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POLICY BULLETIN #13-109-OPE
(This Policy Bulletin Replaces PB #13-106-OPE)

REVISIONS TO SELECTED FORMS

Date: December 16, 2013	Subtopic(s): Forms
🖥 This procedure can now be accessed on the FIAweb.	**Revisions to the Original Policy Bulletin:** This Policy Bulletin is revised to include additional changes to the form **W-450D**. The purpose of this policy bulletin is to inform Job Center, Cash Assistance (CA) and Non-Cash Assistance (NCA) Supplemental Nutrition Assistance Program (SNAP) staff that the following forms have been revised to reflect current logo, program's name change and Agency's terminology.

Please See
PD #07-11-ELI
(W-124H, W-140CC,
W-140DD, W-140EE,
W-140FF, W-140M,
W-140Q, W-140X,
W-140Y, W-140R)

- **W-124H** Report of Claim Determination
- **W-140CC** New Claims Prescreening Form
- **W-140DD** New Claim Calculation Work Sheet
- **W-140EE** Report of Claims Determination Transmittal
- **W-140FF** Potential Food Stamp Overpayments/Claims Tracking Report
- **W-140HH** Memorandum
- **W-140M** Instruction for Completion of Discrepant Information Tracking Form
- **W-140Q** Potential Food Stamp Claims Control Log
- **W-140R** Potential Food Stamp Claims Activity & Monitoring Report
- **W-140X** Discrepant Information Control Log
- **W-140Y** Discrepant Information Control Report
- **W-139D** Benefit Letter
- **W-907MM** Office of Eligibility and Employment Monitoring
- **W-907RR** Notice of Appointment for Home Visit

Used by Office of
Employment Monitoring

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*

Distribution: X

Used by Homelessness Diversion Program	• **W-450D** Diversion Weekly Reporting Form
	
	Revised changes:
	In addition, the following items were removed from the **W-450D**:
	    - Jiggetts program was replaced with FEPS
	    - EIHP (program ended)
	    -"Reporting Date" field and "Single HR" field (category no longer exist)
	
	The following fields were added to the **W-450D**
	    - SSN field
	    - "Week Ending Date" field
	    - "Single/Childless Couple" field
	Center Directors must ensure that all previous versions of the forms and their multilingual equivalents are removed from circulation and recycled.
	
	Samples of the revised forms are attached.
	
	Effective Immediately
	
	Attachments:

⌨ Please use Print on Demand to obtain copies of forms.	

W-124H	Report of Claim Determination (Rev.12/4/13)
W-140CC	New Claims Prescreening Form (Rev.12/4/13)
W-140DD	New Claim Calculation Work Sheet (Rev.12/4/13)
W-140EE	Report of Claims Determination Transmittal (Rev.12/4/13)
W-140FF	Potential Food Stamp Overpayments/Claims Tracking Report (Rev.12/4/13)
W-140HH	Memorandum (Rev.12/4/13)
W-140M	Instruction for Completion of Discrepant Information Tracking Form (Rev.12/4/13)
W-140Q	Potential Food Stamp Claims Control Log (Rev.12/4/13)
W-140R	Potential Food Stamp Claims Activity & Monitoring Report (Rev.12/4/13)
W-140X	Discrepant Information Control Log (Rev.12/4/13)
W-140Y	Discrepant Information Control Report (Rev.12/4/13)
W-139D	Benefit Letter (Rev.12/4/13)
W-450D	Diversion Weekly Reporting Form (Rev.12/16/13)
W-907MM	Office of Eligibility and Employment Monitoring (Rev.12/4/13)
W-907RR	Notice of Appointment for Home Visit (Rev.12/4/13)

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

Date: _____

Case Number: _____

Case Name: _____

NCA SNAP/
Job Center Number: _____

Report of Claim Determination

Participant's Address
Date of Discovery (enter the date the Agency became aware of the overpayment):

SNAP Claim Type

☐ Inadvertent Household Error (IHE) ☐ Intentional Program Violation (IPV) ☐ Agency Error (AE)

☐ Administrative Error (For OFFO use only)

Month of Issuance	Amount Issued	Actual Entitlement	Overpayment*	Month of Issuance	Amount Issued	Actual Entitlement	Overpayment*
	$	$	$		$	$	$
	$	$	$		$	$	$
	$	$	$		$	$	$
	$	$	$		$	$	$
	$	$	$		$	$	$
	$	$	$		$	$	$
	$	$	$		$	$	$
	$	$	$	**Total**	$	$	$

*Cannot exceed amount issued.
 Reminder: SNAP claim not required on cases where overpayment is less than $500.

Reason for Overpayment:

☐ HH failed to give complete/correct information

☐ HH failed to report a change

☐ HH failed to report a change in a timely manner

☐ HH redeemed the original and a replacement benefit

☐ HH received more benefits than it was entitled to, pending a Fair Hearing appeal

☐ Agency failed to act on a reported change in a timely manner

☐ Agency incorrectly computed HH budget or otherwise issued incorrect benefits

☐ Other/remarks: _____

Action Taken/Remarks:

☐ Case closed effective: _____

☐ No action, case already closed; Date: _____

☐ Budget reduced, effective: _____

From $ _____ to $ _____

☐ No action: current budget correct

INSTRUCTIONS:

Complete both pages of this report. Attach photocopies of pertinent documents (budget worksheets, paystubs, computer printouts, etc.) and forward to the **Office of SNAP Fiscal Operations, 98 Flatbush Ave., 2nd Floor, Brooklyn, New York 11217**.

Details of Overpayment

Source of Information   ☐ Computer Match (specify)   ☐ Other (specify)

☐ **Income Not Budgeted/Income Underbudgeted**

Name(s) of Household Member(s) Who Receive(s) Income	Social Security Number(s)	Amount and Source of Income

Explain why income was not budgeted or was underbudgeted: _____

_____

☐ **Resources Not Reported**

Name(s) of Household Member(s) Who Receive(s) Income	Social Security Number(s)	Amount and Source of Income

Remarks: _____

_____

☐ **Other Reason for Overpayment**

Give details: _____

_____

_____

_____

_____

Worker	Date	Supervisor	Date

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

New Claims Prescreening Form

(To Be Used in Evaluating All Potential Supplemental Nutrition Assistance Program [SNAP] Claims)

☐ Job Center No.: _____   ☐ NCA No.: _____   ☐ HASA _____   ☐ BFI _____

Case Name: _____   Caseload: _____   Category/Case Number: _____

Case Status: ☐ Active ☐ Closed/Rejected   CL or RJ Code: _____   Date Closed or Rejected: _____

Note: You must attach this form, along with any required supporting documents, to the Discrepant Information Tracking Form (**W-140M**) after prescreening is completed. **See page 3 for instructions on completing this form.**

1. Is the CNS closing code **E95** or **E72**? ☐ Yes ☐ No
   If **yes, stop!** Check reason code **D1** or **E1** on **page 2**, as appropriate, sign and date this form, and attach it to annotated **W-140M** with a copy of current **TAD** and submit package to Supervisor. For all other closing codes, continue Supplemental Nutrition Assistance Program (SNAP) claim evaluation. NCA SNAP locations, proceed to **Question 3**. All others, proceed to **Question 2**.

