Human Resources Administration
Department of Social Services

FAMILY INDEPENDENCE ADMINISTRATION

James K. Whelan, Executive Deputy Commissioner

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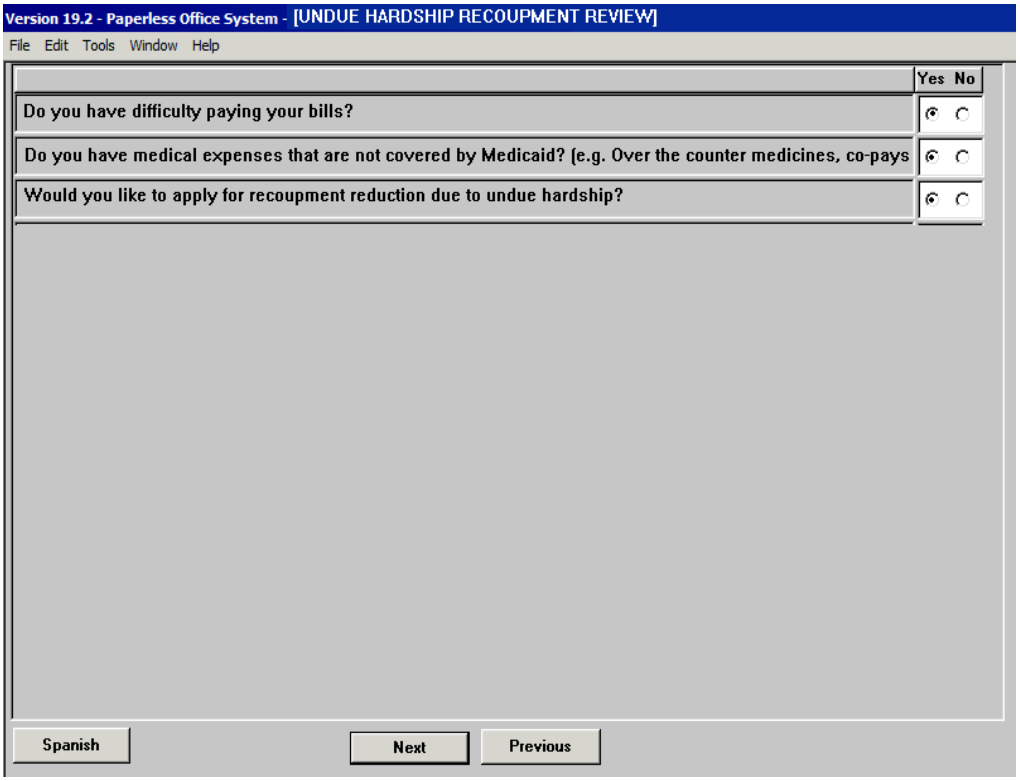
POLICY BULLETIN #15-98-OPE

DETERMINATION OF CASH ASSISTANCE RECOUPMENT RATE DUE TO UNDUE HARDSHIP

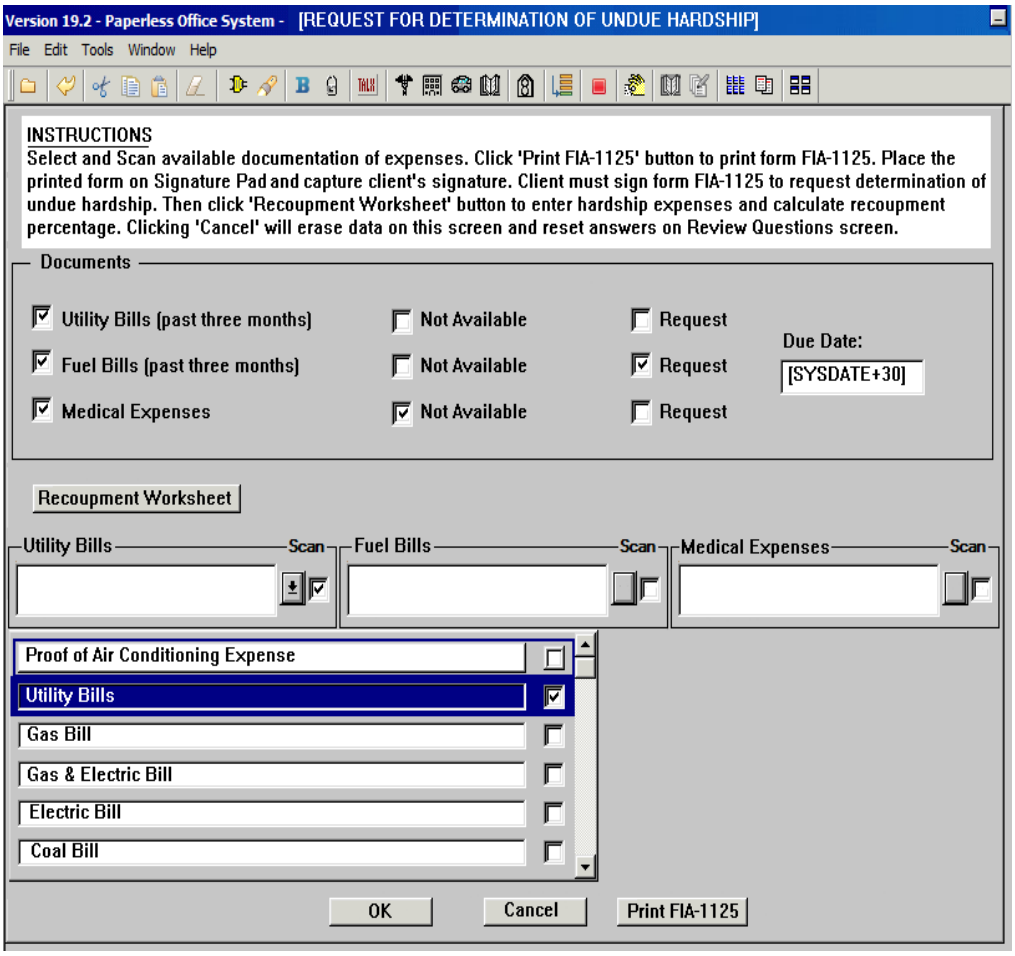
Date: October 19, 2015	**Subtopic(s):** Recoupment
This procedure can now be accessed on the FIAweb.	The purpose of this policy bulletin is to inform Job Center staff of the policies and procedures regarding the determination of undue hardship when a Cash Assistance (CA) grant is being recouped. New York State Social Service Law and regulations mandate that the recoupment of CA grants must not cause undue hardship for the household. A household incurs undue hardship when the income it receives is not enough to pay for the cost of food, shelter, utilities, clothing for the applicant's/participant's children, and/or medical expenses not covered by health insurance. The maximum rate of recoupment is 10% of a household's CA standard of needs. This rate is used to establish all recoupments. A household has the right to claim that a 10% rate of recoupment will cause their household undue hardship. If an undue hardship is determined, the rate of recoupment can be reduced to as low as 5%. At every application and recertification, households with a CA recoupment(s) rate higher than 5%, will be given the opportunity to request a review of the recoupment rate if they claim that the recoupment creates an undue hardship on the household. In addition, participants may request an undue hardship review at any time. Undue hardship determinations will not be done for applicants who are applying for a one shot deal. If the existing rate of recoupment is greater than 5%, the Paperless Office System (POS) will prompt the JOS/Worker to offer the applicant/participant an undue hardship review. This occurs after the **Referrals** screen of the interview is completed.

