



FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #11-86-OPE (This Policy Bulletin replaces CD #85-135)

PAYMENTS TO APPLICANTS/PARTICIPANTS FOR STORAGE OF FURNITURE AND PERSONAL BELONGINGS

| Date: September 2, 2011 | Subtopic(s): Payment of Storage Fees |
|--|--|
| <p> This procedure can now be accessed on the FIAweb.</p> | <p>The purpose of this policy bulletin is to remind all Job Center staff that a Cash Assistance (CA) applicant/participant who places furniture and personal belongings in storage due to circumstances such as housing relocation, eviction or residence in temporary housing may be eligible for payment of storage fees as charged by the storage company that provides the storage. This includes storage of items in states other than New York. The storage payments may be paid as long as eligibility for CA continues and circumstances necessitating the storage continues to exist.</p> <p>There is no regulatory limit on the amount that can be paid for the storage nor are there restrictions on the types of furniture and personal belongings that require storage.</p> <p><u>Restrictions on Use of Storage Fees</u></p> <p>Assistance to pay storage fees is not a benefit meant to continue for an indefinite period of time. If an applicant/participant is residing in permanent housing and resided in such housing when he/she incurred storage expenses, he/she is not entitled to payment of storage fees.</p> <p>Note: The payment of storage fees to an applicant/participant in the past does not establish current eligibility to receive storage fees.</p> |

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or
send an e-mail to *FIA Call Center Fax* or fax to: (917) 639-0298

EAA and EAF Applicants

The cost of essential storage of furniture and personal belongings during relocation, eviction or residence in temporary housing must be met. If an applicant is eligible for EAA (Emergency Assistance for Adults) or EAF (Emergency Assistance for Families), he/she must apply for a One-shot emergency to pay for the storage arrears.

Storage of Furniture and Personal Items Due to Eviction

City Marshal must protect tenant's furniture and belongings for 30 days.

When a tenant is evicted by a City Marshal, the Marshal is required to protect the tenant's furniture and belongings for one month. The Marshal may lock up the apartment for one month or may hire a bonded moving company which is licensed by the New York State Department of Transportation. The Marshal must then direct the moving company to deliver the items removed from the premises to a storage company licensed by the Department of Consumer Affairs.

Unclaimed property will be sold at public auction.

The Marshal must pay the moving and storage companies for moving the belongings and storing them for one month. Property held by the storage company or left in the apartment must be claimed within 30 days by the tenant who was evicted. At the end of 30 days, unclaimed property is sold at a public auction.

Authorization Process

Storage fees for applicants/participants must be applied for on a month-to-month basis.

For participants only, the JOS/Worker must log in the request for storage fees on the Participant Request Control Card (**W-111F**) to track the request.

A determination must be made within seven business days of receipt of all relevant documentation supporting an applicant's/participant's request for storage fees.

The JOS/Worker must enter all requests for Storage fees in the POS **Single Issuance Record Special Grant Requests** window.

Refer to [PD #10-22-SYS](#)

This window prompts the JOS/Worker to record the applicable grant requests from the list of possibilities provided. (see the **Special Grants Requests** window on the next page [storage fees]).

Special Grants window

Instructions: Use the window below to record grant requests. To record a request, click "Yes" for the appropriate row in the window. A Response to Question window will appear to allow you to record the details of the request. Once all requests are recorded, click the Next button to continue.

| | Yes | No |
|---|----------------------------------|-----------------------|
| Housing Related Benefits (rent in advance, moving allowance, security deposit, storage fees, broker's fee, furniture allowance) | <input checked="" type="radio"/> | <input type="radio"/> |
| Replacement of Lost or Stolen Cash | <input type="radio"/> | <input type="radio"/> |
| EAA - Replace SSI Check/Stolen Cash/Mismanaged or Lost Cash | <input type="radio"/> | <input type="radio"/> |
| Property Equipment And Household Item Repair or Replacement. | <input type="radio"/> | <input type="radio"/> |
| Need to Issue a Generic PA Benefit? | <input type="radio"/> | <input type="radio"/> |
| Need to Issue a Generic FS Benefit? | <input type="radio"/> | <input type="radio"/> |
| Are There Mortgage/Property Tax Arrears? | <input type="radio"/> | <input type="radio"/> |
| Rent Supplementation? | <input type="radio"/> | <input type="radio"/> |
| Work-Activity Related Benefits? | <input type="radio"/> | <input type="radio"/> |
| Storage of Furniture and Personal Belongings | <input checked="" type="radio"/> | <input type="radio"/> |

Spanish Next Previous

Yes to Storage fees.

- Select **Yes** to "Storage of Furniture and Personal Belongings," and click **Next**, and the **Response to Question** window appears.

Response to Question window

Please enter the storage fee request information in the window below.

Invoice Amount: \$100.00 Delete Request

Invoice Number: Invoice

From: 07/01/2011 To: 07/31/2011

Vendor Name: Storage Vendor Unit Number: 111

Vendor Address: 123 Main Street

Vendor City: New York State: New York Zip Code: 12345

OK Cancel Scroll Between Rows Request 2 of 3

- Enter the **Invoice Amount**, **Invoice Number**, **From** and **To** dates, **Vendor name** and **Address** information. Click **OK** and the **Special Grants** window above appears.
- Click **Next** to continue. The status of **Task 2** will change to **Completed** and POS will display the updated **SI Grant Requests and Issuance Task List** screen.

SI Task List window for Task 3

The screenshot shows a software window titled "Instructions" with a menu bar (File, Edit, Tools, Window, Help). Below the menu is a text box explaining the task list. The main area contains a list of tasks under the heading "SI Grant Request":

- Task Name:** SI Grant Needs Identified in Interview
Action: This Task must be completed before proceeding.
Status: No Action Required (Button: NA)
- Task Name:** Record Special Grant Requests
Action: This Task must be completed before proceeding.
Status: Completed (Button: GO)
- Task Name:** Requests Details
Action: This Task must be completed before proceeding.
Status: This Task is Next (Button: GO)
- Task Name:** EAF, E-SNA and EAA Financial Eligibility Determination
Action: Complete the required tasks above before doing this task.
Status: Not Done Yet (Button: Wait)
- Task Name:** Print Forms for Client to Sign
Action: Complete the required tasks above before doing this task.
Status: Not Done Yet (Button: Wait)

At the bottom of the window are "Next" and "Previous" buttons.

- Click **Go** for the **Request Details** section and the **Request Details** window appears.