2. If this is a Cash ssistance case, were SNAP benefits issued during period of Cash Assistance overpayment? ☐ Yes ☐ No
   If **no, stop!** Check reason code **T1** on **page 2**, sign and date this form and attach to **W-140M** with copies of Benefit Issuance Case Inquiry (option 3) and Case History (option 4) screens and submit package to Supervisor. If **yes**, proceed to **Question 3.**

3. Has the new case been transferred to another Center (or NCA office)? ☐ Yes ☐ No
   If **yes**, indicate the new Center (or NCA office) number _____; enter case number _____.
   The **W-140CC** and the **W-140M** must be forwarded to the appropriate location. Print and attach a copy of the Case Inquiry Screen (option 4), check reason code **R1** on **page 2**, sign and date this form, attach it to the **W-140M**, and submit package to your Supervisor for forwarding to the new location. If **no**, proceed to **Question 4**.

4. Enter date of actual change _____   Enter date change was reported _____

   Date of last recertification _____

   Based on your review, is household subject to **six-month reporting** (earned and/or unearned income currently being budgeted)?
   ☐ Yes ☐ No
   • If **no**, apply **10-10-10** reporting time frame. Proceed to **Question 5**.
   • If **yes**, was change reported on time? ☐ Yes ☐ No
   • If **no**, proceed to **Question 5**.
   • If **yes**, did changes cause the household to **exceed 130%** of the poverty level **(see page 3 for detailed instructions)**?
     ☐ Yes ☐ No
   • If **no**, check reason code **S1** on **page 2**, sign and date form, attach **W-140M** and give package to Supervisor.
   • If **yes**, there is potential overpayment; proceed to **Question 5**.

5. Enter the period of the SNAP overpayment from (month/year) _____ to (month/year) _____. If based on the reporting requirements for this household, no overpayment occurred, **stop!** Check reason code **S1** on **page 2**, sign and date form, attach to **W-140M** and give package to Supervisor. If there is potential overpayment, proceed to **Question 6**.

6. Enter the total amount of SNAP benefits issued during the **stated** overpayment period _____.

   Was the total amount of SNAP benefits issued during overpayment period **greater than** $500? ☐ Yes ☐ No
   If **yes**, proceed to **Question 7**. If **no**, check reason code **W1** on **page 2**; sign and date the form. Due to **$500 establishment threshold**, processing of SNAP claim is not required.

7. Is additional documentation needed to process the SNAP claim? ☐ Yes ☐ No
   If **yes**, check the appropriate code below for the form that was sent. If **no**, proceed to **Question 8**.

   ☐ **K1** for **W-532** to employer   Date Sent _____   Due Date for Response* _____

   ☐ **M1** for other (specify): _____   Date Sent _____   Due Date for Response* _____

   * In all instances the due date for response shall be **30 calendar days** from the date the request was prepared and sent.

   Check the corresponding reason code below (**K1** or **M1**), sign and date form, attach **W-140M** with a copy of form(s) sent and submit package to Supervisor. Claim will be deferred pending receipt of verification. Upon receipt of income verification, proceed to **Question 8**. If after several attempts, you are unable to obtain verification and the due date has passed, retrieve the claims package with the original **W-140CC**, **W-140M** and copy of verification request. Annotate **W-140CC** with reason code **U1** (insufficient information to calculate SNAP claim) and enter the date amended, and resubmit package to Supervisor.

8. Was the **only** adult in the household when the overpayment occurred an ineligible alien or an ineligible student?
   ☐ Yes ☐ No
   If **yes, stop!** Check reason code **Y1** below, sign and date the form, and attach it to the **W-140M** and forward to Supervisor. If **no**, proceed to **Question 9**.

9. Is there a SNAP claim on the system for the **entire** period of overpayment stated in **Question 5**? ☐ Yes ☐ No
   If **yes, stop!** Print and attach a copy of recoupment screen (option 4, WMS inquiry menu), check reason code **I1** below, sign and date this form, attach to **W-140M** and forward to Supervisor. If **no**, or if there is a partial SNAP claim on the system, proceed to **Question 10**.

10. Reason for SNAP overpayment: ☐ earned income   ☐ unearned income   ☐ non-income-related
    For earned or unearned income, multiply the unbudgeted total gross income by 30 percent (unreported) or 24 percent (Agency error) for the entire period of overpayment. **Result $** _____. Is the result **less than** $500? ☐ Yes ☐ No

    If **yes, stop!** Check reason code **W1** below, sign and date form. Due to **$500 establishment threshold**, processing of SNAP claim is not required. If **no**, develop claim, check reason code **V1** below, sign and date form and attach to **W-140M** with claims package.

    For **non-income-related Supplemental Nutrition Assistance Program (SNAP) overpayment**, multiply the amount of the monthly SNAP reduction by overpayment.

    Result $ _____ Is the result **less than** $500? ☐ Yes ☐ No **(See pages 3 and 4 for detailed instructions)**

    If **yes, stop!** Check reason code **W1** below; sign and date form. Due to **$500 establishment threshold**, processing of SNAP claim is not required. **If no**, develop claim (**see page 4 for detailed instructions**), check **V1** below, sign and date form and attach to **W-140M** with claims package.

REASON CODES (check code that applies)

☐ **D1** Closing code **025/E95** (only person on CA case deceased)	☐ **U1** Insufficient information to calculate SNAP claim: Date amended: _____
☐ **E1** Closing code **E72** (only person on CA admitted to private/public institution)	☐ **V1** Claim submitted and approved
☐ **I1** SNAP claim on system for period of overpayment	☐ **R1** Case transferred to another location
☐ **K1** Wage verification request	☐ **W1** Claim not required pursuant to **$500 establishment threshold**
☐ **M1** Other type of verification requested	
☐ **S1** No overpayment due to reporting, Agency action, and notification time frames	☐ **Y1** No claim – only adult in the household was ineligible alien or ineligible student during period of overpayment
☐ **T1** No SNAP issued during period of CA overpayment	

_____   _____   _____   _____

Worker's Signature   Date   Supervisor's Signature   Date

Instructions for Completion of New Claims Prescreening Form

This form will help you determine whether or not a SNAP claim must be developed, the period and the estimated amount of the claim, or the reason for no claim action. After the prescreening is completed, the **W-140CC** must be attached to the Discrepant Information Tracking Form (**W-140M**), along with any required supporting documents.

Top of Form – Enter identifying information:

1. Location: Enter Center/Office or location number (e.g., No. 26, F-11, etc.) and **check** the location type, Center/Office (NCA, HASA, BFI)
2. Case name and caseload
3. Category of assistance: Family Assistance (FA), Safety Net Cash Assistance (SNCA), Safety Net Non-Cash (SNNC), Safety Net Federally Participating (SNFP) and case number
4. Case status: Active or closed/rejected; if case is closed/rejected, enter closing/rejection code and date of action

Question 1 – Is CNS closing code E95 or E72? If **yes**, no claim is necessary. Check reason code **D1** or **E1** at bottom of page 2, sign and date, attach to **W-140M** with a copy of current **TAD** and give package to Supervisor. For all other closing codes, case must be evaluated for a SNAP claim. NCA SNAP Offices **skip Question 2** and proceed to **Question 3**.

