



FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #12-96-ELI (This Policy Bulletin Replaces PB #12-51-ELI)

2012 OCTOBER CASH ASSISTANCE BASIC ALLOWANCE INCREASE

Date: October 2, 2012	Subtopic(s): Eligibility, Cash Assistance, Supplemental Nutrition Assistance Program																
<p> This procedure can now be accessed on the FIAweb.</p> <p>See revised Form W-203K.</p> <p>A "Normal Grant" is the total amount of the Basic, Shelter, and Energy Allowances for a household equal to one.</p>	<p>This policy bulletin is being issued to inform all staff at Job Centers that the final phase of the 2012 increase in the Cash Assistance (CA) Basic Allowance took effect on October 1, 2012.</p> <p>On October 1, 2012, the CA semimonthly Basic (Preadded) Allowance increased. The Guide to Cash Assistance Budgeting (W-203K) form has been updated to reflect the new Preadded Allowance for each CA household size.</p> <table border="1" data-bbox="448 1033 1516 1182"> <thead> <tr> <th>CA Family size</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> <th>5</th> <th>6</th> <th>Each Additional Person</th> </tr> </thead> <tbody> <tr> <td>Amount</td> <td>\$79</td> <td>\$126</td> <td>\$168</td> <td>\$216.50</td> <td>\$267</td> <td>\$308.50</td> <td>\$42.50</td> </tr> </tbody> </table> <p>The Basic Allowance is currently used in the calculation of CA needs for the following Shelter Types: 01, 02, 03, 06, 11, 13, 23, 24, 25, 26, 27, 30, 33, 38, 39, 40, and 43.</p> <p>The Basic Allowance is also used to determine:</p> <ul style="list-style-type: none"> the shelter amount for individuals paying Room and Board (Shelter Type 04). the "Normal Grant" for Supplemental Nutrition Assistance Program (SNAP) shelter expenses for those individuals on the case who are residing in Residential Treatment Centers (RTC) (Shelter Types 27, 31, and 32). On October 1, 2012, the "Normal Grant" became \$398. the benefit amount for those individuals who are on the case but are not receiving care from the Congregate Care Level 2 Facility (Shelter Type 43). 	CA Family size	1	2	3	4	5	6	Each Additional Person	Amount	\$79	\$126	\$168	\$216.50	\$267	\$308.50	\$42.50
CA Family size	1	2	3	4	5	6	Each Additional Person										
Amount	\$79	\$126	\$168	\$216.50	\$267	\$308.50	\$42.50										

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

For example: If there is a congregate care household of three where one person is receiving care, a Personal Needs Allowance (PNA) will be calculated for the individual receiving care and the two remaining household members not receiving care will receive a basic allowance of \$126.00 semimonthly plus the energy allowance for two people of \$19.75.

The mass rebudgeting/reauthorization (MRB) of all CA and CA/SNAP cases eligible for the increase took place over the weekend of September 15, 2012. The MRB will carry the unique authorization number of **4071947**. As a result of this increase in the CA grant, the SNAP benefits may decrease.

All cases rebudgeted with the Basic Allowance increase will receive a notice (see **Attachment A or A(S)**) informing them of the change in their grant.

The Office of Temporary and Disability Assistance (OTDA) will provide the Family Independence Administration with a list of the excluded cases.

When the exception report is received, the JOS/Worker must:

- calculate, save, and authorize a new budget to reflect the new CA benefit amount;
- ensure that a Client Notices System (CNS) notice is generated (do not use M3E Indicator **A** or **T**); and
- provide a supplementation of the CA grant for any underpayment that occurred as a result of the increase in the CA grant for every cycle from the 10/A/12 to the effective date of the authorized budget.

Households that applied before October 1, 2012, and were denied CA, due to income based on CA benefit levels that were in effect prior to October 1, 2012, must reapply for CA in order to be reevaluated based on the higher CA benefit level.


Shelter Type Codes **14, 15, 16, 19, 28, 29, 34, 35, 42, and 44** will not receive the CA increase because they are in receipt of a PNA, which is not increasing.

Effective Immediately

References:

- [12-ADM-05](#)
- [09-ADM-03](#)
- [09-ADM-13](#)
- [ABEL Transmittal 12-3](#)
- [ABEL Transmittal 12-4](#)

Attachments:

 Please use Print on Demand to obtain copies of forms.