See PB #15-96-SYS
CA POS Release Notes, Version 19.3, Attachment A

When the JOS/Worker clicks the Next button in the Referrals screen, POS will open the **Undue Hardship Recoupment Review** screen. If the participant comes into a Job Center at any other time, apart from recertification, to request an undue hardship review, the JOS/Worker will access this review through the **Change Case Data** Activity.



If the applicant/participant answers "**Yes**" to the question "Would like to apply for recoupment reduction due to hardship?", POS will open into the **Request for Determination of Undue Hardship** screen. The JOS/Worker must then click on the "**Print FIA-1125**" to print out the Request for Determination of Undue Hardship (**FIA-1125**) and open the signature capture window. The applicant/participant will then sign the paper **FIA-1125** on the signature pad so that the signature is captured **both** on the paper **FIA-1125** and electronically.



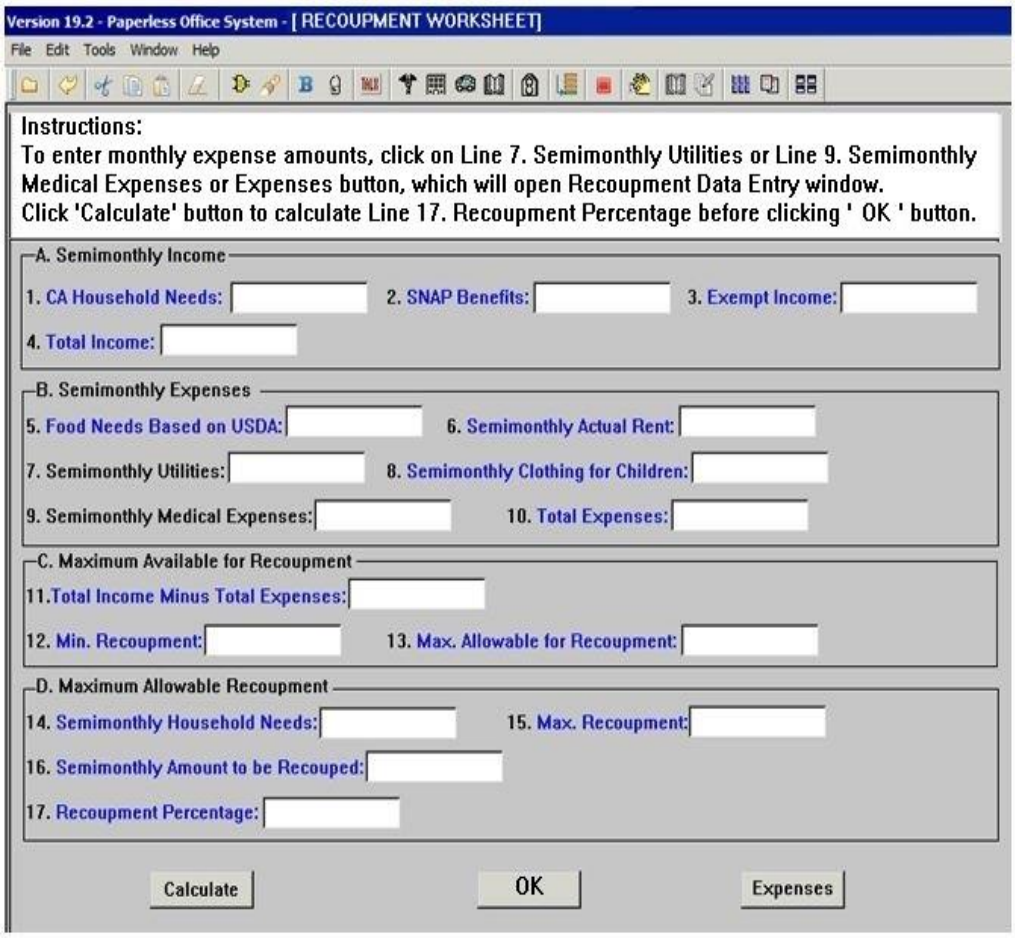
Once the applicant's/participant's signature is captured and committed to the form, the JOS/Worker will proceed with the undue hardship review. The applicant/participant will be asked if they have any utility/fuel payments, rent expenses, and medical expenses not covered by insurance.

If the applicant/participant incurs any of those expenses, the JOS/Worker must ask the individual to provide verification of the prior three months of utility and/or fuel expenses, and/or any medical expenses not covered by insurance.

If the applicant/participant does not have any/all of the prior three months of utility/fuel expenses and/or does not have proof of their uncovered medical expenses but says that he/she can provide them, the JOS/Worker would complete the Request for Documentation of Expenses (**FIA-1125e**) instructing the individual to provide the documentation by the due date on the **FIA-1125e**.The JOS/Worker selects the expense, checks the radio button next to "Request" to request the appropriate verification, and then checks the radio button for the specific utility bill or medical bill requested.

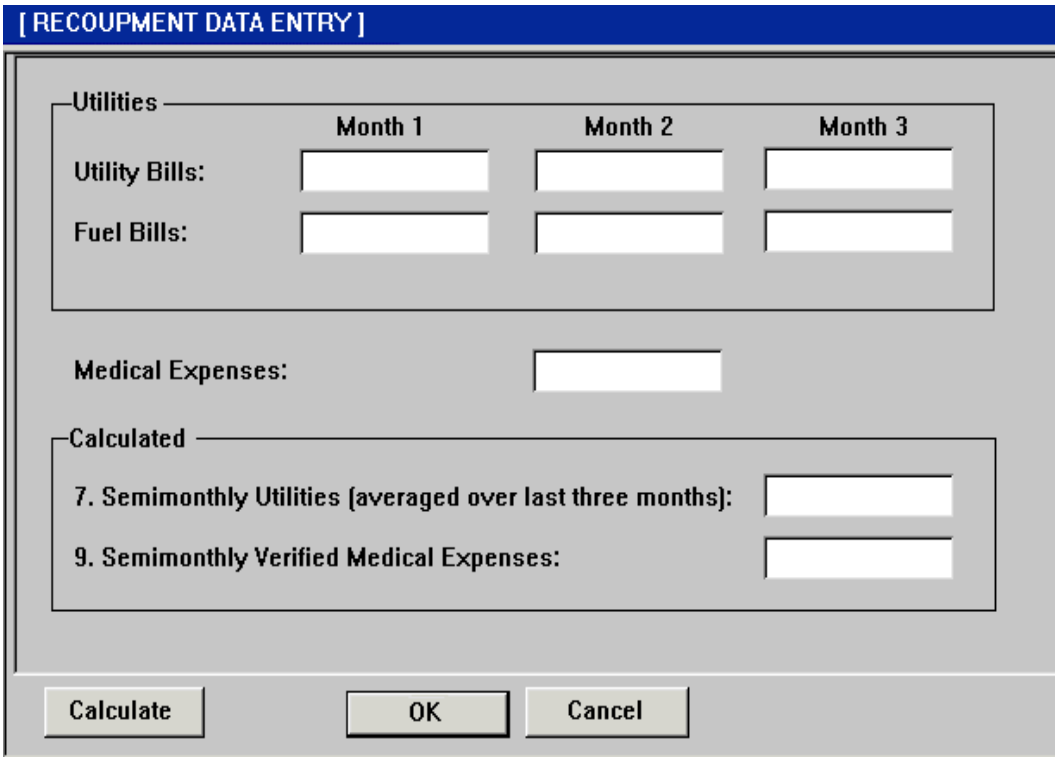
If the applicant/participant does not have the documentation and cannot produce any documents, the JOS/Worker must click the "**Not Available**" radio button.