Question 2 – If this is a Cash Assistance case, have SNAP benefits been issued during period of overpayment? If **no**, do not continue with claim. Check reason code **T1** at bottom of page 2, sign and date, attach to **W-140M** with a copy of the Benefit Issuance (option 3) and Case History (option 4) screens and submit package to Supervisor. If **yes**, proceed to **Question 3**.

Question 3 – Has the new case been transferred to another Center/Office? If **yes**, check reason code **R1**, attach to **W-140M** with copy of Case Inquiry screen (option 4) showing transfer and submit to Supervisor for forwarding to new location. If **no**, proceed to **Question 4.**

Question 4 – Enter date of actual change; enter date change was reported; enter date of last recertification. SNAP households that are subject to six-month-reporting rules (this includes most CA and NCA households with earned and/or unearned income budgeted on their case) are not required to report budgetary changes (excluding ABAWD requirements) until the next recertification, unless there is a change in income that causes the household to exceed 130 percent of the poverty level for the household size. For example, a six-month-reporting household receives an increase in earned income that causes the household to exceed 130 percent of the poverty level for the household size on April 15, but does not report it until its next recertification in June. Since the household was required to report this change within 10 days after the end of the month in which the income exceeded the threshold, June would be counted as the first month of overpayment. Allowing 10 days for reporting, 10 days for Agency action and 10 days for timely notification to the household, June would have been the first month the Agency would have taken budgeting action based on the change, had it been reported on time.

Question 5 – Enter the period of the SNAP overpayment. Enter month and year of period beginning (from) until its end (to). Generally, the first month of overpayment for SNAP households that are not subject to six-month reporting would be the first month that the Agency would have taken budgeting action based on the reported change. For example, a non-six-month-reporting household received income from a new source on April 15, but did not report it. The household should have reported the change by April 25. The Worker would have been required to act on the change and send a notice to the household by May 5. The 10-day notice time frame would have ended on May 15. Therefore, the first month of overpayment would have been June. For cases where client failed to report a change at recertification, the first month of overpayment is the first month of the new recertification period. For example, a six-month-reporting household had a certification period of January 1, 2011, through June 30, 2011. The household did not report at its June recertification interview that the household's income increased in February. The household's income did not rise above 130 percent of the poverty level due to the increase. The first month of overpayment is July, the first month of the new certification period.

Question 6 – Enter the total amount of SNAP issued during the _stated_ overpayment period. Using the WMS SNAP Benefit Issuance screen (**NQCS5C**), add up the monthly SNAP amount issued to the household for each month of the SNAP overpayment period entered on line **5**. Be sure to check the Benefit Issuance Archives to see if the period goes back more than 11 months from the date you are preparing this form. Enter the total on line **6**.

Was the total amount of SNAP issued during the overpayment period greater than $500? If **no**, we are **not** required to develop a claim pursuant to a **$500 establishment threshold** affecting claims against households for overpayments of less than $500. Check reason code **W1**, sign and date form, attach to **W-140M** and give package to Supervisor. If **yes**, proceed to **Question 7**.

Question 7 – Is additional documentation needed to process the SNAP claim? If **no**, proceed to **Question 8**. If **yes**, indicate the type(s) of documentation needed, date the request was sent and the due date for response. In all instances the due date for response shall be **30 calendar days** from the date the request was prepared and sent. Check appropriate code(s) for form(s) sent (**K1** for **W-532** to employer, or **M1** for other type of verification requested [specify type, e.g., UIB]). Check the corresponding box at bottom of form, sign and date, attach to **W-140M** with copy of form(s) sent, and give package to Supervisor for **maintaining** in tickler file until the requested documentation is received or the **30-day** time period has elapsed, whichever comes first.

Upon receipt of income verification, proceed to Question 8. If after several attempts, you are unable to obtain verification and the due date has passed, retrieve the claims package with the original **W-140CC**, the **W-140M** and copy of verification request. Annotate **W-140CC** with reason code **U1** (insufficient information to calculate SNAP claim) and enter the **date amended**, and resubmit package to Supervisor.

Question 8 – Was the only adult in the household when the overpayment occurred an ineligible alien or ineligible student? If **yes**, **stop!** Check reason code **Y1**, sign and date form, attach to **W-140M** and forward to Supervisor. A claim cannot be established due to no eligible adult in the household for the overpayment period. (If the only adult in the household when overpayment occurred was an ineligible alien or an ineligible student and was ineligible during part of the entire overpayment period, a claim **can be established only for the portion of the overpayment period in which the adult was eligible**.) If **no**, proceed to **Question 9**.

Question 9 – Is there a SNAP claim on the system for the <u>entire</u> period of overpayment? If **yes, stop!** Check reason code **I1**, attach recoupment screen, sign and date the form, and attach it to the **W-140M** and forward to Supervisor. If **no**, proceed to **Question 10. (Please note that if there is a partial SNAP claim on the system, a claim must be developed for the remaining period of overpayment.)**

Question 10 – Reason for SNAP Overpayment. Check corresponding box (earned income, unearned income or non-income-related). For <u>earned</u> or <u>unearned income</u>, multiply the unbudgeted total gross income by 30 percent (unreported) or 24 percent (Agency error). For <u>non-income-related SNAP overpayment</u>, multiply the amount of monthly SNAP reduction by the overpayment period. Refer to **W-140M**, **section 2(f)** or compare the current budget with the previous budget to obtain the reduction amount.

Is the result less than $500? If **yes**, check reason code **W1**; processing of SNAP claim is not required due to **<u>$500 establishment threshold</u>**. If **no**, for <u>earned or unearned income</u>, calculate SNAP claim by using the **W-140DD** worksheet. **For non-income-related SNAP overpayment**, develop SNAP claim by using conventional method (**W-122A**, **W-122AA**, **W-122D**, **and W-122DD**).

Complete, sign, date and file copy of this form in the case record. For a case where no claim action is necessary, attach copies of all appropriate documentation (i.e., Benefit Issuance screens, current **TAD**, etc.) and complete **section 2** of the **W-140M**. Submit documentation along with the case record for supervisory review.

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

New Claim Calculation Work Sheet

Case Name:	Center No.:	
Case Number: Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is only for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then do not use it in this calculation.

UNEARNED INCOME/ CONCEALED EARNED INCOME	Month/Year	Income Amount	x 30%	SNAP Overpayment Amount
Formula Number 1 Multiply the unbudgeted unearned income by 30%. The product is the Supplemental Nutrition Assistance Program (SNAP) overpayment. **Example:** If the household without the A/D members received less than the maximum benefits, failed to report UIB income in the amount of $600 for the month and received $220 ATPs, then you would calculate the formula as follows: **$600 x 30% = $180**. $180 represents the SNAP overpayment for the month in question.	Example	$600	30%	$180
Total				

EARNED INCOME (NOT CONCEALED)	Month/Year	Income Amount	x 24%	SNAP Overpayment Amount
Formula Number 1 Multiply the unbudgeted earned income by 24%. The product is the Supplemental Nutritional Assistance Program (SNAP) overpayment. **Example:** If the household without A/D members received less than the maximum benefits, unbudgeted earned income in the amount of $600 for the month and received $220 ATPs, then you would calculate the formula as follows: **$600 x 24% = $144**. $144 represents the SNAP overpayment for the month in question.	Example	$600	24%	$144
Total				

New Claim Calculation Work Sheet

Case Name:		Center No.:	
Case Number:	Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is <u>only</u> for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then <u>do not use</u> it in this calculation.