Request Details window

The screenshot shows a software window titled "Version 15.2.1 - Paperless Office System - [Request Details Window]" with a menu bar (File, Edit, Tools, Window, Help). The window contains the following form fields:

- Instructions:** This window shows a batch of grant requests made on a particular date. Requests made on other dates will appear in separate windows. In addition, grant requests which are related to shelter arrears will appear separately from those which are not related to shelter arrears.
- Date the requests were recorded in the system:** 08/18/2011
- Do the requests need to be back-dated?** Yes No
- Enter the actual date of the request:** [Text Field]
- Enter the reason for the request:** [Text Field]
- Does this applicant/client state that this is an emergency?** Yes No
- Describe the emergency:** [Text Field]
- Is this grant batch related to shelter arrears?** No
- Does the client need to bring back documents?** No

| Additional Allowances Requested | Emergency Non-Emergency | Request Source | Fair Hearing Number | Due Date for Documents |
|--|--|----------------|---------------------|------------------------|
| Storage of Furniture and Personal Belongings | <input type="radio"/> Yes <input type="radio"/> No | [Dropdown] | [Text Field] | 00/00/0000 |

At the bottom of the window are "Next" and "Previous" buttons, and a page indicator "Page 4 of 4".

- Once the **Request Details** window is completed, click **Next** to continue. If additional documentation is required, the due date for the documents must be entered in the **Due Date for Documents** field.

Due date for document

A small window titled "Due Date for Documents" with a text input field containing "00/00/0000".

- Click **Next** to continue once all request details are recorded,

The following message will appear.

“POS will make a permanent record of all the requests shown in this window. Click **OK** to proceed.”

- The status of **Task 3** will change to **Completed** and POS will display the updated **SI Grant Requests and Issuance Task List** screen.
- Click **Go** for **Task 4 (EAF/E-SNA Eligibility Determination)**.

SI Task List window for Task 4

Version 15.2.1 - Paperless Office System - [SI Grant Requests and Issuance] 12:11:40 PM Thursday, August 18, 2011

File Edit Tools Window Help

Instructions
The list below shows the tasks that are part of this activity. You should do the tasks in the order presented. Some tasks are required; you must click the GO button and do the task before going on to the next task or completing the activity. Other tasks are not required and will have a button label of NA. All required tasks must be completed before you can complete the activity.

SI Grant Request

| | | |
|----|---|------|
| 1. | Task Name: SI Grant Needs Identified in Interview | NA |
| | Action: This Task must be completed before proceeding. | |
| | Status: No Action Required | |
| 2. | Task Name: Record Special Grant Requests | GO |
| | <input checked="" type="checkbox"/> Action: This Task must be completed before proceeding. | |
| | Status: Completed | |
| 3. | Task Name: Requests Details | GO |
| | <input checked="" type="checkbox"/> Action: This Task must be completed before proceeding. | |
| | Status: Completed | |
| 4. | Task Name: EAF, E-SNA and EAA Financial Eligibility Determination | GO |
| | <input type="checkbox"/> Action: This Task must be completed before proceeding. | |
| | Status: This Task is Next | |
| 5. | Task Name: Print Forms for Client to Sign | Wait |
| | Action: Complete the required tasks above before doing this task | |
| | Status: Not Done Yet | |

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EAF/E-SNA (Eligibility Determination) window

Instructions

This window shows a batch of grant requests made on a particular date for which the client may be eligible to receive under EAF or E-SNA. Unlike the SNA 125% income test, the EAF test is only applicable to income that is actually available to the EAF household on the date of application, not the household's anticipated or past income. Income guidelines are updated annually. For example, an applying household may have received income exceeding 200% but on the day of EAF application has less than 200% of that income available, therefore passing the income test and any available income is applied to the emergency need.

Request Date: 08/18/2011

Crisis is Due to: [Dropdown]

Other Crisis Details: [Text]

Emergency Type: [Text]

Cause: [Text]

Qualifying child or pregnant individual in household? Yes

Does the household have income available on the day of application? Yes No Available monthly gross income amount: [Text]

Resources available to meet needs? Yes No Total PA resources (from interview): \$00

Emergency is result of refusal without good cause of employment or work activities/community service by employable relative or child? Yes No [View Client Infraction History](#)

Emergency is result of sudden occurrence/situation, unforeseen and beyond the individual's control? Yes No

Utility Arrears Only

Is the applicant/participant the client of record? Yes No

Is the client of record receiving CA or SSI (or additional State payments) on the date of application or request? Yes No

| Grant Request | Does this Grant Represent PA Duplication? | Financially Eligible For: | E-SNA? | Repayment Agreement Required? |
|--|---|---------------------------|---|-------------------------------|
| Storage of Furniture and Personal Belongings | <input type="radio"/> Yes <input checked="" type="radio"/> No | EAF? | <input type="radio"/> Yes <input checked="" type="radio"/> No | NA |

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- Complete the **EAF/E-SNA (Eligibility Determination)** window and advance to **Task 5 - Print Forms for Client to Sign**.

SI Task List window for Task 5

Instructions

The list below shows the tasks that are part of this activity. You should do the tasks in the order presented. Some tasks are required; you must click the GO button and do the task before going on to the next task or completing the activity. Other tasks are not required and will have a button label of NA. All required tasks must be completed before you can complete the activity.

SI Grant Request

- Task Name:** SI Grant Needs Identified in Interview

Action: This Task must be completed before proceeding.

Status: No Action Required

NA
- Task Name:** Record Special Grant Requests

Action: This Task must be completed before proceeding.

Status: Completed

GO
- Task Name:** Requests Details

Action: This Task must be completed before proceeding.

Status: Completed

GO
- Task Name:** EAF, E-SNA and EAA Financial Eligibility Determination

Action: This Task must be completed before proceeding.

Status: Completed

GO
- Task Name:** Print Forms for Client to Sign

Action: This Task must be completed before proceeding.

Status: This Task is Next

GO

Next Previous

Print Forms for Client to Sign window

Instructions

Listed below are a set of forms and notices that must be printed before you may proceed. Click the Print Forms button then pick up the forms from the printer when POS informs you that it has finished printing. If some of the forms require a signature from the client, you will be prompted to collect that signature after you click the Next button.

If, for any reason, one or more of the forms fails to print correctly (paper jam, toner low etc.), you can either reprint one form by clicking on the form in the list below and then click on the Reprint Selected Form button or you can reprint all the forms by clicking on the Reprint All Forms button.

If there is a request for grants under the EAF category, the EAF Eligibility Determination Worksheet will be saved in the case record.

If there is a request for rent arrears, the Repayment Worksheet for Rent Arrears will be saved in the case record.

If there is a request for utility arrears, the Repayment Worksheet for Utility Arrears will be saved in the case record.

| Request Date | Forms to be Printed | |
|--------------|--|--|
| 08/18/2011 | W-1451 T-Determination of Eligibility for Emergency Assistance to Families (EAF) | Storage of Furniture and Personal Belongings |

Print the E-Forms Re-Print Selected E-Form(s) Re-Print All E-Forms

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Note: For active CA cases, POS will prefill the Request for Emergency Assistance or Additional Allowance (For Participants Only) (**W-137A**) when a participant requests a payment of storage fees. In the **Print Forms for Client to Sign** window, JOS/Workers will print the **W-137A** form for participants and capture the participant's signature.