- W-203K** Guide to Cash Assistance Budgeting (Rev. 10/02/12)
- Attachment A** Sample of the Increase in Basic Allowance Notice
- Attachment A (S)** Sample of the Increase in Basic Allowance Notice (Spanish)

Guide to Cash Assistance Budgeting

(Effective October 1, 2012)

Schedule of Semimonthly (S/M) Preadded Allowance (10/1/12)

CA Family Size	1	2	3	4	5	6	Each Additional Person
Amount	\$79.00	\$126.00	\$168.00	\$216.50	\$267.00	\$308.50	\$42.50

Special Situations

- Single persons residing in public shelters can receive a Cash Assistance personal needs allowance of \$22.50 semimonthly.
- Homeless persons who refuse placement in a shelter can receive the preadded, energy and restaurant allowance.
- For family members joining the household for limited periods (e.g., weekends) authorize \$4.00 per day, per person.
- All participants who are billed for rent are entitled to a shelter allowance equal to the rent or the maximum shelter allowance for family size, whichever is less.
- Persons with HIV/AIDS may be limited to a shelter allowance of up to \$480 per month and up to \$330 per month for each additional person on the case.

Schedule 1

Maximum S/M Shelter Allowance with Children[†] (effective 11/1/03)

CA Family Size	1	2	3	4	5	6	7 or More
S/M Amount	\$138.50	\$141.50	\$200.00	\$225.00	\$250.50	\$262.00	\$273.00

Schedule 2

Maximum S/M Shelter Allowance without Children

CA Family Size	1	2	3	4	5	6	7	8 or More
S/M Amount	\$107.50	\$125.00	\$143.00	\$156.00	\$168.50	\$174.50	\$201.50	\$210.50

S/M Energy Grants

CA Family Size	1	2	3	4	5	6	Each Additional Person
S/M Amount	\$12.55	\$19.75	\$26.50	\$34.35	\$42.35	\$48.60	\$6.25

S/M Fuel for Heating: Other than Natural Gas Fuel Type (Oil, Kerosene, Propane) (Code 2)**

CA Family Size	1	2	3	4	5	6	7	8 or More
S/M Amount	\$35.00	\$35.00	\$35.00	\$36.50	\$38.50	\$41.00	\$44.00	\$46.50

S/M Fuel for Heating: Natural Gas Fuel Type (Code 1), Coal (Code 4), Other Code (Code 9)**

CA Family Size	1	2	3	4	5	6	7	8 or More
S/M Amount	\$28.00	\$28.00	\$28.00	\$29.00	\$30.50	\$32.50	\$34.50	\$37.00

S/M Fuel for Heating: Other than Natural Gas Fuel Type (Electric) (Code 3)**

CA Family Size	1	2	3	4	5	6	7	8 or More
S/M Amount	\$45.00	\$45.00	\$45.00	\$47.00	\$49.50	\$53.00	\$56.50	\$60.00

Expenses Incident to Employment

Item of Expense	Allowance
Standard Semimonthly Work Deduction	\$45.00
Earned Income Disregard^{††}	50% of Gross earned income minus standard work deduction

Expenses Incident to Approved Training

Carfare	Public transportation expense
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Schedule of Semimonthly Restaurant Allowance (Includes Sales Tax)

	Dinner	Lunch and Dinner	All Meals
Amount per Person	\$14.50	\$23.50	\$32.00
Pregnant Women, Persons under 18 Years of Age and Full-Time Students Who Will Graduate before 19th Birthday	\$32.50	\$41.50	\$50.00

Schedule of Emergency Assistance Grants for All Cases

Daily Rate

CA Family Size	Preadded and Energy Allowance	*Preadded, Energy and Restaurant Allowance
1	\$6.10	\$8.25
2	\$9.70	\$14.00
3	\$12.95	\$19.35
4	\$16.70	\$25.25
5	\$20.60	\$31.30
6	\$23.80	\$36.60
7	\$27.05	\$42.00
8	\$30.30	\$47.35
9	\$33.55	\$52.75
10	\$36.80	\$58.15
Each Additional Person	\$3.25	\$5.40

[†] Includes pregnant women

^{††} Applicable only to FA household and SNA households with at least one active child.

*Add \$1.20 per individual, if entitled, to the \$50.00 semimonthly restaurant allowances.