UNEARNED INCOME/ CONCEALED EARNED INCOME	Month/Year	Income Amount	Part 1+Part 2 (if needed)	SNAP Overpayment Amount
	Example	$619	$247.50 + $20.70	$250
Formula Number 3 This formula is to be used only in instances where there is an A/D indicator and an excess shelter amount. To determine the excess shelter amount, you must refer to the Budget Summary for the covering period (see **Monthly SNAP Calculation**). Use the amount that says **"Less: Excess"**.				
Multiply the excess shelter amount by 2 = product A. If income is less than or equal to product A ,do formula 3A. If income is greater than product A, do formula 3B				
Formula 3A Multiply product A by 45% = **SNAP overpayment**				
Formula 3B Income minus product A = Difference Multiply product A by 45% = Part 1 Multiply difference by 30% = Part 2 Part 1 + Part 2 = **SNAP overpayment**				
Example: Monthly income $619; Excess shelter $275; ATP $250 **Part 1** $275 X 2 = $550 X 45% = $247.50 **SNAP overpayment is $248.** **Part 2** $619 - $550 = $69 X 30% = $20.70 **Part 1 + Part 2** $247.50 + $20.70 = $268.20 **SNAP overpayment is $250.**				
Total				

New Claim Calculation Work Sheet

Case Name:		Center No.:	
Case Number:	Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is <u>only</u> for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then <u>do not use</u> it in this calculation.

EARNED INCOME (NOT CONCEALED)	Month/Year	Income Amount	Part 1+Part 2 (if needed)	SNAP Overpayment Amount
	Example	$619	$198 + $16.56	$215
Formula Number 3 This formula is to be used only in instances where there is an A/D indicator and an excess shelter. To determine the excess shelter amount, you must refer to the Budget Summary for the covering period (see **Monthly SNAP Calculation**) use the amount that says **"Less: Excess"**. Multiply the excess shelter amount by 2 = product A If income is less than or equal to product A ,do formula 3A. If income is greater than product A, do formula 3B. **Formula 3A** Multiply product A by 36% = **SNAP overpayment** **Formula 3B** Income minus product A = Difference Multiply product A by 36% = Part 1 Multiply difference by 24% = Part 2 Part 1 + Part 2 = **SNAP overpayment** **Example:** Monthly income $619; Excess shelter $275; ATP $250 **Part 1** $275 X 2 = $550 X 36% = $198 **SNAP overpayment is $198.** **Part 2** $619 - $550 = $69 X 24% = $16.56 **Part 1 + Part 2** $198 + $16.56 = $214.56 **SNAP overpayment is $215.**				
Total				

New Claim Calculation Work Sheet

Case Name:		Center No.:	
Case Number:	Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is <u>only</u> for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then <u>do not use</u> it in this calculation.

UNEARNED INCOME/ CONCEALED EARNED INCOME	Month/Year	Income Amount	x 30%	SNAP Overpayment Amount
	Example	$600	30%	$180
Formula Number 4 If a case has an A/D indicator and no excess shelter amount, multiply income by 30%. The product is the SNAP overpayment. **Example:** Unbudgeted SSA income of $600 and excess shelter amount is zero. Calculate formula as follows: **$600 X 30% = $180**. $180 represents the SNAP overpayment for the month in question.				
Total				
EARNED INCOME (NOT CONCEALED)	Month/Year	Income Amount	x 24%	SNAP Overpayment Amount
	Example	$600	24%	$144
Formula Number 4 In the case has an A/D indicator an **no** excess shelter amount, multiply by 24%. The product is the SNAP overpayment. **Example:** Unbudgeted earned income of $600 and excess shelter amount is zero. Calculate formula as follows: **$600 X 24% = $144**. $144 represents the SNAP overpayment for the month in question.				
Total				

SAMPLE

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

New Claim Calculation Work Sheet

Case Name:		Center No.:	
Case Number:	Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is only for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then do not use it in this calculation.

UNEARNED INCOME/ CONCEALED EARNED INCOME	Month/Year	Income Amount	x 30%	SNAP Overpayment Amount
Formula Number 1 Multiply the unbudgeted unearned income by 30%. The product is the Supplemental Nutrition Assistance Program (SNAP) overpayment. **Example:** If the household without the A/D members received less than the maximum benefits, failed to report UIB income in the amount of $600 for the month and received $220 ATPs, then you would calculate the formula as follows: **$600 x 30% = $180**. $180 represents the SNAP overpayment for the month in question.	Example	$600	30%	$180
Total				

EARNED INCOME (NOT CONCEALED)	Month/Year	Income Amount	x 24%	SNAP Overpayment Amount
Formula Number 1 Multiply the unbudgeted earned income by 24%. The product is the Supplemental Nutritional Assistance Program (SNAP) overpayment. **Example:** If the household without A/D members received less than the maximum benefits, unbudgeted earned income in the amount of $600 for the month and received $220 ATPs, then you would calculate the formula as follows: **$600 x 24% = $144**. $144 represents the SNAP overpayment for the month in question.	Example	$600	24%	$144
Total				

SAMPLE

New Claim Calculation Work Sheet

Case Name:		Center No.:	
Case Number:	Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is only for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then do not use it in this calculation.

UNEARNED INCOME/ CONCEALED EARNED INCOME	Month/Year	Income Amount	Part 1+Part 2 (if needed)	SNAP Overpayment Amount
	Example	$619	$247.50 + $20.70	$250
Formula Number 3 This formula is to be used only in instances where there is an A/D indicator and an excess shelter amount. To determine the excess shelter amount, you must refer to the Budget Summary for the covering period (see **Monthly SNAP Calculation**). Use the amount that says **"Less: Excess"**. Multiply the excess shelter amount by 2 = product A. If income is less than or equal to product A ,do formula 3A. If income is greater than product A, do formula 3B **Formula 3A** Multiply product A by 45% = **SNAP overpayment** **Formula 3B** Income minus product A = Difference Multiply product A by 45% = Part 1 Multiply difference by 30% = Part 2 Part 1 + Part 2 = **SNAP overpayment** **Example:** Monthly income $619; Excess shelter $275; ATP $250 **Part 1** $275 X 2 = $550 X 45% = $247.50 **SNAP overpayment is $248.** **Part 2** $619 - $550 = $69 X 30% = $20.70 **Part 1 + Part 2** $247.50 + $20.70 = $268.20 **SNAP overpayment is $250.**				
Total				

New Claim Calculation Work Sheet

Case Name:		Center No.:	
Case Number:	Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is only for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then do not use it in this calculation.