- Once all signatures are saved, click **Next** to continue. The status of **Task 5** will change to **Completed** and POS will display the updated **SI Grant Requests and Issuance Task List** screen.
- Advance to Task 6 – **Outstanding Requests**.

SI Task List window for Task 6

Instructions

The list below shows the tasks that are part of this activity. You should do the tasks in the order presented. Some tasks are required; you must click the GO button and do the task before going on to the next task or completing the activity. Other tasks are not required and will have a button label of NA. All required tasks must be completed before you can complete the activity.

SI Grant Request

| | | |
|----|--|----|
| 2. | Task Name: Record Special Grant Requests | GO |
| ✓ | Action: This Task must be completed before proceeding. | |
| | Status: Completed | |
| 3. | Task Name: Requests Details | GO |
| ✓ | Action: This Task must be completed before proceeding. | |
| | Status: Completed | |
| 4. | Task Name: EAF, E-SNA and EAA Financial Eligibility Determination | GO |
| ✓ | Action: This Task must be completed before proceeding. | |
| | Status: Completed | |
| 5. | Task Name: Print Forms for Client to Sign | GO |
| ✓ | Action: This Task must be completed before proceeding. | |
| | Status: Completed | |
| 6. | Task Name: Outstanding Requests, Documentation/Verification and Referrals | GO |
| ✋ | Action: This Task must be completed before proceeding. | |
| | Status: This Task is Next | |

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Outstanding Request List window

| Request | Date | Request Source | Emg | SI | Recur | Status |
|--|------------|-----------------------|-----|-----|-------|------------|
| Other (Special Grant Request) | 06/21/2011 | Client Request-Person | Yes | Yes | | Complete |
| Storage of Furniture and Personal Belongings | 08/18/2011 | Client Request-Person | Yes | | | Incomplete |

- Select the Storage Fee request and click **Edit** and the **Request Action** window appears. The JOS/Worker must enter the decision for the request in this window.

Request Action window

Refer to [PB #11-85-SYS](#)

Request approved

Approved Requests

- If the agency will pay the storage fee, select **Accept**, to accept the request, enter the **Approved Amount**, **From** and **To** dates and click **Close** and the **Outstanding Requests** window appears.
- Click **Next** on the **Outstanding Requests** window to continue and click on the Grant Data Entry section, and the **Single Issue Grant Summary** window appears. POS prefills the Special Grant code **21** (Storage Fees) in the **Grant Summary** window.

Single Issue Benefit Data Entry window

Refer to PB #11-85-SYS

- Click **Grant Details** to access the **Single Issue Benefit Data Entry** window to prepare the Single Issue Grant and a Public Assistance Single Issue Authorization (**LDSS-3575**) Form.

- The JOS/Worker must enter the required information on this window and click **Done**.

Note: Storage fee payments of **\$999.99** or less require the approval of the AJOSI. Payments that exceed **\$999.99**, require the approval of the AJOSII.

- The JOS/Worker sends the case to his/her Supervisor for approval.
- The Supervisor must approve the grant request and the grant data entry windows and will print either the Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (**W-145HH**) to notify an applicant of the approval or denial of the request, or the Action Taken on Your Request for Emergency Assistance or the Additional Allowance Form (For Participants Only) (**W-137B**) to notify a participant.

Refer to [PB #09-132-OPE](#) for details on use of the **W-145HH**.

Denied Requests

If the storage fee request will be denied, the JOS/Worker must:

- Access Task 6 (Outstanding Requests), select the Storage Fee request and click the **Edit** button to access the **Request Action** window.
- Select **Deny** in the **SI Grant Decision** section to deny the request, enter the denial reason and click **Close** to return to the **Outstanding Requests** window appears.

The screenshot shows the 'Request Action' window for a 'Storage of Furniture and Personal Belongings' request. The 'SI Grant Decision' section is active, with the 'Deny' radio button selected. A callout box labeled 'Request denied' points to the 'Deny' button. Other fields include 'Invoice Amount: \$100.00', 'Vendor: Storage Vendor', 'Address: 123 Main Street', and 'Decision Due Date: 08/22/2011'.

- The JOS/Worker sends the case to his/her Supervisor for approval.
- The Supervisor must approve the denial and will print either the Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (**W-145HH**) to notify an applicant of the denial of the request, or the Action Taken on Your Request for Emergency Assistance or the Additional Allowance Form (For Participants Only) (**W-137B**) to notify a participant.

Effective Immediately

Related Items:[PB #09-132-OPE](#)[PB #11-85-SYS](#)[PD #10-22-SYS](#)**References:**

02 ADM 2


18 NYCRR 352.6(d) and (f)

18 NYCRR 397.5(k)

Temporary Assistance Source Book Chapter 12 Section A. 4. k.
Section D. 12.

Temporary Assistance Source Book Page Chapter 16 Section F.

[Temporary Assistance Source Book](#) Page Chapter 27 Section A. 7.**Attachments:**

 Please use Print on Demand to obtain copies of forms.

| | |
|--------------------|--|
| W-111F | Participant Request Control Card (Rev. 09/02/11) |
| W-137A | Request for Emergency Assistance or Additional Allowance (Rev. 4/30/09) |
| W-137A (S) | Request for Emergency Assistance or Additional Allowance (Spanish) (Rev. 4/30/11) |
| W-137B | Action Taken on Your Request for Emergency Assistance or Additional Allowance (Rev. 5/3/11) |
| W-137B (S) | Action Taken on Your Request for Emergency Assistance or Additional Allowance (Spanish) (Rev. 5/3/11) |
| W-145HH | Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Rev. 7/20/11) |
| W-145HH (S) | Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Spanish) (Rev. 7/20/11) |

Participant Request Control Card

Job Center No. _____ Group _____

Month _____ Year _____

Page _____ of _____

| Request Date | No. of Ext. Days | Participant's Name | Case Number | Case-Load | Participant Request | | | | | | Action Taken | | Sign Off Date | Req. Iss. Date | Act. Iss. Date |
|--------------|------------------|--------------------|-------------|-----------|---------------------|----------------------------|-------------|---------|--------------|----------|--------------|----|---------------|----------------|----------------|
| | | | | | H/H Add. | Other Add. Allow (Specify) | Emergencies | | | Approved | Denied | | | | |
| | | | | | | | Shelter | Utility | Other (spec) | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | | | |

SAMPLE

Group Total _____ Job Center Total _____

Date: _____
Case Name: _____
Case Number: _____
Caseload: _____
Center: _____
Worker Telephone No.: _____
FH&C Telephone No.: _____

Request for Emergency Assistance or Additional Allowance (For Participants Only)

Please fill out this form if you need emergency assistance or an additional allowance.