Note: If the household's rent is sufficient to establish a reduction in the rate of recoupment to 5%, no additional verification of expense is required. To determine if the applicant's/participant's rent alone is sufficient to establish a reduction to 5%, staff must click "**Recoupment Worksheet**" then click "**Calculate**" without inputting any additional expenses. If the rent alone is not sufficient to establish a reduced recoupment rate to 5%, the JOS/Worker must then enter the expenses.



To enter the expense, the JOS/Worker clicks (in Section B) on the semi-monthly utilities and/or medical expense or the expenses button of the Recoupment Worksheet screen.

After the JOS/Worker clicks on the expenses, a **Recoupment Data Entry** screen will open up and the JOS/Worker will enter the monthly expenses for the three prior months and/or medical expenses not covered by medical insurance. (See screen below.)



Once complete, the JOS/Worker will select the calculate button and POS will calculate the semi-monthly expense. The JOS/Worker will review the expense information and if it is correct, he/she will click the "**OK**" button. This will transfer the data into line 7 and 9 on the Recoupment Worksheet. Once back in the Recoupment Worksheet, the JOS/Worker will click "**Calculate**" to determine if the household is eligible for a reduction in the rate of recoupment.

Eligible for Reduction

If the household is eligible for a reduction in the rate of recoupment, POS will systematically transmit the reduction to Welfare Management System (WMS). The Outcome of Review of Undue Hardship Claim (**FIA-1125a**) will be auto-filled and a copy will be mailed to the applicant/participant through the print to mail (PTM) process.

Ineligible for Reduction

If the household is ineligible for a reduction in the rate of recoupment or failed to provide enough documentation of expenses to qualify for a recoupment rate reduction, the applicant/participant will be mailed an **FIA-1125a** as well as the **W-145F**, through PTM, to show how the agency reached its decision.

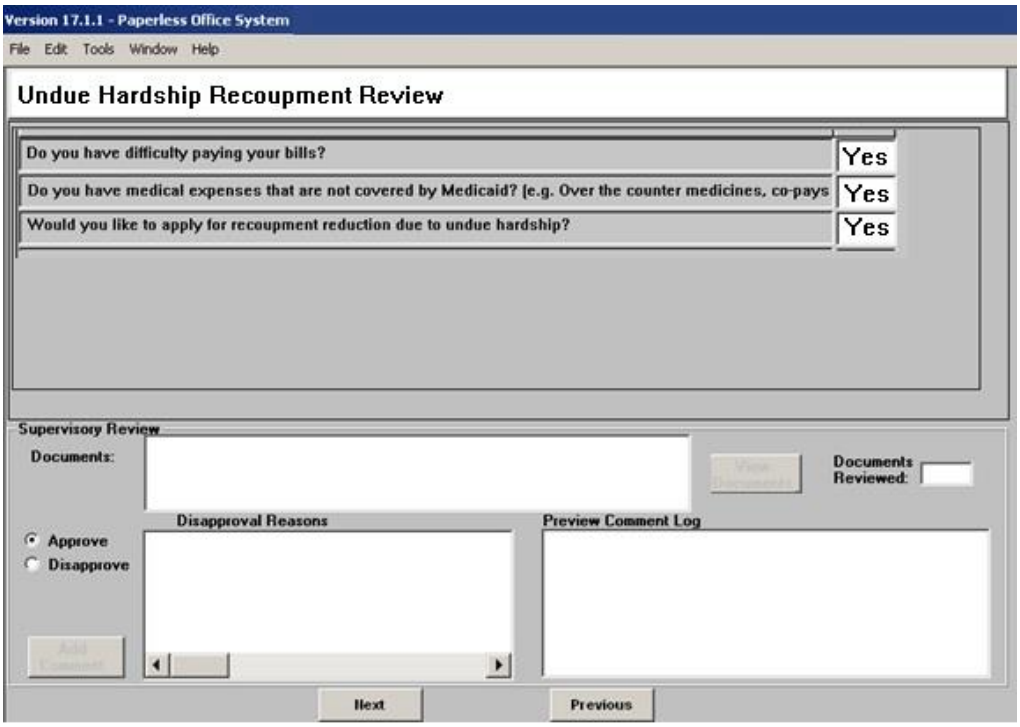
If the household is deemed eligible for a reduced recoupment rate evaluation but is determined ineligible for CA, the reduction determination will not be done. The **FIA-1125a** will be mailed to the applicant/participant explaining that a determination cannot be made because the household is ineligible for CA. If the household later becomes eligible for CA, the undue hardship recoupment reduction review will be done at that time.