Enter the appropriate code in the fuel type field on the household screen (NSBL02**) of the budget in the WMS.

**HUMAN RESOURCES ADMINISTRATION
P.O. BOX 02-9121, BROOKLYN GPO,
BROOKLYN, NEW YORK 11202-9121**

New York State
Office of Temporary and
Disability Assistance



**TA GRANT INCREASE
October '12/NYC**

Case Number:
Local Office / Unit
Worker:

General Telephone No. for
Questions or Help:

Notice Date: August 25, 2012

Dear PA Recipient:

This Notice is to tell you that this agency intends to CHANGE your benefits as follows:

PUBLIC ASSISTANCE: Beginning October 1, 2012, your public assistance benefit will go FROM _____ TO _____ because your basic allowance has increased.

The benefit amount is the amount before recoupments or restrictions are taken.

Recoupment: If you have a recoupment in place, the same recoupment percentage will continue to be taken.

Restriction: An example of a restriction is an amount taken from your benefit and paid directly to your landlord or to the electric company. No new restrictions are being imposed at this time.

Your monthly public assistance grant will change as a result of an increase in the basic allowance. The reason for this increase is that New York State has passed a Law which increases the basic allowance part of your public assistance grant. To determine the specific increase in your Basic Allowance before recoupments or restrictions are taken, look at the chart below, determine the number of persons receiving PA in your case and note the increase beginning October 1, 2012.

The Regulation which allows us to do this is 18 NYCRR § 352.1(a).

Family Size	1	2	3	4	5	6	Each Additional Person
Basic Allowance eff: 7/1/2012	150	239	317	409	505	583	+80
Basic Allowance eff: 10/1/2012	158	252	336	433	534	617	+85
Difference	+8	+13	+19	+24	+28	+34	+5

As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP) and any reference to Food Stamp benefits or Food Stamps (FS) shall mean SNAP benefits.

Supplemental Nutrition Assistance Program (SNAP)

Beginning October 2012, your SNAP benefits will be reduced as a result of the increase in public assistance benefits as set forth in this notice. We count your public assistance (PA) benefit as income when we determine the amount of your SNAP benefits. When your PA income increases, your SNAP benefits decrease. Generally, a three-dollar (\$3) increase in income will result in a one-dollar (\$1) decrease in SNAP benefits.

The Regulations which require us to do this are 18 NYCRR 387.10 and 387.15.

Medical Assistance

Your Medical Assistance benefits will continue unchanged.

The Regulation which allows us to do this is 18 NYCRR 360-3.3.

Attachment A YOU HAVE THE RIGHT TO APPEAL THIS DECISION. READ BELOW ON HOW TO APPEAL THIS DECISION.

CONFERENCE (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing. If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See "Keeping Your Benefits The Same" below.)

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by **mail**, by **phone**, by **fax**, by **walk-in** or **online**.

- (1) Telephoning: 1-800-342-3334 (please have this notice with you when you call) OR
- (2) FAX: Sending a copy of this notice to (518) 473-6735.
- (3) Walk-In: Bring a copy of this notice to New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, NYC.
- (4) Writing: By sending a copy of both pages of this notice completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, PO Box 1930, Albany, NY 12201. Please keep a copy for yourself
- (5) Online: Complete an online request form at: <http://www.otda.state.ny.us/oah/forms.asp>

I want a fair hearing. The Agency's action is wrong because _____

Signature of Client: _____ Date: _____

Name (print): _____ Case Number: _____

Your Address: _____

Telephone Number: _____

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, fax, by walk-in or online, please write to ask for a fair hearing before the deadline.

You have the following number of days from the date of this notice to request a fair hearing:

Public Assistance: 60 days

Food Stamps: 90 days

KEEPING YOUR PUBLIC ASSISTANCE BENEFITS THE SAME: We will restore your Public Assistance benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. If you lose the fair hearing, you will have to pay back any Public Assistance benefits you got but should not have gotten, 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 back this notice, check the box or boxes below:

I do not want my Public Assistance benefits kept the same until the Fair Hearing decision is issued:

KEEPING YOUR FOOD STAMP BENEFITS THE SAME: If you request a fair hearing before (10 days from date of notice), you will continue to receive your food stamp benefits unchanged until the fair hearing decision is issued, **unless:** if, at the hearing, the hearing officer determines that you are not complaining about an incorrect computation of your benefits or that there has been a misapplication or misinterpretation of law or regulations, the hearing officer may determine that you were not entitled to have food stamp benefits continue unchanged until the fair hearing decision is issued, and order that the reduction take effect immediately.