Remember:

- (1) You may be asked for proof of what you tell us. If you have trouble obtaining proof, your Worker must help you.
- (2) You may still need to see your Worker. If you do, you will be given an appointment.

SECTION I: EMERGENCY ASSISTANCE

The type of emergency assistance I am requesting is:

SAMPLE

The reason I need emergency assistance is:

SECTION II: ADDITIONAL ALLOWANCES

I am requesting the following allowance(s) for special need(s):

- | | |
|--|--|
| <input type="checkbox"/> Back rent | <input type="checkbox"/> Additional allowance for fuel |
| <input type="checkbox"/> Repair of essential household items | <input type="checkbox"/> Additional allowance to maintain or restore utility service |
| <input type="checkbox"/> Back mortgage and/or taxes | <input type="checkbox"/> Property repairs |
| <input type="checkbox"/> Pregnancy allowance | <input type="checkbox"/> Replacement of clothing lost as a result of a disaster such as homelessness or fire |
| <input type="checkbox"/> Restaurant allowance because I cannot prepare meals where I am living | <input type="checkbox"/> Other: |

Burial allowance – you or your duly authorized representative must apply for this allowance at the Burial Claims Unit
25 Chapel Street, Room 606
Brooklyn, NY 11201
Telephone: (718) 473-8310

Expenses related to moving:

- Moving expenses
- Security deposit/agreement
- Broker's/finder's fee/voucher
- Furniture and other household items
- Storage of furniture and personal belongings

New Address: _____
(include apt. no.)

City _____ State _____ Zip Code _____

When did you move? _____ New rent: \$ _____

Landlord's name: _____

Primary tenant's name: _____

Address: _____
(include apt. no.)

City _____ State _____ Zip Code _____

SECTION III: WORK ACTIVITY-RELATED SUPPORTIVE SERVICES

I am requesting the following supportive services:

- Child care allowance within approved limits, if needed
- Clothing for participants in job search activities who have **exceptional** circumstances, such as homelessness or a recent fire and lack of appropriate clothing
- Necessary public transportation
- Activity/engagement-related licensing, uniform or durable goods fee within approved limits, upon submission of documentation certifying the need for such items
- Other work activity-related supportive services: _____

WEP agencies and/or contractors are responsible for providing necessary safety equipment or job-related clothing for their participants.

Necessary supportive services will be provided when you begin a work activity. If your needs change or if you are not receiving a needed service, you should apply for an additional allowance.

SECTION IV: ADD PERSON TO CASE

If you do not have all this information, you can still submit this form to your Worker.

I want to add the following person(s) to my cash assistance case:

New Baby

Name: _____
First Name M.I. Last Name

Date of Birth: _____

Social Security Number (if known): _____

Adult living with me:

(This person must complete an application to receive assistance.)

Name: _____
First Name M.I. Last Name

Date Moved In: _____

Date of Birth: _____

Social Security Number (if known): _____

Relationship: _____

Child entered home

Name: _____
First Name M.I. Last Name

Date of Returned: _____

Date of Birth: _____

Social Security Number (if known): _____

Click here to insert a picture

Participant's Signature

Date of Request

Time of Request

AM PM

Worker's Signature

Date

Fecha: _____
Nombre del Caso: _____
Número del Caso: _____
Unidad de Casos: _____
Centro: _____
Núm. de Teléfono del Trabajador: _____
Núm. de Tel. del FH&C: _____

Petición para Asistencia de Emergencia o Asignación Adicional (Sólo para Participantes)

Favor de completar este formulario si necesita asistencia de emergencia o una asignación adicional.

Recuerde:

- (1) Puede que se le pida prueba de los datos que nos proporcione. Si tiene problemas en obtener pruebas, su Trabajador tiene que ayudarlo.
- (2) Puede que aún necesite reunirse con su Trabajador. En tal caso, se le programará una cita.

SECCIÓN I: ASISTENCIA DE EMERGENCIA

El tipo de asistencia de emergencia que estoy solicitando es:

SAMPLE

La razón por la cual necesito asistencia de emergencia es la siguiente:

SECCIÓN II: ASIGNACIONES ADICIONALES

Estoy solicitando la(s) siguiente(s) asignación(es) para necesidad(es) especial(es):

- | | |
|--|---|
| <input type="checkbox"/> Alquiler atrasado | <input type="checkbox"/> Asignación adicional para combustible |
| <input type="checkbox"/> Reparación de artículos del hogar de primera necesidad | <input type="checkbox"/> Asignación adicional para mantener o restaurar servicios de electricidad y gas |
| <input type="checkbox"/> Hipoteca y/o impuestos atrasados | <input type="checkbox"/> Reparaciones a la propiedad |
| <input type="checkbox"/> Asignación para embarazo | <input type="checkbox"/> Reemplazo de ropa perdida a raíz de desastres tal como desamparo o incendio |
| <input type="checkbox"/> Asignación para restaurante porque no puedo preparar comidas donde estoy viviendo | <input type="checkbox"/> Otras asignaciones: |
| <input type="checkbox"/> Asignación para entierros – usted o su representante debidamente autorizado debe solicitar esta asignación en la Unidad de Reclamos de Entierro 25 Chapel Street, Sala 606 Brooklyn, NY 11201 Teléfono: (718) 473-8310 | |

Gastos relacionados con la mudanza:

- Gastos de mudanza
- Depósito/acuerdo de garantía
- Pago de comisión/comprobante de agente
- Muebles y otros artículos del hogar
- Almacenamiento de muebles y artículos personales

Nueva Dirección: _____

(con núm. de apto.)

Ciudad Estado Código Postal

¿Cuándo se mudó? _____ Nuevo alquiler: \$ _____

Nombre del casero: _____

Nombre del inquilino principal: _____

Dirección: _____
(con núm. de apto.)

Ciudad Estado Código Postal

SECCIÓN III: SERVICIOS DE APOYO RELACIONADOS CON ACTIVIDADES DE TRABAJO

Estoy solicitando los siguientes servicios de apoyo:

- Asignación de cuidado infantil dentro de los límites aprobados, de ser necesario
- Ropa para participantes que realicen actividades relacionadas a la búsqueda de trabajo, que se encuentren en situaciones **fuera de lo común**, tales como desahucio o incendio reciente y no tener la vestimenta adecuada.
- Otros servicios de apoyo relativos a actividades de trabajo:
- Transporte público necesario
- Cuota de autorización, relacionada con actividad/participación, de uniformes o bienes duraderos dentro de los límites aprobados, a la hora de presentar la documentación que compruebe la necesidad de dichos artículos

Las agencias de WEP y/o los contratistas tienen la responsabilidad de proporcionar a sus participantes la ropa o el equipo de seguridad necesarios para el trabajo.