EARNED INCOME (NOT CONCEALED)	Month/Year	Income Amount	Part 1+Part 2 (if needed)	SNAP Overpayment Amount
	Example	$619	$198 + $16.56	$215
Formula Number 3 This formula is to be used only in instances where there is an A/D indicator and an excess shelter. To determine the excess shelter amount, you must refer to the Budget Summary for the covering period (see **Monthly SNAP Calculation**) use the amount that says **"Less: Excess"**. Multiply the excess shelter amount by 2 = product A If income is less than or equal to product A ,do formula 3A. If income is greater than product A, do formula 3B. **Formula 3A** Multiply product A by 36% = **SNAP overpayment** **Formula 3B** Income minus product A = Difference Multiply product A by 36% = Part 1 Multiply difference by 24% = Part 2 Part 1 + Part 2 = **SNAP overpayment** **Example:** Monthly income $619; Excess shelter $275; ATP $250 **Part 1** $275 X 2 = $550 X 36% = $198 **SNAP overpayment is $198.** **Part 2** $619 - $550 = $69 X 24% = $16.56 **Part 1 + Part 2** $198 + $16.56 = $214.56 **SNAP overpayment is $215.**				
Total				

New Claim Calculation Work Sheet

Case Name:		Center No.:	
Case Number:	Caseload:	Date:	Claim Date:

Before using this form you must be able to answer "Yes" to all three of the following questions:

1. Is the category of the claim Inadvertent Household Error (IHE) or Agency Error (AE)? ☐ Yes ☐ No

2. Was earned/unearned income the **sole reason** for the overpayment? ☐ Yes ☐ No

3. Was the household receiving **less than** the maximum benefit level during the period of the overpayment? ☐ Yes ☐ No

If you answered "No" to any of the above questions, you cannot use this form. The claim must be developed using the conventional calculation method.

NOTE: This form is only for claim establishment when the reason for over issuance is income (whether the income is not reported or not included in the benefit calculation). It will replace the **W-122D** and **W-122DD** series in many instances and will therefore reduce the time in claim processing. The formulas apply to new income only. If the income is known to the WMS system, then do not use it in this calculation.

UNEARNED INCOME/ CONCEALED EARNED INCOME	Month/Year	Income Amount	x 30%	SNAP Overpayment Amount
	Example	$600	30%	$180
Formula Number 4 If a case has an A/D indicator and no excess shelter amount, multiply income by 30%. The product is the SNAP overpayment.				
Example: Unbudgeted SSA income of $600 and excess shelter amount is zero. Calculate formula as follows: **$600 X 30% = $180**.				
$180 represents the SNAP overpayment for the month in question.				
Total				
EARNED INCOME (NOT CONCEALED)	Month/Year	Income Amount	x 24%	SNAP Overpayment Amount
	Example	$600	24%	$144
Formula Number 4 In the case has an A/D indicator an **no** excess shelter amount, multiply by 24%. The product is the SNAP overpayment.				
Example: Unbudgeted earned income of $600 and excess shelter amount is zero. Calculate formula as follows: **$600 X 24% = $144**.				
$144 represents the SNAP overpayment for the month in question.				
Total				

SAMPLE

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

Date: _____

Center: _____

To: Claims Intake Unit
98 Flatbush Avenue, 2nd Floor
Brooklyn, New York 11217

Report of Claims Determination Transmittal

1. Complete this form in triplicate (original and two copies).

2. Send original and one copy with the completed SNAP claims attached to the above address.

3. Retain one copy in the "Completed Actions" file folder along with a Discrepant Eligibility Information Tracking Form (Form **W-140M**) for each case listed.

4. Upon receiving your claims, the Office of SNAP Fiscal Operations will sign the bottom of this form and return a signed copy of the form as verification that they have received the claims. When you receive the receipt copy of this form, remove the unsigned copy of the form from your "Completed Actions" file folder and replace it with the signed copy. If you have not received a signed copy within seven (7) days from the date of sending the claims, please call the Office of SNAP Fiscal Operations at (718) 237-8231 to determine whether or not your claims were received.

Case Name	Case Number	Claim Amount	Claim Type (IHE, IPV, AE)

Please acknowledge receipt by signing on line indicated below.

_____   _____
Signature   Date

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

Potential Supplemental Nutrition Assistance Program (SNAP) Overpayments/Claims Tracking Report

Location No.: _____   Period Ending:_____

Check one ☑:

☐ Job Center   ☐ HASA
☐ NCA SNAP   ☐ IREA/BFI

	Number of Claims Deferred				Number of Verification Requests		Number of No Claims					Number of Claims Developed and Forwarded to SNAP Fiscal Operations	Totals
See reverse for description of codes.													

Make entries on line 4 only; do not write in shaded areas.

See reverse for description of codes.	D1	E1	R1	U1	K1	M1	I1	S1	T1	W1	Y1	V1	
Line 1 - Balance from prior report													
Line 2 - Number of new potential SNAP overpayments added this reporting period													
Line 3 - Subtotals (Add Lines 1 and 2)													
Line 4 - Number and breakdown of potential SNAP overpayments evaluated this reporting period													
Line 5 - Balance (Subtract Line 4 from Line 3)													

Line 6 to Line 7e - Number of potential SNAP overpayments on line 5 that is:

	D1	E1	R1	U1	K1	M1	I1	S1	T1	W1	Y1	V1	
Line 6 - **Not overdue**, no more than 120 days past the date of discovery													
Line 7 - **Overdue**, more than 120 days past the date of discovery													
Line 7a- **Overdue**, 121 – 150 days past the date of discovery													
Line 7b- **Overdue**, 151 – 180 days past the date of discovery													
Line 7c- **Overdue**, 181 – 210 days past the date of discovery													
Line 7d- **Overdue**, 211 – 240 days past the date of discovery													
Line 7e- **Overdue**, more than 240 days past the date of discovery													

SAMPLE

Potential Supplemental Nutrition Assistance Program (SNAP) Overpayments/Claims Tracking Report

(Codes Description)

Deferral Codes

D1 = Closed code E95 - only person on CA case
      now deceased

E1 = Closed code E72 - only person on CA case
      now admitted to private institution

R1 = Transferred to another location

U1 = Insufficient documentation to calculate
      SNAP claim

Reason Codes for No Claim

I1 = SNAP claim on system for period of
        overpayment

S1 = No overpayment due to reporting, agency
        action and notification time frames

T1 = No SNAP benefits issued during period of CA
        overpayment

Y1 = No claim - only adult in the household was an
        ineligible alien or ineligible student during the
        period of overpayment

W1 = No claims required based on special waiver

Verification Request Codes

K1 = Wage verification requested

M1 = Other type of verification request

Code for Claim Developed

V1 = Claim developed and forwarded to SNAP Fiscal Operations

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

Memorandum

Date: _____

To: Centralized Claims Calculation Unit
98 Flatbush Ave, bsmt.
Brooklyn, NY 11201

From: _____   _____
Location Name   Location Number

Subject: **Report of Potential SNAP Claims Transmittal**
(To be used only for cases with changes other than income)

1. Complete this form in triplicate (original and two copies).

2. Include in this packet, the original and one copy of this form, as well as the New Claims Prescreening Form **(W-140M)** and all relevant documentation.

3. Retain one copy in the "Potential SNAP Overpayments" file folder, along with a **W-140M** for each case listed**.**

4. Upon receiving your packets, the Centralized Claims Calculation Unit will sign the bottom of the **W-140HH** and return a signed copy to verify that they have received them. When you receive the returned copy of this form, remove the unsigned copy of the form from your "Potential SNAP Overpayments" file folder and destroy it. Place the signed copy in the "Completed Actions" file folder. If you have not received a signed copy within seven days from the date of sending the claims, please call the Centralized Claims Calculation Unit at (718) 666-4327 to determine if your packets were received.