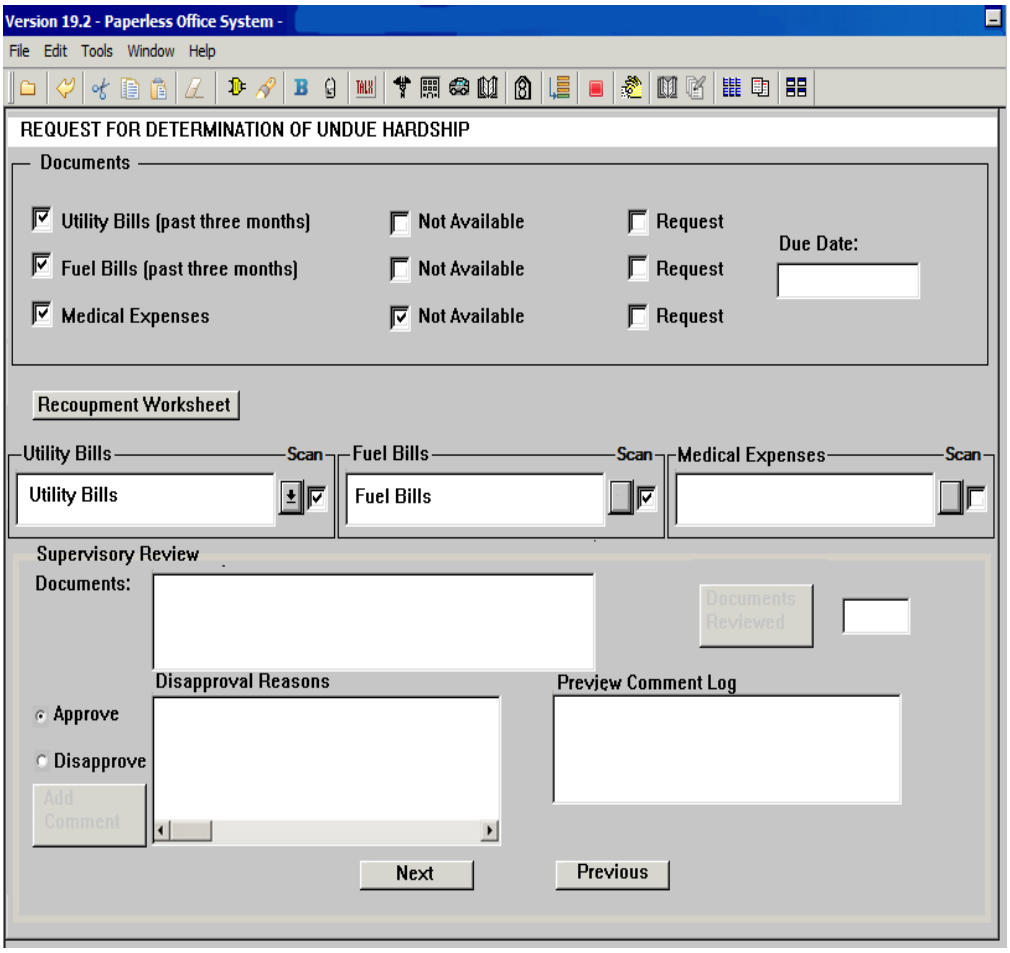
If the household is determined eligible for a recoupment rate reduction, the reduction will be applied to all outstanding recoupments, including recoupments related to intentional program violations (IPVs), on the case at that time.

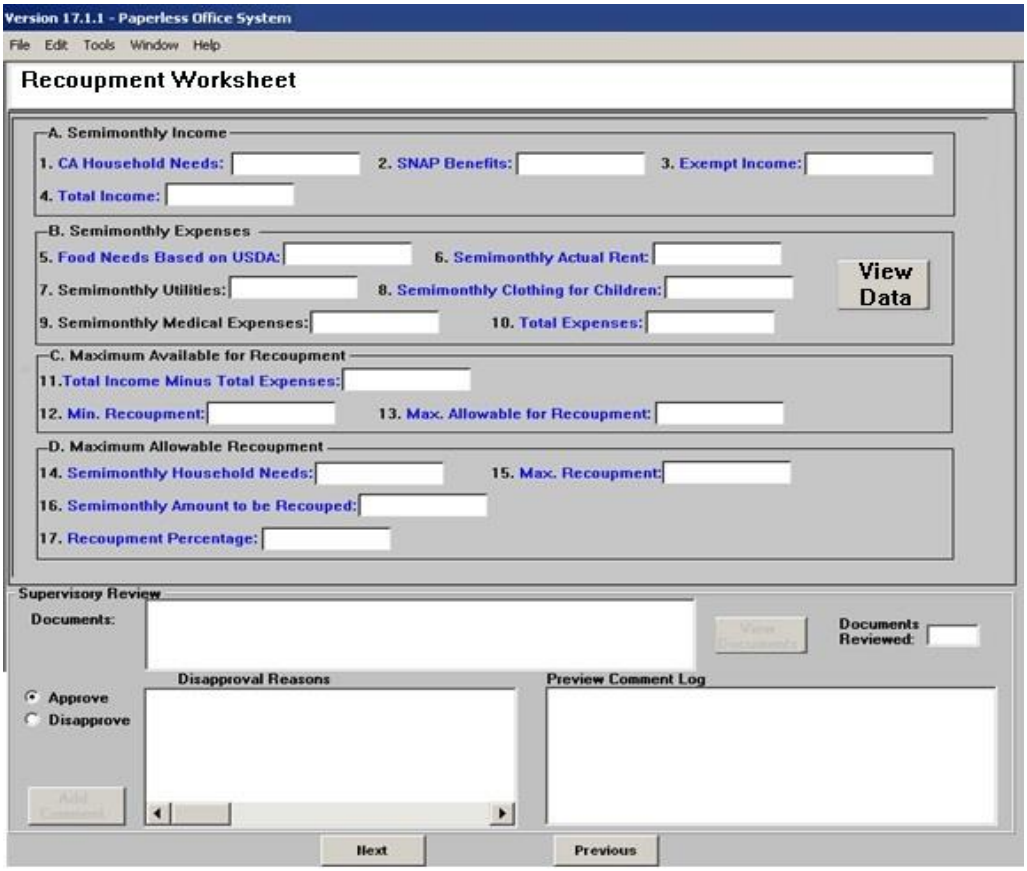
If the JOS/Worker previously requested documentation to support the undue hardship and the documents are still outstanding, POS will insert a Change Case Data activity in the JOS/Worker's queue. When the applicant/participant submits the documents and the JOS/Worker receives the supporting documentation, the JOS/Worker will complete the undue hardship review in the **Change Case Data** activity.

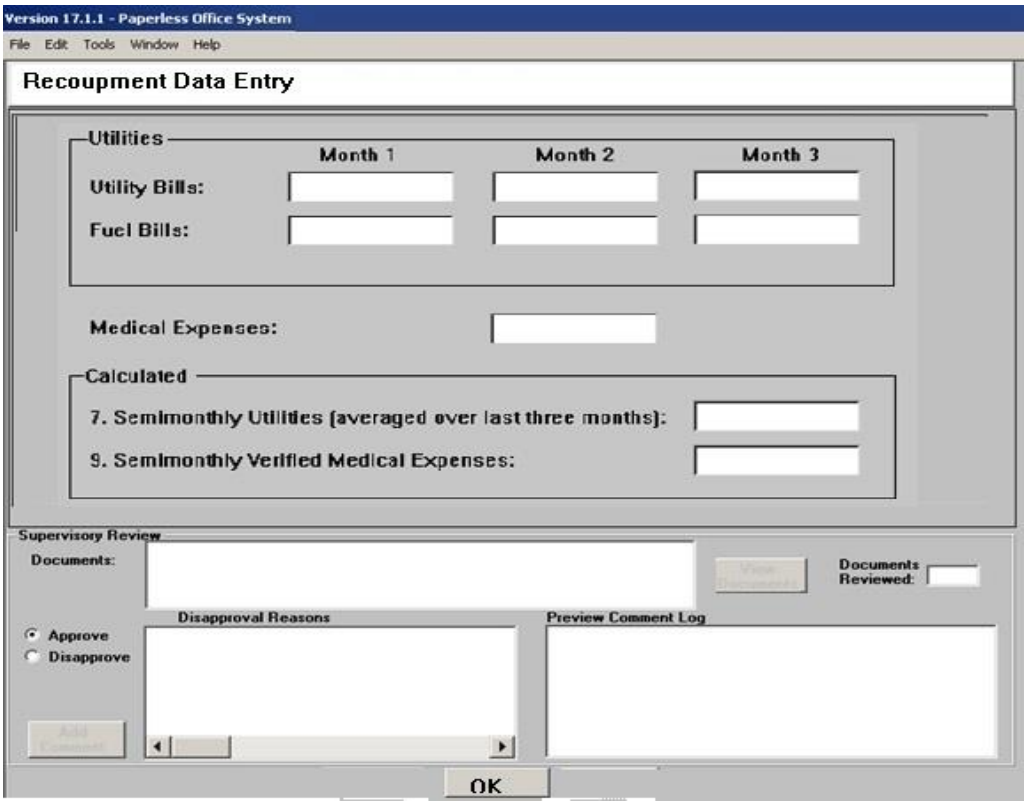
After the JOS/Worker has completed all current activity, the AJOSI/Supervisor will review all case data and approve or disapprove the activity as necessary. These supervisory screens are read only (see screen shots below).