If you asked for a fair hearing and your benefits were continued at the same level they were before this notice and you lose the fair hearing, you will owe any food stamps that you should not have received. We are required by Federal Law to recover any food stamp overpayments. We must make a claim against you for any food stamps you receive that you were not entitled to, which may be collected by reduction of future food stamp allotments, lump sum installment payments or through legal action. If you want to avoid this possibility, you can check the box below. You can also indicate over the telephone or in a letter that you do not want your food stamp benefits continued unchanged. If you check the box, the action described on page 1 of this notice will be taken on the effective date.

I do not want my Food Stamp benefits kept the same until the Fair Hearing decision is issued.

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.

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, 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.

LEGAL ASSISTANCE: If you think you need a lawyer to help you with this problem, you may be able to get a lawyer at no cost to you by contacting your local Legal Aid Society or other legal advocate group. For the names of other lawyers, check your 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 file. If you call, write or fax to us, we will send you free copies of the documents from your file that we will provide the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your file that 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 Hearings, 14 Boerum Place, Brooklyn, New York 11201.**

If you want copies of documents from your case file, you should ask them ahead of time. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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 us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

**HUMAN RESOURCES ADMINISTRATION
P.O. BOX 02-9121, BROOKLYN GPO,
BROOKLYN, NEW YORK 11202-9121**

New York State
Office of Temporary and
Disability Assistance



**AUMENTO DEL SUBSIDIO DE
ASISTENCIA TEMPORAL
Octubre 2012 / NYC**

Nº de caso:
Oficina Local / Unidad
Trabajador(a):

Nº de teléfono general para
preguntas o ayuda:

Fecha del aviso: **25 de agosto de 2012**

Estimado(a) beneficiario(a) de Asistencia Pública:

Por medio de esta notificación le comunicamos que esta agencia tiene el propósito de MODIFICAR sus beneficios, tal como lo explicamos a continuación.

ASISTENCIA PÚBLICA: comenzando el 1º de octubre de 2012, su beneficio de asistencia pública cambiará DE _____ A _____ debido a que su asignación básica ha aumentado.

El monto de este beneficio es el monto antes de las deducciones de los montos recuperados o las restricciones.

Montos recuperados: si actualmente usted tiene pendiente una recuperación, se continuará deduciendo el mismo porcentaje de recuperación.

Restricción: ejemplo de una restricción sería el monto que se deduce de su beneficio y se paga directamente al arrendador o a la compañía de servicios públicos. Por el momento, no se están imponiendo nuevas restricciones.

El monto mensual de su subsidio de asistencia pública se modificará como resultado de un aumento en la asignación básica. El motivo de este aumento es que el Estado de Nueva York ha adoptado una nueva ley la cual aumenta la asignación básica de su subsidio de asistencia pública. Para saber exactamente cuál es el aumento de su asignación básica antes de las deducciones de los montos recuperados o las restricciones, examine el cuadro de abajo, tome en cuenta el número de personas incluidas en su caso que reciben asistencia pública y observe el aumento que entra en vigor el 1 de octubre de 2012.

Esta decisión se basa en la Reglamentación 18 NYCRR § 352.1(a).

Tamaño del Grupo Familiar	1	2	3	4	5	6	Por cada persona adicional:
Asignación básica, efect:7/1/2012	150	239	317	409	505	583	+80
Asignación básica, efect:10/1/2012	158	252	336	433	534	617	+85
Diferencia	+8	+13	+19	+24	+29	+34	+5

A partir del 29 de agosto de 2012, toda referencia al Programa de Cupones para Alimentos en esta notificación se estará refiriendo al Programa de Asistencia Suplementaria (SNAP, por sus siglas en inglés). Así mismo, toda referencia a beneficios de Cupones para Alimentos o Cupones para Alimentos (FS) querrá decir beneficios o subsidio SNAP.

Programa de Asistencia de Nutrición Suplementaria (SNAP, siglas en inglés)

A partir de octubre de 2012, su subsidio de SNAP se reducirá a consecuencia del aumento en los beneficios de asistencia pública tal como se señalan en la presente notificación. Tomamos en cuenta su beneficio de asistencia pública (PA) como ingreso cuando calculamos el monto de su subsidio SNAP. Cuando su ingreso de asistencia pública aumenta, su subsidio de SNAP disminuye. Por lo general, un aumento de tres dólares (\$3) en el ingreso, tiene como resultado una reducción de un dólar (\$1) en el subsidio SNAP.