Se brindarán los servicios necesarios cuando usted empiece una actividad de trabajo. Si se produce algún cambio en sus necesidades, o si usted no está recibiendo un servicio necesario, debería solicitar una asignación adicional.

SECCIÓN IV: AÑADA A UNA PERSONA AL CASO

Si usted no tiene toda esta información, puede presentar este formulario a su Trabajador de todos modos.

Deseo añadir a la(s) siguientes personas a mi caso de asistencia en efectivo:

Recién nacido

Nombre: _____
Nombre Inicial Apellido

Fecha de Nacimiento: _____

Número de Seguro Social (si lo sabe): _____

Adulto que vive conmigo

(Esta persona tiene que llenar una solicitud para recibir asistencia).

Nombre: _____
Nombre Inicial Apellido

Fecha de ingreso: _____

Niño ingresó al hogar

Nombre: _____
Nombre Inicial Apellido

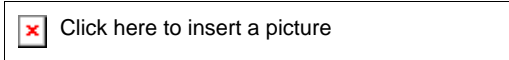
Fecha de Regreso: _____

Número de Seguro Social (si lo sabe): _____

Fecha de Nacimiento: _____

Número de Seguro Social (si lo sabe): _____

Relación: _____



Firma del Participante

Fecha de la Petición

Hora de la Petición

AM PM

Firma del Trabajador

Fecha

Date: _____
Case Number: _____
Case Name: _____
Center: _____
Caseload: _____
Worker _____
Telephone No.: _____
FH&C _____
Telephone No.: _____

Action Taken on Your Request for Emergency Assistance or Additional Allowance (For Participants Only)

The Agency's decision(s) regarding your benefit program(s) is/are explained below, next to the checked box(es) .

This Notice applies only to your request for an additional allowance to meet a special need, a change in grant, or an application for emergency assistance. If your request for additional assistance is denied, your ongoing Cash Assistance case will not be affected.

On _____, you requested Emergency Assistance Additional Allowance for:
(Date)

SAMPLE

Your request for _____ has been accepted. You will receive:

One payment in the amount of \$ _____ . Period covered, if applicable: _____

Method of payment:

- Broker's or finder's fee/voucher Check to be picked up by you at your Job Center Check mailed to your home
- As an addition to your regular public grant, which can be obtained through the EBT system Security deposit agreement Direct vendor check
- Other action: _____
- You will receive a second notice informing you as to how your ongoing benefits will be affected.

On _____, you were referred to the Burial Claims Unit at 25 Chapel Street, Room 606, Brooklyn, NY 11201, (718) 473-8310, to apply for a burial allowance.

Your request for _____ has been denied because:

The law(s) and/or regulation(s) that allow(s) us to do this is/are 18 NYCRR (please see the section numbers below):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Addition to Household § 352.30 | <input type="checkbox"/> Additional Allowance for Fuel § 352.5 | <input type="checkbox"/> Back Mortgage and/or Taxes § 352.7(g) | <input type="checkbox"/> Back Rent § 352.7(g) |
| <input type="checkbox"/> Broker's or Finder's Fee/Voucher § 352.6(a) | <input type="checkbox"/> Catastrophic Loss (replacement of clothing and furniture lost in fire, flood or other disaster) § 352.7(d) | <input type="checkbox"/> Furniture and Other Household Items § 352.7(a) | <input type="checkbox"/> Moving Expenses § 352.6(a) |
| <input type="checkbox"/> Payment to Maintain or Restore Utility Services § 352.5 | <input type="checkbox"/> Pregnancy Allowance § 352.7(k) | <input type="checkbox"/> Property Repairs § 352.4(d), § 352.6(e) | <input type="checkbox"/> Rent Security Deposit/ Letter of Guarantee § 352.6(a) |
| <input type="checkbox"/> Repair of Essential Household Items § 352.7(b) | <input type="checkbox"/> Restaurant Allowance § 352.7(c) | <input type="checkbox"/> Semimonthly Fuel for Heating Allowance § 352.5(b) | <input type="checkbox"/> Storage of Furniture and Personal Belongings § 352.6(f) |
| <input type="checkbox"/> Work Activity Related Supportive Services § 385.4 | | | |

SAMPLE

Other (specify): _____

JOS/Worker's Signature

Date

Supervisor's Signature

Date

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION
SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.**

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 the Fair Hearing and Conference (FH&C) unit phone number on **page 1** of this notice or write to us at the address on **page 1** of this notice. 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 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.)
- (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: **14 Boerum Place, Brooklyn, NY 11201**
- (5) **ONLINE:** Complete an online request form at: <http://www.otda.ny.gov/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.

If you have a disability, and cannot travel, you may appear through a representative, either a friend, relative or lawyer. If your representative is not a lawyer, or an employee of a lawyer, your representative must bring the hearing officer a written letter, signed.

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: If you want more information about your case, how to ask for a Fair Hearing, how to see your file or how to get additional copies of documents, call or write to us at the phone number/address listed on **page 1** of this notice.

FAIR HEARING REQUEST

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 Cash Assistance, medical assistance or social services issues and ninety (90) days for Food Stamp 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. **Note:** If your situation is extremely serious please explain your situation; the State will attempt to process your request for a Fair Hearing as quickly as possible. If you call to request a Fair Hearing, please be prepared to explain your situation to the person who answers the phone.

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

SAMPLE

Print Name: _____
Name M.I. Last Name

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Centro: _____
Unidad de Casos: _____
Núm. de Teléfono del Trabajador: _____
Núm. de Teléfono de FH&C: _____

Medidas Tomadas con Respecto a su Petición de Asistencia de Emergencia o Una Asignación Adicional (Sólo para Participantes)

La(s) decisión(es) de la Agencia con respecto a su(s) programa(s) de beneficio(s) se explica(n) más abajo, junto a la(s) casilla(s) marcada(s) .

Este Aviso sólo se refiere a su petición de una asignación adicional para satisfacer una necesidad específica, un cambio en la concesión o una solicitud de asistencia de emergencia. Si su petición de asistencia adicional es rechazada, su caso actual de Asistencia en Efectivo no será afectado.

El _____ (Fecha) usted solicitó Asistencia de Emergencia Asignación Adicional para:

SAMPLE

- Su solicitud de _____, ha sido aceptada. Usted recibirá:
- Un pago por la cantidad de \$ _____. Período de cobertura, si corresponde: _____.

Método de pago:

- Pago/comprobante de agente o intermediario Cheque que debe ser recogido por usted en su Centro de Trabajo Cheque enviado por correo a su hogar
- Un suplemento a su concesión pública usual, que se puede obtener a través del sistema de EBT Acuerdo de depósito de garantía Cheque directo al contratista
- Otra medida: _____

Usted recibirá un segundo aviso informándole de cómo serán afectados sus beneficios actuales.