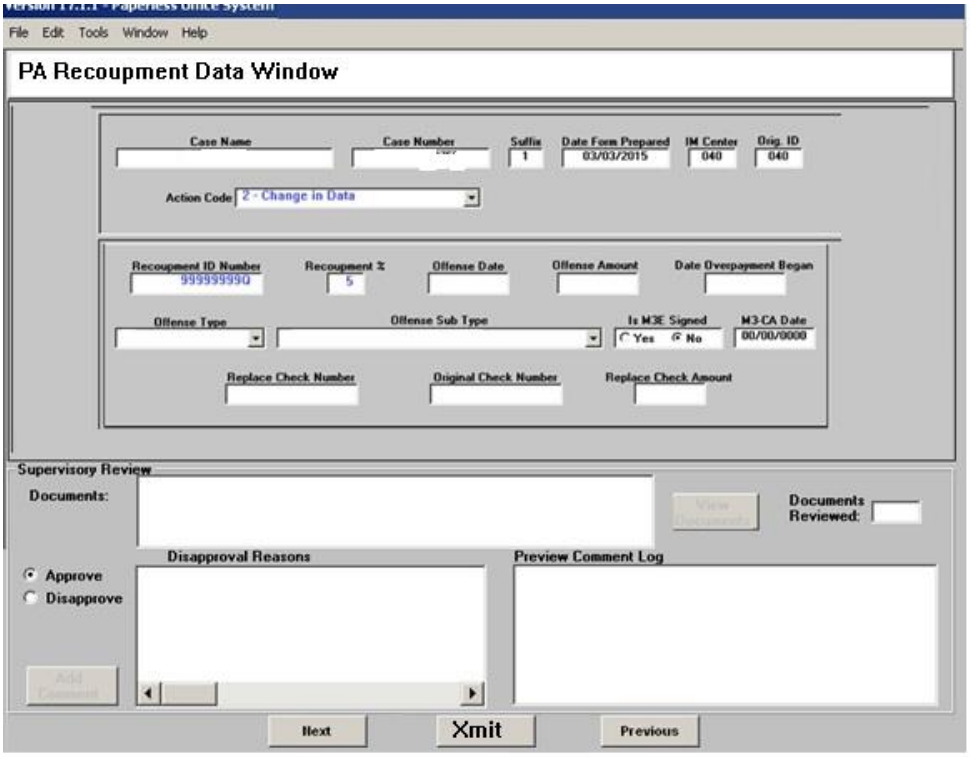
Note: In Selective Case Review Centers (SCR), the AJOSI/ Supervisor will only review the case if the applicant/participant is not granted an undue hardship recoupment rate reduction.


Version 17.1.1 - Paperless Office System
File Edit Tools Window Help
Undue Hardship Recoupment Review
Do you have difficulty paying your bills?
Yes
Do you have medical expenses that are not covered by Medicaid? (e.g. Over the counter medicines, co-pays
Yes
Would you like to apply for recoupment reduction due to undue hardship?
Yes
Supervisory Review
Documents:
Documents Reviewed:
Disapproval Reasons
Preview Comment Log
Approve
Disapprove
Add Comment
Next
Previous


Version 19.2 - Paperless Office System -
File Edit Tools Window Help
REQUEST FOR DETERMINATION OF UNDUE HARDSHIP
Documents
Utility Bills (past three months)
Not Available
Request
Due Date:
Fuel Bills (past three months)
Not Available
Request
Medical Expenses
Not Available
Request
Recoupment Worksheet
Utility Bills
Scan
Utility Bills
Fuel Bills
Scan
Fuel Bills
Medical Expenses
Scan
Supervisory Review
Documents:
Documents Reviewed
Disapproval Reasons
Preview Comment Log
Approve
Disapprove
Add Comment
Next
Previous


Version 17.1.1 - Paperless Office System
File Edit Tools Window Help
Recoupment Worksheet
A. Semimonthly Income
1. CA Household Needs:
2. SNAP Benefits:
3. Exempt Income:
4. Total Income:
B. Semimonthly Expenses
5. Food Needs Based on USDA:
6. Semimonthly Actual Rent:
7. Semimonthly Utilities:
8. Semimonthly Clothing for Children:
9. Semimonthly Medical Expenses:
10. Total Expenses:
View Data
C. Maximum Available for Recoupment
11. Total Income Minus Total Expenses:
12. Min. Recoupment:
13. Max. Allowable for Recoupment:
D. Maximum Allowable Recoupment
14. Semimonthly Household Needs:
15. Max. Recoupment:
16. Semimonthly Amount to be Recouped:
17. Recoupment Percentage:
Supervisory Review
Documents:
Documents Reviewed:
Disapproval Reasons
Preview Comment Log
Approve
Disapprove
Next
Previous


Version 17.1.1 - Paperless Office System
File Edit Tools Window Help
Recoupment Data Entry
Utilities
Month 1
Month 2
Month 3
Utility Bills:
Fuel Bills:
Medical Expenses:
Calculated
7. Semimonthly Utilities (averaged over last three months):
9. Semimonthly Verified Medical Expenses:
Supervisory Review
Documents:
Documents Reviewed:
Disapproval Reasons
Preview Comment Log
Approve
Disapprove
OK



If the case action is disapproved by the AJOSI/Supervisor, the case will be returned to the JOS/Worker for corrective action. If the case is approved, the AJOSI/Supervisor will complete all approvals and necessary transmissions. All additional activity and further transmissions will be transmitted after the Approval activity is complete.

Note: For any cases that will not be processed in POS (i.e. multi-suffix cases), the undue hardship recoupment review must be done manually. This review includes the case look-up to determine if the household has any recoupment(s) greater than 5%. If the household has a recoupment(s) greater than 5%, the JOS/Worker will manually complete the **FIA-1125**, **W-145F**, **FIA-1125(e)**, and the **FIA-1125(a)**. The JOS/Worker will print these forms from HRA eDocs. If the household qualifies for CA and a recoupment rate reduction, the JOS/Worker must manually complete the PA Recoupment Data Entry Form – WMS **(Form LDSS-3573-NYC)**. When the JOS/Worker has completed the case activity, the JOS/Worker will process the eligible case as per PB #15-67-SYS Revision to the Paperless Alternative Module.