Conforme Reglamentación 18 NYCRR 387.10 y 387.15.

Asistencia Médica

Sus beneficios de Asistencia Médica continuarán sin cambios.

Esta decisión se basa en Reglamentación 18 NYCRR 360-3.3.

USTED TIENE EL DERECHO DE APELAR EN CONTRA DE ESTA DECISIÓN. LEA A CONTINUACIÓN SOBRE EL PROCESO DE APELACIÓN.

CONFERENCIA (reunión informal con nosotros): si usted cree que nuestra decisión es incorrecta o no comprende nuestra decisión, sírvase llamarnos para solicitar una reunión. Llame al número de teléfono para conferencias que aparece en el **anverso** de esta notificación o escribanos a la dirección que aparece en el **anverso** de esta notificación. En algunos casos, ésta es la forma más rápida de resolver problemas. Le recomendamos hacerlo, aunque haya solicitado una audiencia imparcial. Si **solamente** solicita una reunión con nosotros; no mantendremos sus beneficios sin cambios mientras dure el proceso de apelación. Sus beneficios se mantendrán sin cambios solamente si usted solicita una audiencia imparcial estatal. (Vea la sección abajo titulada «Mantener sus Beneficios sin Cambios»).

CÓMO SOLICITAR UNA AUDIENCIA IMPARCIAL: puede solicitar una audiencia imparcial **por correo, por teléfono, por fax, en persona o por internet.**

- (1) Por teléfono: 1-800-342-3334 (favor de tener a mano esta notificación cuando llame)
- (2) Por fax: envíe una copia de esta notificación a (518) 473-6735.
- (3) En persona: traiga una copia de todas las partes de este aviso a: *New York State Office of Temporary and Disability Assistance, 14 Boerum Place, Brooklyn, NYC.*
- (4) Por escrito: rellene este aviso y envíe ambas partes de esta notificación a: *Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.* Favor de quedarse con una copia.
- (5) *Por internet:* rellene una petición electrónica en el siguiente sitio: <http://www.otda.state.ny.us/oah/forms.asp>

Deseo una audiencia imparcial. La decisión de la agencia es incorrecta porque: _____

Firma del cliente: _____ Fecha: _____

Nombre (letra de imprenta) _____ N° de caso: _____

Su dirección: _____

Número de teléfono: _____

Si no puede comunicarse con la Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York por teléfono, por facsímil, en persona o por vía electrónica, favor de solicitar por escrito una audiencia imparcial antes del vencimiento del plazo.

Usted tiene el siguiente lapso de tiempo dentro del cual puede solicitar una audiencia imparcial:

Asistencia Pública: 60 días

Cupones para Alimentos: 90 días

MANTENER SUS BENEFICIOS DE ASISTENCIA PÚBLICA SIN CAMBIOS: reanudaremos sus beneficios de Asistencia Pública al mismo nivel en que estaban antes de esta notificación si usted solicita una audiencia imparcial antes de la fecha de vigencia señalada en esta notificación. Si no se decide a su favor en la audiencia imparcial, tendrá que devolver todos los beneficios de asistencia pública que recibió y que no debía haber recibido mientras esperaba por la decisión de la audiencia imparcial. Si usted no quiere que sus beneficios continúen sin cambios hasta que se tome la decisión, deberá informárselo al Estado cuando llame para solicitar la audiencia imparcial o si usted devuelve este aviso, marque la(s) casilla(s) a continuación:

No deseo que mis beneficios de Asistencia Pública continúen al mismo nivel hasta que se remita la decisión de la audiencia imparcial.

MANTENER SUS BENEFICIOS DE CUPONES PARA ALIMENTOS SIN CAMBIOS: si usted solicita una audiencia imparcial antes de (10 días de la fecha de esta notificación), continuará recibiendo sus beneficios de cupones para alimentos sin cambios hasta que se tome una decisión en la audiencia imparcial, **a menos que:** si durante la audiencia, el oficial a cargo, determina que su queja no tiene que ver con un cálculo incorrecto de sus beneficios o si determina que la ley o reglamento se interpretó o se aplicó de manera indebida, el oficial puede dictaminar que usted no tenía derecho a que continuaran sus beneficios de cupones para alimentos sin cambios en espera de la decisión de la audiencia imparcial, y como resultado ordenar que la reducción entre en vigor inmediatamente.