Case Name	Case Number

Please acknowledge receipt by signing on line indicated below

Signature: _____   Date: _____

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

Discrepant Information Tracking Form
(To be Prepared in Triplicate)

SECTION I - TRACKING INFORMATION

Center #/Location _____ Case Name _____

Unit/Group Worker _____ Case Number and Suffix_____

Source of Discrepant Information (☑ check one):

☐ Other automated List **(enter type and run date)** _____

☐ IEVS Computer Match Hit (☐ WRS ☐ UIB ☐ Bendex – ☑ check one and enter run date) _____

☐ Other Computer Match Hits - Non-IEVS (Enter type and run date) _____

☐ Periodic Report/Eligibility Mailout (Circle one)

☐ Change reported by participant at recertification or other participant contact

☐ Miscellaneous Referral (indicate type) _____

☐ Mail Correspondence ☐ FIA-3A

☐ QC referral or other In-House Audit (Circle one)

☐ BFI and/or Fiscal and Program Integrity Referral (Circle one)

Date Discrepant Information forwarded to Unit/Group Supervisor _____
(N/A for changes reported by participant at recertification or other participant contact)

Resolution Due Date_____ **(see page 2 for instructions)**

SECTION II - DISCREPANT INFORMATION RESOLUTION ACTIVITY
(This section is to be completed by the Worker assigned to resolve the discrepant information received.)

Date of Discovery _____ **Date Resolved** _____

1. **NO CASE ACTION REQUIRED**

    1a) ☐ Case previously closed _____ Code_____

    1b) ☐ Case transferred to _____ Effective _____

    1c) ☐ Action previously taken - current budget correct

    1d) ☐ Other (specify) _____

2. **BUDGET REDUCTION** for ☐ HASA Cash Assistance cases ☐ SNAP benefits (☑ check one or both as applicable)

    2a) ☐ <u>Semi-monthly</u> CA grant amount **PRIOR** to budget reduction _____

    2b) ☐ <u>Semi-monthly</u> CA grant amount **AFTER** budget reduction_____ Effective date of change _____

    2c) ☐ <u>Semi-monthly</u> amount of **CA** reduction _____

    2d) ☐ Monthly SNAP allotment **PRIOR** to budget reduction _____

    2e) ☐ Monthly SNAP allotment **AFTER** budget reduction _____ Effective date of change _____

    2f) ☐ Monthly **amount** of the **SNAP** reduction _____

3. **CASE CLOSING** for ☐ HASA Cash Assistance cases ☐ SNAP benefits (☑ check one or both as applicable)

    3a) ☐ <u>Semi-monthly</u> CA grant amount **PRIOR** to case closing _____

    3b) ☐ Closing code _____ Effective_____

    3c) ☐ Monthly SNAP allotment **PRIOR** to case closing _____

    3d) ☐ Closing code _____ Effective _____

4. **CASH ASSISTANCE RECOUPMENT** (For HASA only)

    Did the discrepant information result in a Cash Assistance recoupment? ☐ YES ☐ NO

    4a) If YES, enter the CA recoupment amount _____

    4b) If YES, enter the period of the Cash Assistance overpayment: From _____ To_____

    4c) If YES, enter the CA offense code _____

SECTION III - SNAP CLAIM ACTIVITY (This section must be completed in all instances.)

☑ check only one from 5 or 6 in this section. Use lines 5a - 5b if the discrepant information results in potential SNAP claim.
Line 6a - 6d are to be used if no SNAP claim is required.

5. SNAP CLAIM REQUIRED

5a) ☐ Potential SNAP claim - development pending

5b) ☐ Potential SNAP claim - claim developed and forwarded for supervisory review and signoff

6. NO SNAP CLAIM REQUIRED

6a) ☐ No SNAP claim required - information reported and acted upon timely

6b) ☐ No SNAP claim required - no current reduction or closing, no prior SNAP overpayment occurred

6c) ☐ No SNAP claim required - CA Recoupment for Offense Codes C-17 or E-17 only, no other case action required

6d) ☐ No SNAP claim required - other (specify) _____

SECTION IV - SIGNATURES

_____   _____
Worker Signature   Date   Unit Supervisor Signature   Date

SEE PAGE 3 FOR INSTRUCTIONS ON COMPLETING THIS FORM

SAMPLE

Instructions for Completion of Discrepant Information Tracking Form (W-140M)

The Center/Location Director's designee prepares a **W-140M** in triplicate for incoming **Mail Correspondence, FIA-3A's, QC referrals, Other In-House Audits and Periodic Reports/Eligibility Mailouts.** The designee attaches the information and forwards two copies of the **W-140M** and the discrepant information to the appropriate Unit/Group Supervisor for distribution.

The Worker completes the **W-140M** when received from the Director's designee, or prepares this form in triplicate when taking an adverse action as a result of the discrepant information and when the information also indicates a possible SNAP overpayment.

SECTION I - TRACKING INFORMATION
For each case, enter the following information:

- **Center #/Location**
- **Case Name**
- **Unit/Group Worker**
- **Case Number and Suffix**

Source of Discrepant Information - ☑ Check appropriate box for source of information. In addition, for IEVS matches (WRS, UIB, Bendex), Non-IEVS matches (e.g., Home attendant), and Automated Lists (e.g., ACME, Discharged Students), specify type and indicate run date. For Periodic Reports/Eligibility Mailouts, QC Referrals or Other In-House Audits, and BFI and/or Fiscal and Program Integrity referrals, check appropriate source. For miscellaneous referrals, indicate type.

Date Discrepant Information Forwarded to Unit/Group Supervisor - The Director's designee enters the date the information was received. No date is required for changes reported by participant at recertification or other participant contact.

Resolution Due Date - The Director's designee enters a due date for **Mail Correspondence, FIA-3A's, QC Referrals** and **Other In-House Audits**, and **Periodic Reports/Eligibility Mailouts**. The Worker enters the due date as annotated on the computer matches, other automated lists or the follow-up action required request from the Division of Financial Review and Processing (DFRP).

SECTION II - DISCREPANT INFORMATION RESOLUTION ACTIVITY

The Worker completes this section after taking action to resolve the discrepant information.

Date of Discovery - Date the Supervisor or Worker receives discrepant information that may affect the household's SNAP case, not the date the information is verified. The date of discovery is used to track the time it takes to assess the discrepant information, make changes to the case and, if appropriate, establish a SNAP overpayment claim and determine the period of overpayment. A date of discovery must be determined and recorded in the case record/folder for every instance of discrepant information received, regardless if the result is a case change and/or a SNAP overpayment claim.

Date Resolved - Enter the date you completed the case action(s) resulting from the discrepant information.

1. **No Case Action Required -** If the discrepant information does not result in a case closing, reduction, or a CA recoupment, check the reason for no action required. If the case is already closed, indicate date and closing code in Item 1a. If the case has been transferred, indicate the new location and effective transfer date in Item 1b. If action was already taken, check item 1c.

2. **Budget Reduction -** Semi-monthly amount of Cash Assistance grant and/or SNAP benefits prior to reduction, new monthly amount and effective date of reduction and monthly amount of the reduction. Items 2a through 2c apply to cases with Cash assistance overpayments; items 2d through 2f apply to cases with SNAP overpayments.