El _____, usted fue enviado a la Unidad de Reclamos de Sepultura (Burial Claims Unit) en 25 Chapel Street, Sala 606, Brooklyn, NY 11201, (718) 473-8310, para solicitar una asignación de sepultura.

Su petición de _____ ha sido rechazada debido a que:

La(s) ley(es) y/o reglamento(s) que nos permite(n) hacer esto es/son 18 NYCRR (favor de ver la sección a continuación):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Agregar una Persona al Hogar § 352.30 | <input type="checkbox"/> Asignación Adicional para Combustible § 352.5 | <input type="checkbox"/> Pagos Atrasados de Hipoteca y/o Impuestos § 352.7(g) | <input type="checkbox"/> Alquiler Atrasado § 352.7(g) |
| <input type="checkbox"/> Pago/Comprobante de Agente o Intermediario de Bienes Raíces §352.6(a) | <input type="checkbox"/> Pérdida Catastrófica (reemplazo de ropa y muebles perdidos por un fuego, inundación u otro desastre) § 352.7(d) | <input type="checkbox"/> Muebles y Otros Artículos Domésticos § 352.7(a) | <input type="checkbox"/> Gastos de Mudanza § 352.6(a) |
| <input type="checkbox"/> Pagos para Mantener o Restaurar Servicios de Electricidad y Gas § 352.5 | <input type="checkbox"/> Asignación para Embarazo §352.7(k) | <input type="checkbox"/> Reparaciones a la Propiedad § 352.4(d), § 352.6(e) | <input type="checkbox"/> Depósito de Garantía de Alquiler/Carta de Garantía § 352.6(a) |
| <input type="checkbox"/> Reparaciones de Artículos Domésticos Indispensables §352.7(b) | <input type="checkbox"/> Asignación para Restaurante § 352.7(c) | <input type="checkbox"/> Asignación Quincenal de Combustible para Calefacción § 352.5(b) | <input type="checkbox"/> Almacenamiento de Muebles y Pertenencias Personales § 352.6(f) |
| <input type="checkbox"/> Actividad de Trabajo Relacionada con Servicios de Apoyo § 385.4 | | | |

SAMPLE

Otros (datos específicos): _____

Firma del JOS/Trabajador

Fecha

Firma del Supervisor

Fecha

**USTED TIENE EL DERECHO DE APELAR CONTRA ESTA DECISIÓN.
ASEGÚRESE DE LEER LA SECCIÓN DE INFORMACIÓN SOBRE CONFERENCIAS
Y AUDIENCIAS IMPARCIALES DE ESTE AVISO SOBRE CÓMO APELAR CONTRA ESTA DECISIÓN.**

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 al número de teléfono de la unidad de Audiencias Imparciales y Conferencias (Fair Hearing and Conference – FH&C) que aparece en la **primera página** de este aviso, o escribanos a la dirección que también aparece en la **primera página** de este aviso. 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 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) 473-5735**.

(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 Temporal y para Incapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) en:
14 Boerum Place, Brooklyn, NY 11201.

(5) **POR INTERNET:** Complete una solicitud de formulario electrónico conectándose a:
<http://www.otda.ny.gov/oah/forms.asp>

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.

Si usted está incapacitado(a), y no puede transportarse, puede comparecer mediante un representante, ya sea un amigo, pariente o abogado. Si su representante no es abogado, ni empleado(a) de abogado, su representante debe traer una carta firmada al oficial de Audiencia Imparciales.

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, podría 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 pedirlos 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: Si desea más información sobre su caso, cómo pedir una Audiencia Imparcial, cómo revisar su archivo o cómo obtener copias adicionales de documentos, llame o escribanos al número telefónico y/o dirección que aparecen en la **primera página** de este aviso.

PETICIÓN DE AUDIENCIA IMPARCIAL

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 en Efectivo, asistencia médica o servicios sociales y noventa (90) días para asuntos de Cupones para Alimentos.

Si no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporal y para Incapacitados (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. **Nota:** Si su circunstancia es sumamente urgente, favor de explicarlo en detalle, el Estado hará todo esfuerzo de procesar su solicitud para una Audiencia Imparcial lo más pronto posible. Si usted llama para solicitar una Audiencia Imparcial, por favor esté preparado para explicar su situación a la persona que conteste el teléfono.

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

SAMPLE

Nombre en Letras de Molde: _____
Nombre I. Apellido

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____

Date: _____
Case Number: _____
Case Name: _____
Caseload: _____
Worker Name: _____
Worker Telephone Phone: _____
FH&C Telephone Number: _____

Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only)

The Agency's decision(s) regarding your application(s) is/are explained below next to the marked box(es) .

Immediate Needs

This notice applies only to your request for assistance to meet an immediate need. If you have also applied for ongoing cash assistance, this notice does not affect your application for ongoing Cash Assistance. You will also receive a notice advising you of this Agency's decision on your application for ongoing Cash Assistance when your eligibility has been determined.

If your application for ongoing Cash Assistance is denied for failure to comply with eligibility requirements, a second request for an immediate needs/emergency grant for "no food" or items relating to personal care, filed within three months of the original application denial, may also be denied unless you can document good cause for your original failure to comply.

On _____, you requested assistance to meet an immediate need of:

We are giving you this notice to tell you that your request for an immediate needs grant was evaluated and the following decision was made:

- An emergency preinvestigation grant in the amount of \$ _____ will be available to you on _____.
(Date)
- An emergency grant (one-shot deal) has been provided in the amount of \$ _____ for _____.
- A personal care kit has been provided on _____.
(Date)
- A Goodwill Voucher has been provided in the amount of \$ _____ for _____ on _____.
(Date)
- If this box is checked, you are responsible for repaying \$ _____ as shown:
 - This amount must be repaid to us in accordance with the agreement to repay that you signed on _____.
(Date)
 - You must repay the amount shown above because it is more than the Human Resources Administration (HRA) shelter maximum of \$ _____ for your family size of _____ for each month of arrears that HRA agreed to pay.

Immediate Needs (Continued)

- Assistance to meet a food-related immediate need is denied because you:
- failed to establish/document identity
 - have excess resources
 - are an undocumented alien
 - received an immediate needs grant in the past 90 days and failed to subsequently comply with eligibility requirements
 - were issued same day Food Stamps
 - other reason for denial (please specify):

- Assistance to meet a nonfood-related immediate need is denied because you:
- failed to establish/document identity
 - have excess resources
 - are an undocumented alien
 - received an immediate needs grant in the past 90 days and failed to subsequently comply with eligibility requirements
 - applied for Cash Assistance on _____ (within the last three months) and were issued one of the following: (Date)
 - immediate need(s) grant(s)
 - personal care kit(s)
 - Goodwill Voucher(s)
 - other grants (please specify):

and subsequently, failed to comply with the eligibility requirements without good cause. The regulations that allow us to do this are 18 NYCRR § 351.1, § 351.8, and § 352.7.