Si usted solicitó una audiencia imparcial y sus beneficios continuaron al mismo nivel que estaban antes de esta notificación y la audiencia imparcial no se decide a su favor, usted tendrá que devolver el monto de beneficios de cupones para alimentos que recibió pero que no debería haber recibido. Estamos obligados por ley federal a recuperar todo monto en exceso de cupones para alimentos. Debemos establecer una reclamación por todo monto de cupones para alimentos que usted haya recibido indebidamente, y recuperarlo por medio de reducciones en cantidades futuras de cupones para alimentos, en pagos de sumas globales o por medio de la vía judicial. Si no quiere que estas acciones se lleven a cabo, marque la siguiente casilla. Además, nos puede notificar por teléfono o en una carta, que usted no desea que sus beneficios de cupones para alimentos continúen sin cambios. Si usted marca la casilla, la acción descrita en la página 1 de esta notificación se llevará a cabo en la fecha de vigencia establecida.

No deseo que mis beneficios de Cupones para Alimentos continúen al mismo nivel, hasta que se remita la decisión de la audiencia imparcial.

LO QUE SUCEDE EN UNA AUDIENCIA IMPARCIAL: el Estado le enviará un aviso informándole cuándo y dónde se realizará la audiencia imparcial.

En la audiencia, usted tendrá la oportunidad de explicar por qué cree que nuestra decisión es incorrecta. Puede traer consigo a un abogado, a un familiar o a un(a) amigo(a), o a alguien más que pueda ayudarle a exponer su caso. Si usted no puede presentarse, puede enviar a otra persona en su representación. Si la persona que lo representará no es un abogado, debe entregarle a esta persona una carta, dirigida al funcionario de audiencias, en la cual usted declara que desea que dicha persona lo represente en la audiencia.

En la audiencia, usted y su abogado u otro representante, tendrán la oportunidad de explicar por qué creen que nuestra decisión es incorrecta, como también la oportunidad de presentar, ante el funcionario de audiencias, documentos que demuestren nuestra equivocación. Con el fin de ayudarle a exponer el motivo de nuestra equivocación, le sugerimos presentar testigos que puedan avalar su caso. También, le sugerimos presentar documentos tales como: comprobantes de pagos salariales, contrato de alquiler, recibos, cuentas médicas, etc. En la audiencia, usted y su abogado u otro representante, podrán interrogar a los testigos que nosotros presentemos o los que usted presente con motivo de avalar su caso.

ASISTENCIA LEGAL: si cree que necesita representación legal en la resolución de este problema, puede obtener los servicios de un abogado, sin costo alguno, comunicándose con la Sociedad de Ayuda Legal (*Legal Aid Society*) u otra asociación de defensa legal de su localidad. Puede encontrar los nombres de otros abogados en las páginas amarillas, bajo «Abogados» (*“Lawyers”*).

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: en preparación para la audiencia imparcial, usted tiene derecho a revisar el archivo de su caso. Si nos llama, nos escribe o nos envía un fax, le enviaremos copias gratis de documentos en su archivo; los mismos que entregaremos al funcionario de audiencias en la audiencia imparcial. Además, si nos llama o nos escribe o nos manda un fax, le enviaremos copias gratis de documentos específicos en su archivo y los cuales usted considere necesarios en preparación para la audiencia imparcial. Si desea solicitar documentos o averiguar la modalidad a seguir para consultar su archivo, llámenos al (718) 722-5012 o al número de fax (718) 722-5018 o mande una carta a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201.**

Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Normalmente se le envían dentro de tres (3) días hábiles de la fecha de petición. Si solicita las copias faltando menos de cinco (5) días hábiles de la fecha fijada para la audiencia, los documentos se le entregarán el día de la audiencia.

INFORMACIÓN: si desea información adicional sobre su caso, cómo solicitar una audiencia imparcial, cómo consultar su archivo o cómo obtener copias adicionales de documentos, sírvase llamarnos al número de teléfono señalado en el **anverso** de este aviso o mande una carta a la dirección que figura en el **anverso** de esta notificación.