See PB #15-67-SYS Revision to the Paperless Alternative Module

Effective Immediately.

References:

90 ADM-39 (IV)(C)
TASB, Chapter 22, Section G(2)(a)-(d), pages 22-9 to 22-11.
18 NYCRR 352.31(d)(2).
NYS Social Services Law 106-b.

Related Items:

PB #15-96-SYS	CA POS Release Notes 19.3, Attachment A
PB #15-67-SYS	Revision to the Paperless Alternative Module (PAM)

Attachments:

Please use Print on Demand to obtain copies of forms.

FIA-1125 (E)	Request for Determination of Undue Hardship
FIA-1125 (S)	Request for Determination of Undue Hardship (Spanish)
FIA-1125a (E)	Outcome of Review of Undue Hardship Claim
FIA-1125a (S)	Outcome of Review of Undue Hardship Claim (Spanish)
FIA-1125e (E)	Request for Documentation of Expenses
FIA-1125e (S)	Request for Documentation of Expenses (Spanish)
W-145F	Recoupment Worksheet to Determine Undue Hardship (Rev. 10/19/15)
W-145F(S)	Recoupment Worksheet to Determine Undue Hardship (Spanish) (Rev. 10/19/15)

FIA-1125 (E) 10/19/2015
LLF

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

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Request for Determination of Undue Hardship

You were previously notified that a recoupment will be taken from your Cash Assistance benefits to repay an overpayment of benefits at a recoupment rate of 10%. The notice informed you that if you feel that the rate of recoupment would cause you undue hardship, you should contact your worker to request an undue hardship determination. If it is determined that the rate of recoupment is causing you undue hardship, the rate of recoupment may be decreased to as low as 5%.

An undue hardship means that you do not have enough money to pay for food, shelter, utilities, clothing, or to pay for medical expenses not covered by your health insurance.

In order to claim undue hardship, please sign and date the bottom of this form and submit it to us. You should also submit verification of any of the following items to support your claim:

- Utility bills for the past three months;
- Fuel bills for the past three months;
- Evidence of the need to purchase items to meet a health condition as verified by a doctor or other health professional where the cost of these items is not covered by your health insurance (e.g. over-the-counter medicines or remedies)

We will also take into consideration other income your household receives, the amount of rent you pay, and the cost of clothing and food based on the information we have in your file.

Once we receive this signed request from you, we will determine if you qualify for a reduction in your rate of recoupment. We will send you written notification of our determination that will include a copy of the Recoupment Worksheet to Determine Undue Hardship (**W-145F**).

☐ **I would like to claim undue hardship**

To help support my claim of undue hardship, I have submitted verification of the following expenses:
☐ Utility bills (for the past three months)
☐ Fuel bills (for the past three months)
☐ Medical expenses (not covered by health insurance)

_____ _____ _____

Signature Date Telephone Number

FIA-1125 (S) 10/19/2015
LLF

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

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Petición de Determinación de Dificultad Excesiva

A usted se le notificó previamente que se efectuará una recuperación de sus beneficios de Asistencia en Efectivo para reembolsar un sobrepago de beneficios a la tasa de recuperación del 10%. El aviso le informó que si usted estima que la tarifa de recuperación le causaría dificultad excesiva, debe comunicarse con su trabajador para solicitar una determinación de dificultad excesiva. Si se determina que la tasa de recuperación le está causando dificultad excesiva, esta tasa puede reducirse hasta el porcentaje tan bajo del 5%.

La dificultad excesiva significa que usted no tiene suficiente dinero para pagar la comida, el albergue, los servicios públicos, la ropa, o los gastos médicos que no estén cubiertos por su seguro médico.

Para reclamar la dificultad excesiva, favor de presentarnos este formulario firmado y fechado por usted en la parte inferior de este formulario. Además, usted debe presentar comprobante de cualquiera de los siguientes artículos para apoyar su reclamo;

- Facturas de servicios públicos de los últimos tres meses;
- Facturas de combustible de los últimos tres meses;
- Prueba de la necesidad de comprar artículos para satisfacer una afección médica comprobada por un médico u otro profesional de salud, en el caso que el costo de dichos artículos no estén cubiertos por su seguro médico (p.ej. medicamentos o remedios sin receta).

Nosotros también tomaremos en consideración otros ingresos que reciba su hogar, la cantidad de alquiler que usted pague, y el costo de su ropa y de su comida según la información que tengamos en su expediente.

Una vez hayamos recibido de parte suya esta petición firmada, nosotros determinaremos si usted cualifica para una reducción en su tasa de recuperación. Posteriormente le enviaremos un aviso por escrito de nuestra determinación que incluirá una copia de la Hoja de Cálculos de Recuperación para Determinar Dificultad Excesiva (**W-145F [S]**).

☐ **Deseo reclamar dificultad excesiva.**

Para apoyar mi reclamo de dificultad excesiva, he presentado comprobantes de los siguientes gastos:
☐ Facturas de servicios públicos (de los últimos tres meses)
☐ Facturas de combustible (de los últimos tres meses)
☐ Gastos médicos (no cubiertos por el seguro médico)

Firma _____ Fecha _____ Número de Teléfono _____

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

Date: _____

Case Name: _____

Case Number: _____

Center Number: _____

Fair Hearing and Conference Unit (FH&C) Number: _____

Outcome of Review of Undue Hardship Claim

We have completed our review of your claim of undue hardship.

☐ We have determined that you have undue hardship and we will be reducing the rate of your recoupment from _____% to _____%.

☐ We have determined that you do not qualify for a reduction in your rate of recoupment.

☐ Since you have not provided us with verification of expenses you claimed to have when you asked us to determine your eligibility for a reduction in your rate of recoupment, we calculated your eligibility for the reduction based only on the information we currently have in your case file and have determined that you currently do not qualify for a recoupment rate reduction.

If you provide the verification of additional expenses you can request that the Agency re-evaluate your eligibility for a reduced rate. You can make this request to your local Job Center at any time.

We have enclosed the Recoupment Worksheet to Determine Undue Hardship (**W-145F**) to show you how we reached our determination.

☐ An undue hardship determination can only be done for households that are receiving Cash Assistance benefits. Since your application for Cash Assistance benefits was denied, we cannot make a determination at this time.

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

Conference and Fair Hearing Information

CONFERENCE

If you think our decision is wrong, or if you do not understand our decision, please call us to set up a conference (a conference is an informal meeting with us). To do this, call the Fair Hearing and Conference (FH&C) unit phone number on **page 1** of this notice or write to us at the address on **page 1** of this notice. Sometimes this is the fastest way to solve a problem you may have. We encourage you to do this even if you have asked for a Fair Hearing. If you ask for a conference, you are still entitled to a Fair Hearing.

STATE FAIR HEARING

How to Ask for a Fair Hearing: If you believe the decision(s) we are making is/are wrong, you may request a State Fair Hearing by telephone, in writing, fax, in person or online.

