722-5018** or write to **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201**. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: A RECOUPMENT at the rate of ______ percent (%) is being taken against your Cash Assistance. If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d). Your recoupment rate will appear on the Notice of Intent to Reduce Cash Assistance [**M-328a**]).

FAIR HEARING REQUEST

Continuing Your Benefit(s): Your benefits will continue unchanged until a Fair Hearing decision is issued, if you ask for a Fair Hearing before the effective date stated in this notice.

Please be reminded that if you ask for a conference only, and not a State Fair Hearing, within the time frame indicated in the Continuing Your Benefits section, your benefits will not stay the same.

If you lose the Fair Hearing, you will have to pay back any benefits you received, but should not have received, while you were waiting for the decision. If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a Fair Hearing or, if you send this notice, check the box below:

☐ **I do not want to keep my benefits the same until the Fair Hearing decision is issued.**

Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within sixty (60) days from the date of the notice for public assistance issues.
If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, in person, or online, please write to ask for a Fair Hearing before the deadline.

☐ **I want a Fair Hearing. The Agency's decision is wrong because:**

SAMPLE

Print Name: ______________________________ Case Number: ______________

Address: __________ ______ ________ ________ ______________ Telephone: ______________
Street Apt.# City State Zip Code

Signature: ______________________________ Date: ______________

NYC Human Resources Administration | Family Independence Administration
Department of Social Services

Hoja sobre Audiencia Imparcial Oportuna para la Continuación de Beneficios
Información sobre Conferencias y Audiencias Imparciales

CONFERENCIA

Si usted considera que nuestra decisión ha sido errónea, o si no la entiende, por favor llámenos para arreglar una conferencia (reunión informal con nosotros). Para ello, llame o escríbale al Centro que está encargado de su caso. A veces este resulta el modo más rápido de solucionar algún problema que pueda tener. Le recomendamos que así lo haga, aun si ha pedido una Audiencia Imparcial. En el caso de solicitar una conferencia, usted seguirá teniendo derecho a una Audiencia Imparcial.

AUDIENCIA IMPARCIAL ESTATAL

Cómo Solicitar una Audiencia Imparcial: Si este aviso le está informando de que usted debe un sobrepago de Asistencia en Efectivo, usted tiene que llamar para solicitar una Audiencia Imparcial dentro 60 días de la fecha que se encuentra en este aviso. Si usted no llama para una Audiencia Imparcial dentro los 60 días de la fecha que se encuentra en este aviso, en el futuro usted no puede reclamar que la decisión de la agencia de que usted debe este sobrepago de Asistencia en Efectivo es errónea. Si usted considera que la(s) decisión(es) que estamos tomando es/son errónea(s), puede solicitar una Audiencia Imparcial Estatal por teléfono, por escrito, por fax, en persona o por Internet.

(1) POR TELÉFONO: Llame al **(800) 342-3334**. (Favor de tener este aviso a la mano cuando llame.)

(2) POR ESCRITO: Envíe una copia de todo el aviso, con la sección "Petición de Audiencia Imparcial" llenada, a:
Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201
(Favor de guardar una copia para usted.)

(3) POR FAX: Envíe una copia de todo el aviso, con la sección "Petición de Audiencia Imparcial" llenada, al número: **(518) 473-6735**.

(4) EN PERSONA: Traiga una copia de todo el aviso, con la sección "Petición de Audiencia Imparcial" llenada, a la Oficina de Audiencias Administrativas, Oficina de Asistencia Temporaria y para Incapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a cualquiera de las siguientes direcciones: **14 Boerum Place, Brooklyn** o **330 West 34th Street, 3rd Floor, Manhattan**.

(5) POR INTERNET: Llene una solicitud de formulario electrónico conectándose a: **http://www.otda.state.ny.us/oah/forms.asp**

SAMPLE

Qué Puede Esperar de la Audiencia Imparcial: El Estado le enviará una notificación que le informará de cuándo y dónde se llevará a cabo la Audiencia Imparcial. En la audiencia, usted tendrá la oportunidad de explicar la razón por la que considera que nuestra decisión es errónea. Para ayudarle a presentar su caso, usted puede traer a la audiencia a un abogado y/o testigos como familiares o amigos, y/o entregarle al Funcionario de la Audiencia cualquier documento escrito relacionado con su caso tal como: talones de paga, contratos de arrendamiento, recibos, cuentas y/o declaraciones médicas, etc. Si no puede acudir a la audiencia, puede enviar a alguien que le represente. Si tal representante no es abogado, usted debe proporcionarle una carta para que el Funcionario de la Audiencia sepa que usted desea que tal persona le represente. Durante la audiencia, usted, su abogado o su representante también pueden interrogar a los testigos por parte nuestra o suya, para aclarar el caso.