3. **Case Closing -** If you are taking action to close the Cash Assistance and/or SNAP case, check appropriate box(es) and enter information as applicable; semi-monthly amount of Cash Assistance grant and/or SNAP benefits prior to the case closing, the closing code and effective date of closing. Items 3a and 3b apply to Cash Assistance cases; items 3c and 3d apply to SNAP cases.

4. **Cash Assistance Recoupment -** Check YES or NO. If, as a result of the discrepant information, the household received more Cash Assistance than entitled, enter information in items 4a (recoupment amount), 4b (period of overpayment) and 4c (CA offense code).

SECTION III - SNAP CLAIM ACTIVITY- Check only one box from 5 or 6 in this section.
The Worker must complete this section **in all instances**.

5. SNAP Claim Required - If the discrepant information results in a potential SNAP claim, check the box next to the sentence that matches the follow-up action you are taking when completing this form.

6. No SNAP Claim Required - If no SNAP claim is required, check the box next to the sentence which indicates the reason no claim is required. If "other reason" is selected, specify the reason in the space on line 6d.

SECTION IV - SIGNATURES

The Worker and Unit/Group Supervisor signs and dates this form. **In the Centers, the Supervisor must attach the original form to the case record for forwarding to Control along with all budget reductions, case closings, and/or CA recoupment actions.**

SAMPLE

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

Potential Supplemental Nutrition Assistance Program (SNAP) Claims Control Log

Resolution Code	Date Resolved	Evaluation Due Date	Case Name	Case Number/Suffix	Worker Assigned (Group/Worker #)	Date Evaluation Completed	Prescreening Code (from New Claims Prescreening Form)

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

POTENTIAL SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) CLAIMS ACTIVITY & MONITORING REPORT

Location_____   Week Ending _____

SNAP   DASIS   Job Center   ICP   Computer Match Unit   BFI   (Circle One)

Line 1	**Balance from the Previous Week**	
Line 2	**# of resolutions added this week**	
Line 3	**Subtotal**	
Line 4	**# Evaluated and/or Claim Developed**	
Line 5	**Balance at the end of the week**	
Line 6	**# Awaiting SNAP Claim Resolution- Due date not reached**	
Line 7	**Total # Awaiting SNAP Claim Evaluation – Overdue:**	
Line 8A	**1-7 Days**	
Line 8B	**8-14 Days**	
Line 8C	**15-21 Days**	
Line 8D	**22-30 Days**	
Line 8E	**Over 30 Days**	

SAMPLE

Prepared by (Print)_____   Date_____

Signature_____

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

Discrepant Information Control Log

Source of Information	Date Received	Resolution Due Date	Case Name	Case Number/Suffix	Worker Assigned (Group/Wrkr #)	Date Resolved	Potential SNAP Claim? Yes or No* (see note below)	MONTHLY REBUDGET (SAVINGS)		MONTHLY CLOSING (SAVINGS)		CA Recoup Amount	SNAP Claim Amount
								CA (semi-monthly x 2)	SNAP	CA (semi-monthly x 2)	SNAP		
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$
								$	$	$	$	$	$

*Note: Enter "Y" if Items 5a or 5b, in Section III of the Discrepant Information Tracking Form (W-140M) is checked. Enter "N" if Items 6a, 6b, 6c, or 6d in Section III of form W-140M is checked.

Form W-140Y
Rev. 12/4/13

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

Discrepant Information Control Report

Location Name: _____   **Location Number:** _____

(Check One): ☐ **HASA**   ☐ **NCA SNAP** Center   **For the Week Ending:**

Prepared By (Print Name): _____   **Signature:** _____   **Date:** _____

		IEVS Computer Match (WRS, UIB, Bendex)	Non-IEVS Computer Match (Home Attendant, Marriage, Foster Care, NYCHA)	Other Automated Lists (ACME, Discharged Students, etc.)	Mail Correspondence	Change Reported by the Participant at Recertification or Other Contact	FIA -3As	Quality Control Referral or Other In-House Audits	Periodic Report/ Eligibility Mailout Responses	Bureau of Fraud Investigation (BFI) or Fiscal and Program Integrity Referrals	Miscellaneous Referrals	TOTALS
Line 1	**Prior Balance** (Enter the balances from line 5 of last week's **W-140Y**.)											
Line 2	**Number of New Items Received This Week** (Enter the # of new items from each source that were received this week.)											
Line 3	**Total Requiring Resolution** (Add lines 1 and 2 and enter the totals on this line.)											
Line 4	**Number of Eligibility Discrepancies Resolved** (Enter the number of discrepancies that were resolved this week based on the # of completed **W-140Ms** returned to the designee.)											
Line 5	**Balance** (Number of Resolutions Outstanding - subtract line 4 from line 3)											
Line 5A	**Of the Balance on line 5, enter the number of Outstanding Eligibility Discrepancies That Have Not Reached Their Due Date (**Obtain by reviewing **W-140Y**).											
Line 5B	**Number of Discrepancies Awaiting Resolution which are Overdue** (Obtain by reviewing **W-140Y**. However, line 5A plus line 5B must equal the total entered on line 5.)											
Line 6A*	**1-7 Days** (Of the balance entered on line 5B, enter the number of unresolved eligibility discrepancies which are 1-7 days overdue.)											
Line 6B*	**8-14 Days** (Of the balance entered on line 5B, enter the number of unresolved eligibility discrepancies which are 8-14 days overdue.)											
Line 6C*	**15-21 Days** (Of the balance entered on line 5B, enter the number of unresolved eligibility discrepancies which are 15-21 days overdue.)											
Line 6D*	**22-30 Days** (Of the balance entered on line 5B, enter the number of unresolved eligibility discrepancies which are 22-30 days overdue.)											
Line 6E*	**Over 30 Days** (Of the balance entered on line 5B, enter the number of unresolved eligibility discrepancies which are more than 30 days overdue.)											

***NOTE: Lines 6A - 6E must add up to the total entered on Line 5B**

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

Date: _____

Case Number: _____

Case Name: _____

Job Center: _____

Benefit Letter

The above-named client is eligible to receive a monthly rent allowance above the regular maximum allowance available to Cash Assistance clients. We can provide this rent grant after receiving a lease or letter that verifies that the client lives at the address and pays rent in the amount stated.