- Other action taken on your application:

Medical Assistance

- If you need help with your medical bills, you must apply separately for Medical Assistance. If you want more information about eligibility for Medical Assistance, call the Worker's telephone number listed on **page 1**.
- Your Medical Assistance stays the same.
- Your application for Medical Assistance is being reviewed. We will send you our decision within 30 days.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION
SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.**

Conference and Fair Hearing Section

If you think our decision was wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2:

1. Ask for a meeting (conference) with one of our supervisors;
2. Ask for a State Fair Hearing with a State hearing officer.

1) 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 the Fair Hearing and Conference (FH&C) Unit telephone number on **page 1** of this notice or write to us at the address on **page 1** of this notice. 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.

2) STATE FAIR HEARING

You have the following number of days from the date of this notice to ask for a Fair Hearing:

| Benefit Area | Time Limit |
|--|------------|
| Cash Assistance, Medical Assistance, Social Services | 60 days |
| Food Stamp Benefits | 90 days |

If this notice is telling you that you must repay cash assistance because you signed a repayment agreement, or because the shelter arrears that HRA agreed to pay is more than the HRA shelter maximum, and if you do not agree that you must repay or you do not agree with the amount HRA says you must repay, you must call for a Fair Hearing. If you do not call for a Fair Hearing, you cannot claim in the future that the Agency's decision that you owe the debt was wrong. The time limit for calling for a Fair Hearing on the issue of the repayment is the same as the limit for any cash assistance action this notice is telling you about, 60 days.

How to Ask for a Fair Hearing: If you believe the decision(s) we are making is/are wrong, you may request a State Fair Hearing by telephone, in 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.)
- (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:
14 Boerum Place, Brooklyn, NY 11201.
- (5) ONLINE:** Complete an online request form at: <http://www.otda.ny.gov/oah/forms.asp>

If you cannot reach the New York State Office of Temporary and Disability Assistance by telephone, by fax or online, please write to ask for a Fair Hearing before the deadline.

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. You can bring a lawyer, a relative, a friend or someone else to help you do this. 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 this person a letter to show the Hearing Officer that you want this person to represent you at the hearing.

If you have a disability, and cannot travel, you may appear through a representative, either a friend, relative or lawyer. If your representative is not a lawyer, or an employee of a lawyer, your representative must bring the hearing officer a written letter, signed.

At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the Hearing Officer written papers that explain why we are wrong.

To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, or doctor's statements.

At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

IF YOUR SITUATION IS EXTREMELY SERIOUS, THE STATE WILL ATTEMPT TO PROCESS YOUR REQUEST FOR A FAIR HEARING AS QUICKLY AS POSSIBLE. IF YOU CALL TO REQUEST A FAIR HEARING, PLEASE BE PREPARED TO EXPLAIN YOUR SITUATION TO THE PERSON WHO ANSWERS THE TELEPHONE. IF YOU WRITE, FAX OR CONTACT US ONLINE INSTEAD, PLEASE BE SURE TO EXPLAIN YOUR SITUATION.

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: If you want more information about your case, how to ask for a Fair Hearing, how to see your file or how to get additional copies of documents, call or write to us at the telephone number/address listed on **page 1** of this notice.

FAIR HEARING REQUEST

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

Print Name: _____ Case Number: _____

Name M.I. Last Name

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Signature: _____ Date: _____

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Unidad de Casos: _____
Nombre del Trabajador: _____
Número de Tel. del Trabajador: _____
Número de Tel. de FH&C: _____

Aviso de Decisión sobre la Asistencia para Cubrir una Necesidad Inmediata o Asignación Especial (Sólo para Solicitantes)

La(s) decisión(es) de la Agencia respecto a su(s) solicitud(es) se explica(n) más abajo junto a la(s) casilla(s) marcada(s) .

Necesidades Inmediatas

Este aviso corresponde solamente a su solicitud de asistencia para cubrir una necesidad inmediata. Si usted también ha solicitado Asistencia en Efectivo continua, este aviso no afecta su solicitud de dicha asistencia. Usted también recibirá un aviso notificándole de la decisión de esta Agencia sobre su solicitud de Asistencia en Efectivo continua cuando se haya determinado su elegibilidad.

Si su solicitud de Asistencia en Efectivo continua es rechazada debido a incumplimiento de requisitos de elegibilidad, puede que también se rechace una segunda solicitud de concesión de emergencia/necesidad inmediata para artículos "no alimentarios" relacionados con el cuidado personal, si la misma es presentada menos de tres meses después de haber sido rechazada la primera solicitud, a menos que usted muestre pruebas válidas que justifiquen su incumplimiento respecto a los requisitos de la primera solicitud.

El _____, usted solicitó asistencia para cubrir una necesidad inmediata de:

Por medio del presente aviso le informamos que hemos evaluado su solicitud respecto a una concesión para cubrir necesidades inmediatas y la decisión es la siguiente:

- Una concesión de emergencia preinvestigación por la cantidad de \$ _____ estará a su disposición el _____
(Fecha)
- Se le ha otorgado una concesión única de emergencia por la cantidad de \$ _____ para _____
- Se le ha facilitado un botiquín de cuidado personal (personal care kit) el _____
(Fecha)
- Se le ha otorgado un Comprobante de Buena Voluntad de \$ _____ para _____ el _____
(Fecha)
- Si se marca esta casilla, usted es responsable por el reembolso de \$ _____ como indicado:
 - Esta cantidad se nos tiene que pagar conforme al acuerdo de reembolso que usted firmó el _____
(Fecha)
 - Usted tiene que reembolsar la cantidad indicada más arriba porque es superior al máximo de albergue de la Administración de Recursos Humanos (Human Resources Administration – HRA) de \$ _____ para el tamaño de su familia con _____ personas para cada mes de atraso que HRA acordó pagar.

Necesidades Inmediatas (Continuación)

- Asistencia para cubrir una necesidad inmediata relacionada con la alimentación se le ha rechazado porque:
- no estableció/documento la identidad
 - tiene recursos en exceso
 - es un extranjero indocumentado
 - recibió una concesión para necesidades inmediatas en los últimos 90 días y no cumplió posteriormente los requisitos de elegibilidad
 - a usted se le expedieron Cupones para Alimentos el mismo día
 - Otro razón por el rechazo (por favor especifique):

- Asistencia para cubrir una necesidad inmediata no relacionada con la alimentación se le ha rechazado porque:
- no estableció/documento la identidad
 - tiene recursos en exceso
 - es un extranjero indocumentado
 - recibió una concesión para necesidades inmediatas en los últimos 90 días y no cumplió posteriormente los requisitos de elegibilidad
 - solicitó Asistencia en Efectivo el _____ (dentro de los últimos tres meses), usted recibió:

- (Fecha)
- concesión(es) para necesidades inmediatas
 - botiquín(es) de cuidado personal
 - Comprobante(s) de Buena Voluntad
 - Otras concesiones (por favor especifique).

y posteriormente, no cumplió con los requisitos de elegibilidad sin motivo justificado. Los reglamentos que nos permiten hacer esto son 18 NYCRR § 351.1, § 351.8, y § 352.7.