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, puede obtener tal asistencia comunicándose con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede localizar la Sociedad de Ayuda Legal o grupo de abogacía más cercano buscando en las Páginas Amarillas (Yellow Pages) bajo "lawyers" (abogados).

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un facsímil, le proporcionaremos copias gratuitas de los documentos que se encuentran en su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por facsímil, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para pedir documentos o para averiguar como revisar su archivo, llámenos al **(718) 722-5012**, por facsímil al **(718) 722-5018** o escriba a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201**. Si desea copias de documentos contenidos en su archivo, debe pedirlas con anticipación. Éstas se le enviarán dentro de un plazo adecuado antes de la fecha de la audiencia. Los documentos serán enviados por correo sólo si lo solicita específicamente.

INFORMACIÓN: Un REEMBOLSO con un porcentaje del _____ (%) se está tomando contra su caso de Asistencia en Efectivo. Si usted cree que el reembolso de este porcentaje causará a su familia penuria indebida, debe comunicarse con su trabajador para explicarle su razón. Penuria indebida significa que la persona no tiene suficiente dinero para comer, para refugio o para electricidad y gas, para conseguir ropa necesaria, comprar artículos de primera necesidad o pagar necesidades médicas que no estén cubiertas por la Asistencia Médica. Su trabajador le explicará qué comprobantes tendrá que presentar para demostrar que el reembolso con este porcentaje le causará penuria indebida. Si nosotros decidimos que el porcentaje del reembolso causará penuria indebida, el porcentaje del reembolso se cambiará a entre el 5 y 10%. El porcentaje del reembolso tiene que ser de por lo menos el 5%. Esta decisión está basada en el reglamento Estatal 18 NYCRR § 352.31(d). Su tasa de reembolso aparecerá en el Aviso de la Intención de Reducir la Asistencia en Efectivo [**M-328a (S**)].

PETICIÓN DE AUDIENCIA IMPARCIAL

Mantenimiento de Su(s) Beneficio(s): Su(s) beneficio(s) continuará(n) sin cambios, hasta que se emita la decisión de la Audiencia Imparcial, si usted solicita una Audiencia Imparcial antes de la fecha de entrada en vigor indicada en el presente aviso.

Favor de tener presente que si usted sólo pide una conferencia, y no una Audiencia Imparcial Estatal, dentro de la fecha indicada en la sección de Mantenimiento de Su(s) Beneficio(s), sus beneficios no quedarán iguales.

Si usted pierde la Audiencia Imparcial, tendrá que reembolsar cualquier beneficio que haya recibido, sin tener derecho al mismo, mientras esperaba la decisión. Si usted no desea que sus beneficios se mantengan sin cambios hasta que se emita una decisión, debe informarle al Estado cuando llame para pedir una Audiencia Imparcial o, si envía este aviso de regreso, marque la casilla a continuación:

☐ **No deseo que mis beneficios continúen sin cambios hasta que la decisión de la Audiencia Imparcial sea emitida.**

Fecha Límite: Si usted desea que el Estado revise nuestra decisión, tiene que solicitar una Audiencia Imparcial dentro de sesenta (60) días a partir de la fecha de este aviso para asuntos de asistencia pública.

Si no logra comunicarse con la Oficina de Asistencia Temporal y de Asistencia para Incapacitados del Estado de Nueva York (New York State Office of Temporary and Disability Assistance) por teléfono, por fax, en persona o por Internet, favor de enviar por escrito su solicitud de Audiencia Imparcial antes de la fecha límite.

☐ **Deseo una Audiencia Imparcial. La decisión de la Agencia es errónea porque:**

SAMPLE

Nombre en Letras de Molde: ______________________ Núm. del Caso: ______________

Dirección: __________ ______ ________ ________ ______________ Teléfono: ______________
Calle Apto.# Ciudad Estado Código Postal

Firma: ______________________________ Fecha: ______________

Date: ______________________________

Case Number: ______________________________

Case Name: ______________________________

Notice of Completed Recoupment

SAMPLE

Human Resources Administration
Department of Social Services
Family Independence Administration

Form M-328d (S) LLF 6/4/10

Fecha: ______________________________

Número del Caso: ______________________________

Nombre del Caso: ______________________________

Aviso de Reembolso Completo

SAMPLE