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

(2) WRITE: Send a copy (and keep a copy for yourself) of this entire notice, with the "Fair Hearing Request" section completed, to:

Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201

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

(4) IN PERSON: Bring a copy of this entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at:
14 Boerum Place, Brooklyn NY 11201

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

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

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

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

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

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

FAIR HEARING REQUEST

Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within sixty (60) days from the date of the notice for Cash Assistance, medical assistance, or social services issues; and you must ask within ninety (90) days for Supplemental Nutrition Assistance Program (SNAP) issues.

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

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

Print Name: _____ _____ _____ Case Number: _____
Name M.I. Last Name

Address: _____

_____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

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

Fecha: _____

Nombre del Caso: _____

Número del Caso: _____

Número del Centro: _____

Número de la Unidad de Conferencia y Audiencia Imparcial (FH&C): _____

Resultado de la Revisión de Reclamación de Privación Excesiva

Nosotros hemos terminado nuestra revisión de su reclamación de privación excesiva.

☐ Hemos determinado que usted está experimentando una privación excesiva y estaremos reduciendo la tasa de su recuperación del _____% al _____%.

☐ Hemos determinado que usted no reúne los requisitos para una reducción en su tasa de recuperación.

☐ Dado que usted no nos ha proporcionado el comprobante de gastos que declaró a la hora de pedirnos que determináramos su elegibilidad para una reducción en su tasa de recuperación, calculamos su elegibilidad para la reducción sólo basado en la información del archivo de su caso. Hemos determinado que usted actualmente no reúne los requisitos para una reducción en la tasa de recuperación.

Si usted proporciona el comprobante de gastos adicionales, puede solicitar que la Agencia reevalúe su elegibilidad para la tasa reducida. Usted puede presentar esta solicitud en su Centro de Trabajo local en cualquier momento.

Nosotros hemos adjuntado la Hoja de Cálculo de Recobro para Determinar Privación Económica Excesiva (**W-145F [S]**) para demostrarle cómo llegamos a nuestra determinación.

☐ Sólo se puede hacer una determinación de privación excesiva para los hogares que reciben beneficios de Asistencia en Efectivo. No podemos hacer ninguna determinación en este momento puesto que a usted se le denegó su solicitud para beneficios de Asistencia en Efectivo.

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

Información sobre Conferencias y Audiencias Imparciales

CONFERENCIA

Si usted considera que nuestra decisión ha sido errónea, o si no la entiende, por favor llámenos para programar una conferencia (reunión informal con nosotros). Para ello, llame al número de teléfono de la unidad de Audiencias Imparciales y Conferencias (FH&C) en la **página 1** de este aviso, o escríbanos a la dirección en la **página 1** de este aviso. A veces éste resulta el modo más rápido de solucionar algún problema que pueda tener. Le recomendamos que así lo haga, aun si ha solicitado una Audiencia Imparcial. En el caso de solicitar una conferencia, usted seguirá teniendo derecho a una Audiencia Imparcial.

AUDIENCIA IMPARCIAL ESTATAL
Cómo Solicitar una Audiencia Imparcial: Si usted considera que la(s) decisión(es) que estamos tomando es/son errónea(s), puede solicitar una Audiencia Imparcial Estatal por teléfono, por escrito, por fax, en persona o por Internet.

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

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

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

(4) EN PERSONA: Traiga una copia de todo este aviso, con la sección "Petición de Audiencia Imparcial" llenada, a la Oficina de Audiencias Administrativas, Oficina de Asistencia Temporaria y para Discapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a la siguiente dirección:
14 Boerum Place, Brooklyn, NY 11201.

(5) POR INTERNET: Llene un formulario de petición electrónica en: **http://www.otda.state.ny.us/oah/forms.asp**

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

Si usted padece una discapacidad, y no puede trasladarse, puede comparecer mediante un representante, o un amigo, pariente o abogado. Si su representante no es abogado, ni es empleado de abogado, su representante debe traerle al funcionario de audiencias una carta escrita y firmada.

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

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

INFORMACIÓN: Si usted desea más información sobre su caso, cómo solicitar una Audiencia Imparcial, cómo revisar su archivo o cómo obtener copias adicionales de documentos, llame o escríbanos al número telefónico y/o dirección que aparecen en la **página 1** de este aviso.

PETICIÓN DE AUDIENCIA IMPARCIAL

Fecha Límite: Si usted desea que el Estado revise nuestra decisión, tiene que solicitar una Audiencia Imparcial dentro de sesenta (60) días a partir de la fecha de este aviso para asuntos de Asistencia en Efectivo, asistencia médica, o de servicios sociales; y tiene que presentar solicitud dentro de noventa (90) días para asuntos del Programa de Asistencia de Nutrición Suplementaria (SNAP).

Si usted no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporaria y para Discapacitados por teléfono, por fax, en persona o por Internet, favor de solicitar por escrito una Audiencia Imparcial antes de la fecha límite.

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

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

Dirección: _____

_____ Teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____

FIA-1125e (E) 10/19/2015
LLF

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

Date: _____

Case Name: _____

Case Number: _____

Center Number: _____

Fax Number: _____

Request For Documentation Of Expenses

(Undue Hardship Determination)

In connection with your request for a hardship determination, please provide documentation of the expenses checked below which you claimed you have. The documentation must be returned by _____. If we do not receive documentation by that date, we will determine your eligibility for a reduced recoupment rate based only on the information we already have in your case file.

Please return this form to us along with the requested documentation below. You may submit the documentation to us in person in the business reply envelope provided to you, or you may fax it to us at the number listed above.

- ☐ Utility bills for the past three months
- ☐ Fuel bills for the past three months
- ☐ Medical expenses as verified by a doctor or other health professional that are not covered by health insurance

Once we complete our evaluation of your claim of undue hardship, we will send you a letter to notify you of the Agency's determination along with a worksheet showing how the Agency calculated your recoupment rate.

_____

Worker's Signature

FIA-1125e (S) 10/19/2015
LLF

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

Fecha: _____

Nombre del Caso: _____

Número del Caso: _____

Número de Centro: _____

Número de Fax: _____

Petición de Documentación de Gastos

(Determinación de Privación Excesiva)

Con respecto a su petición de determinación de privación, favor de proporcionar documentación de los gastos marcados a continuación que usted afirmó tener. La documentación debe devolverse para el _____. Si nosotros no recibimos la documentación para esa fecha, determinaremos su elegiblidad para una tasa de recuperación reducida sólo según la información que ya tenemos en su expediente de caso.

Por favor devuélvanos este formulario junto con la documentación solicitada a continuación. Usted puede presentarnos la documentación en persona, enviarla en el sobre con franqueo pagado que se le proporcionó, o puede enviárnosla por fax al número listado mas arriba.

- ☐ Facturas de servicios públicos por los últimos tres meses
- ☐ Facturas de combustible por los últimos tres meses
- ☐ Gastos médicos comprobados por un médico u otro profesional de salud no cubiertos por seguro médico

Una vez llevemos a cabo la evaluación de su alegación de privación excesiva, le enviaremos a usted una carta para notificarle de la determinación de la Agencia junto con una hoja que indicará cómo calculamos su tasa de recuperación.