_____   _____
Worker   Date

Form W-450D
Rev. 12/16/13

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

☐ CA Status   ☐ Contact
 1. CA   1. Office
 2. Non-CA   2. Field
 3. Applicant   3. Phone

Date Opened: _____

Week Ending Date: _____

Case Number: _____

Case Name: _____

Center: _____

SSN: _____

Single/Childless Couple: _____

DIVERSION WEEKLY REPORTING FORM

REFERRAL TYPES

New Case?   Type   6. Housing Court Referrals   13. Case Management Unit   99. Other, specify
Yes ☐   10. Section 8 Default Referrals   15. ACS Subsidy Referrals
          ☐   11. NYCHA At-Risk Referrals   16. Section 8 Certificate FUP   _____
No ☐   12. Financial Planning Unit   17. RAA - Job Center   _____

HOUSING RELATED SERVICES: Code the frequency of the services given this week in the appropriate space

☐ Dispossess Intervention   ☐ 6-day/72 hrs   ☐ Landlord Contact   ☐ Section 8 Recertification   ☐ FEPS Referral

☐ Post Eviction   ☐ Seek Apartment/ Real Estate   ☐ Third Party Information   ☐ Housing Located   ☐ Other (specify)

☐ Legal Services Referral   ☐ Housing Court Intervention   ☐ Double Up Information   ☐ FEPS Information   _____

SUPPORT SERVICES: Code "I" in the appropriate space for services given this week

☐ One-Shot Deal Approved (Assessment Only)   ☐ Accepted for CA (Assessment Only)   ☐ Budget Error Corrected (Case Management)   ☐ Carfare Issued   ☐ Other (specify)

☐ Arrears Paid by JC (Case Management)   ☐ New Apartment Expenses   ☐ Restaurant Allowance Approved   ☐ Double Up Shelter Allowance   _____

SUPPORTIVE SERVICES: Code the frequency of the services given this week in the appropriate space

☐ Health Related   ☐ Short Term Counseling   ☐ Education/ Training   ☐ Employment   ☐ Child Care   ☐ Other (specify)

_____

PLEASE COMPLETE THIS AREA FOR ALL RAA-CASES

Revised?

Yes ☐   Actual Monthly Rent _____   Arrears Period: From _____ To _____

No ☐   Total Arrears _____   Legal Fees _____   TOTAL OWED _____

RESULTS OF DISCUSSION WITH LANDLORD

Discussion Date _____   New Arrears _____   New Monthly Rent _____

Lease Duration (number of months) _____

RELOCATION EXPENSES

New Apartment _____   Security Deposit _____   Check Delivery Date _____

Moving Fees _____   Broker's Fees _____   TOTAL PAID _____

RAU (Y/N) ☐   Outcome Code ☐   If Outcome Code is 13 or 14.
                                            Please include *Arrears Paid* below

Approval Date _____   Outcome Date _____

Caseworker's Initials _____

Supervisor's Signature _____   Date _____

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

Job Center: _____

Office of Eligibility and Employment Monitoring

Address: _____

_____

Date: _____

Dear _____ :

On _____ , a scheduled visit was made to your home at _____ (A.M./P.M.) but you were not at home.
　　　(date)　　　　　　　　　　　　　　　　　　　　　　　(time)

Please call the telephone number listed below by _____ to schedule another appointment. Your cooperation is vital
　　　　　　　　　　　　　　　　　　　　　　　(date)

to ensuring that you are receiving the correct amount of Cash Assistance, SNAP and/or Medicaid benefits.

Sincerely,

_____
Caseworker/Auditor

_____
Telephone Number

- -

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

Centro de Trabajo: _____

Oficina de Control de Elegibilidad y Empleo   Dirección: _____

_____

Fecha:: _____

Estimado(a) _____ :

El _____ , se hizo una visita programada a su hogar a las _____ (A.M./P.M.) pero usted no se
(fecha)   (hora)
encontraba en la casa.

Favor de llamar antes del _____ al número de teléfono indicado a continuación para fijar otra cita.
(fecha)
Su cooperación es esencial para asegurar que usted esté recibiendo la cantidad correcta de beneficios de

Asistencia en Efectivo, SNAP y/o Medicaid.

Atentamente,

_____
Trabajador del Caso/Auditor

_____
Número de Teléfono

· ·

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

Date: _____

Job Center: _____

Address: _____

Case Name: _____

Case Number: _____

OEEM Caseworker/
Auditor: _____

Telephone Number: _____

Notice of Appointment for Home Visit

Your Cash Assistance/Supplemental Nutrition Assistance Program (SNAP) case has been selected for a review by the Office of Eligibility and Employment Monitoring (OEEM). The OEEM Caseworker/Auditor named above will visit you at your home

on _____ between the hours of _____ and _____ .

Please call the telephone number listed above as soon as you receive this letter, to confirm the appointment date. If the scheduled appointment date or time is inconvenient for you, please call us immediately to arrange another appointment.

Please have the following information and documents available at the time of the home visit:

- Birth Certificates, Baptismal Certificates or proof of citizenship for all household members, including SNAP recipients
- Social Security cards for all household members
- Proof of alien status (if applicable), e.g., Alien Registration Card
- Marriage Certificate
- Absent parent information/child support verification
- Rent recipients; NYCHA rent book; lease; name, address and telephone number of landlord
- Documentation of subsidized housing (if applicable)
- Statement from Primary Tenant of rent charged, and who resides in apartment
- Proof of ownership for one, two or three-family house
- Employment wage statements
- Social Security and Worker's Compensation award notices
- Statements of any other benefits/awards, (e.g., Veterans, Unemployment Insurance Benefits)
- Bank books; insurance policies
- Clinic cards for children not in school
- Current utility and telephone bills

Sincerely,

_____   _____
OEEM Caseworker/Auditor   Telephone Number

Fecha: _____

Centro de Trabajo: _____

Dirección: _____

Nombre del Caso: _____

Número del Caso: _____

Trabajador(a) del Caso/
Auditor(a) de OEEM: _____

Número de Teléfono: _____

Aviso de Cita para Visita al Hogar

Su caso de Asistencia en Efectivo/Programa de Asistencia de Nutrición Suplementaria (SNAP) ha sido seleccionado para una revisión por parte de la Oficina de Seguimiento de Elegibilidad y de Empleo (Office of Eligibility and Employment Monitoring – OEEM). El trabajador(a) Social/Auditor(a) de OEEM nombrado más arriba le visitará su hogar el _____ entre las horas de _____ y _____.

Favor de llamar al número de teléfono indicado más arriba tan pronto reciba esta carta para que se pueda confirmar la fecha de su cita. Si la fecha o la hora de la cita programada no le es conveniente, favor de llamarnos inmediatamente para concertar otra cita.

Favor de tener disponible la siguiente información y documentos a la hora de la visita al hogar:

- Actas de Nacimiento, Certificados de Bautismo, o prueba de ciudadanía de todos los miembros de su hogar, incluyendo los beneficiarios de SNAP.
- Tarjeta de Seguro Social para todos los miembros del hogar.
- Prueba de Condición de Extranjero, si corresponde, por ejemplo la Tarjeta de Registro de Extranjero.
- Acta de Matrimonio
- Información del/la padre/madre ausente/verificación de manutención de niños.
- Recibos de alquiler; libro del alquiler de NYCHA; contrato de arrendamiento; el nombre, la dirección y el número telefónico del casero.
- Documentación de vivienda subsidiada (si corresponde).
- Declaración del inquilino principal que especifique cuánto paga de alquiler, y quiénes residen en el apartamento.
- Prueba de titularidad para una casa de una, dos o tres familias.
- Estado mensual de salario.
- Notificación del otorgamiento de beneficios de Seguro Social e Indemnización del Trabajador.
- Estado de cualquier otro beneficio/concesión, (por ejemplo, Beneficios de Seguro de Desempleo, para Veteranos).
- Libretas bancarias; pólizas de seguros.
- Tarjetas clínicas de niños que no asisten a la escuela.
- Cuentas actuales de servicios públicos y de teléfono.

Atentamente,

_____   _____
Trabajador(a)/Auditor(a) de OEEM   Número Telefónico