- Otras acciones tomadas hacia su solicitud:

Asistencia Médica

- Si usted necesita ayuda para pagar sus facturas médicas, tiene que solicitar Asistencia Médica por separado. Si desea más información sobre elegibilidad para Asistencia Médica, llame al número de teléfono de su Trabajador en la **página 1**.
- Su Asistencia Médica permanecerá sin cambios.
- Se está evaluando su solicitud de Asistencia Médica. Le enviaremos nuestra decisión dentro de 30 días.

**USTED TIENE EL DERECHO DE APELAR CONTRA ESTA DECISIÓN.
ASEGÚRESE DE LEER LA SECCIÓN DE INFORMACIÓN SOBRE CONFERENCIAS Y AUDIENCIAS
IMPARCIALES DE ESTE AVISO SOBRE CÓMO APELAR CONTRA ESTA DECISIÓN.**

Sección sobre Conferencias y Audiencias Imparciales

Si usted cree que nuestra decisión fue equivocada, puede solicitar una revisión de nuestra decisión. Corregiremos nuestros errores. Usted puede tomar ambas medidas 1 y 2:

1. Solicitar una reunión (conferencia) con unos de nuestros supervisores;
2. Solicitar una audiencia imparcial Estatal con un Oficial de Audiencia Imparcial.

1) CONFERENCIA

Si usted cree que nuestra decisión es errónea, o si no entiende nuestra decisión, favor de llamarnos para programar una conferencia (reunión informal con nosotros). Para ello, llame al número de teléfono de la unidad de Audiencias Imparciales (Fair Hearing and Conference – FH&C) en la **página 1** de este aviso o escriba a la dirección en la **página 1** de este aviso. A veces esta resulta ser la manera más rápida de resolver un problema que usted pueda tener. Le recomendamos a que así haga, aun si ha solicitado una Audiencia Imparcial. El solicitar una conferencia no le impide solicitar además una Audiencia Imparcial.

2) AUDIENCIA IMPARCIAL ESTATAL

Usted tiene el siguiente número de días desde la fecha de este aviso para solicitar una Audiencia Imparcial:

| Tipo de Beneficios | Plazo Límite |
|---|--------------|
| Asistencia en Efectivo, Asistencia Médica, Servicios Sociales | 60 días |
| Beneficios de Cupones para Alimentos | 90 días |

Si este aviso le indica que usted debe reembolsar Asistencia en Efectivo porque firmó un acuerdo de reembolso, o porque los pagos atrasados de albergue que la HRA acordó reembolsar suman más que el máximo para albergue de la HRA, y si usted no está de acuerdo en efectuar este reembolso o si no está de acuerdo con la cantidad que la HRA estipula que usted debe reembolsar, debe llamar para solicitar una Audiencia Imparcial. Si usted no llama para una Audiencia Imparcial, no podrá reclamar posteriormente que la decisión de la agencia que usted tiene una deuda fue errónea. El plazo límite para llamar para una audiencia imparcial sobre el reembolso es el mismo que el plazo límite para cualquier medida de Asistencia en Efectivo sobre la cual este aviso le informa, 60 días.

Cómo Solicitar una Audiencia Imparcial: Si usted cree que la(s) decisión(es) que estamos tomando es/son erróneo, puede solicitar una Audiencia Imparcial Estatal por teléfono, por escrito, 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:
(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 Temporal y para Incapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a: **14 Boerum Place, Brooklyn, NY 11201**.

(5) POR INTERNET: Complete una solicitud electrónica conectándose a:
<http://www.otda.ny.gov/oah/forms.asp>

Si usted no puede comunicarse con la Oficina de Asistencia Temporal y para Incapacitados del Estado de Nueva York por teléfono, por fax o por Internet, favor de escribir para solicitar una Audiencia Imparcial antes de la fecha límite.

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. Usted puede traer a la audiencia a un abogado, un pariente, un amigo, o alguien para que le ayude con este propósito. Si usted no puede presentarse en persona, puede enviar a alguien que le represente. Si va a enviar a alguien que no es abogado a la audiencia que le represente, debe darle a esa persona una carta para el oficial de audiencias que indique que usted desea que esta persona le represente en la audiencia.

Si usted está incapacitado(a), y no puede transportarse, puede comparecer mediante un representante, ya sea un amigo, pariente o abogado. Si su representante no es abogado, ni empleado(a) de abogado, su representante debe traer una carta firmada al oficial de Audiencias Imparciales.

Durante la audiencia, usted y su abogado u otro representante tendrán la oportunidad de explicar por qué estamos equivocados y la oportunidad de entregarle al Oficial de Audiencias documentos que aclaren por qué estamos equivocados.

Para ayudarle a explicar en la audiencia por qué usted cree que estamos equivocados, usted debe traer a cualquier testigo que le puedan ayudar. Además, debe traer cualquier documento que tenga, como: talones de paga, contratos de arrendamiento, recibos, cuentas, declaraciones médicas.

En la audiencia, usted y su abogado u otro representante pueden interrogar a los testigos por parte nuestra o suya.

SI SU SITUACIÓN ES EXTREMADAMENTE GRAVE, EL ESTADO INTENTARÁ TRAMITAR SU PETICIÓN DE AUDIENCIA IMPARCIAL LO MÁS RÁPIDO POSIBLE. SI USTED LLAMA PARA SOLICITAR UNA AUDIENCIA, FAVOR DE ESTAR LISTO PARA EXPLICAR SU SITUACIÓN A LA PERSONA QUE CONTESTE EL TELÉFONO. SI ESCRIBE, FAXEA O SE COMUNICA CON NOSOTROS POR INTERNET, NO FALTE EN EXPLICAR SU SITUACIÓN.

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, podría 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 cómo 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 pedirlos con anticipación. Éstos 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: Si desea más información sobre su caso, cómo pedir una Audiencia Imparcial, cómo revisar su archivo o cómo obtener copias adicionales de documentos, llame o escribanos al número telefónico y/o dirección que aparecen en la **página 1** de este aviso.

PETICIÓN DE AUDIENCIA IMPARCIAL

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

Nombre en Letras de Molde: _____ Núm. del Caso: _____
Nombre I. Apellido

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____ Teléfono: _____

Firma: _____ Fecha: _____