_____

Firma del Trabajador

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

Recoupment Worksheet to Determine Undue Hardship

(Round down all money figures to the nearest 50¢)

Case Number:		**Category:**	
Case Name Suffix:		**Center Number:**	

A. Semimonthly Income	**Total to be shared**	**Suffix to be Recouped**	**Other People in Household**
1. CA Household Needs			
2. SNAP Benefits (1/2 of Monthly SNAP Benefit)			
3. Exempt Income (Employment Incentive, child support bonus payments, etc.)			
4. Total Income (**Lines 1, 2 + 3**)			
B. Semimonthly Expenses			
5. Food Needs Based on USDA – Thrifty Food Plan: 1 Person = $97.00 — 5 Persons = $385.50 2 Persons = $178.50 — 6 Persons = $462.50 3 Persons = $255.50 — 7 Persons = $511.00 4 Persons = $324.50 — 8 Persons = $584.50 $71.00 for each additional person			
6. Semimonthly Actual Rent			
7. Semimonthly Utilities (Averaged over last three months)			
8. Semimonthly Clothing for Children on Suffix being Recouped ($12.50 x _____ Children)			
9. Semimonthly Verified Medical Expenses of Persons on Suffix Being Recouped			
10. Total Expenses (**Lines 5, 6, 7, 8, 9**)			
C. Maximum Available for Recoupment			
11. Total Income Minus Total Expenses (**Line 4** minus **Line 10**)			
12. Minimum Recoupment (5% of **Line 1**)			
13. Maximum Available for Recoupment (Larger of **Line 11** or **12**)			
D. Maximum Allowable Recoupment			
14. Semimonthly Household Needs of Suffix Being Recouped (From **Line 1**)			
15. Maximum Recoupment (10% of **Line 14**)			
16. Semimonthly Amount to be Recouped (Smaller of **Line 13** or **15**)			
17. Recoupment Percentage (**Line 16** divided by **Line 14**)			

Signature and Title of Staff Member Completing Worksheet

Date

Instructions

(Round down all amounts to the nearest 50¢)

Line 1: Enter semimonthly household needs. Include rent payments issued as two-party checks or paid directly to the landlord.

Line 2: Enter semimonthly SNAP Benefit. For composite or mixed household cases, enter the household's semimonthly SNAP Benefit in the first column; prorate this amount for the case to be recouped and enter the prorated amount in the second column.

Line 3: Enter all semimonthly exempt income such as the $45.00 work disregard, earned income disregard, and child support bonus payments.

Line 4: Total of **lines 1**, **2** and **3**.

Line 5: Enter the food needs for the participant's family based on the USDA Thrifty Food Plan.

Line 6: Enter the semimonthly rent amount paid by the participant's or the department to the landlord. Do not include any portion of the rent paid by friends or relatives to the landlord. For composite cases, enter the household's semimonthly rent (actually charged) in the first column; prorate this amount for the case to be recouped and enter the prorated amount in the second column.

Line 7: Enter the average utility expense (if any) from heat and electric bills submitted for the last three months. For composite cases, enter the semimonthly amount paid by the household in the first column; prorate this amount for the case to be recouped and enter the prorated amount in the second column.

Line 8: Multiply the number of children in the household by $12.50 and enter the total.

Line 9: Enter the average semimonthly medical expense not covered by Medicaid (must be verified).

Line 10: Total of **lines 5**, **6**, **7**, **8** and **9**.

Line 11: Subtract the amount on line 10 (Total Expense) from the amount on line 4 (Total Income) and enter the difference.

Line 12: Enter 5% of the amount on **line 1**.

Line 13: Enter the amount on **line 11** or **12**, whichever is larger.

Line 14: Enter the semimonthly household needs.

Line 15: Enter 10% of the amount on **line 14**.

Line 16: Enter the amount on **line 13** or **15**, whichever is smaller.

Line 17: Divide the amount on **line 16** by the amount on **line 14** to obtain the maximum allowable percentage of recoupment. Round down the percentage to the nearest whole percentage. For example, 6.7% would be rounded down to 6%.

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

Cálculo de Recuperación para Determinar Dificultad Excesiva

(Redondee todas las cantidades de moneda a los más cercanos 50¢ inferiores)

Número del Caso:		**Categoría:**	
Sufijo del Número del Caso:		**Núm. de Centro:**	

A. Ingreso Quincenal	**Suma que se compartirá**	**Sufijo que se Recuperará**	**Otras Personas en el Hogar**
1. Necesidades del hogar de CA			
2. Beneficios de SNAP (1/2 del Beneficio Mensual de SNAP)			
3. Ingreso Exento (Incentivo de Empleo, pagos de prima para manutención de niños, etc.)			
4. Suma de Ingresos **(Línea 1, 2 + 3)**			
B. Gastos Quincenales			
5. Necesidades Alimentarias Basadas en el Plan Económico de Comidas (Thrifty Food Plan) del USDA 1 Persona = $97.00 — 5 Personas = $385.50 2 Personas = $178.50 — 6 Personas = $462.50 3 Personas = $255.50 — 7 Personas = $511.00 4 Personas = $324.50 — 8 Personas = $584.50 $71.00 para cada persona adicional			
6. Cantidad Real de Alquiler Quincenal			
7. Gastos de Servicios Públicos Quincenales (Promedio de los últimos tres meses)			
8. Recuperación de Ropa Quincenal para Niños en el Sufijo ($12.50 x _____ Niños)			
9. Recuperación de Gastos Médicos Quincenales Verificados de las Personas en el Sufijo			
10. Suma de los Gastos **(Líneas 5, 6, 7, 8, 9)**			
C. Máximo Disponible para la Recuperación			
11. Suma de Ingreso Menos Suma de los Gastos (**Línea 4** menos **Línea 10**)			
12. Recuperación Mínima (5% de la **Línea 1**)			
13. Cantidad Máxima Disponible para ser Recobrada (Lo Mayor de la **Línea 11** o **12**)			
D. Recuperación Máxima Permisible			
14. Recuperación de Necesidades Quincenales de la Familia del Sufijo (De la **Línea 1**)			
15. Máxima Cantidad de Recuperación (el 10% de la **Línea 14**)			
16. Cantidad Quincenal que se recuperará (Lo Menor de la **Línea 13** o **15**)			
17. Porcentaje de la Recuperación (Cantidad de **Línea 16** dividida por la cantidad en **Línea 14**)			

Firma/Título del Miembro del Personal que Llenó este Formulario

Fecha

Instrucciones

(Redondee todas las cantidades a los más cercanos 50¢ inferiores)

Línea 1: Anote la cantidad de las necesidades quincenales del hogar. Incluya los pagos de alquiler efectuados como cheques de dos partes o pagos directos al casero.

Línea 2: Anote los Beneficios quincenales de SNAP. En casos de hogares compuestos o mixtos, anote el Beneficio quincenal de SNAP del hogar en la primera columna; prorratee esta cantidad respecto al caso a ser recuperado y anote la cifra prorrateada en la segunda columna.

Línea 3: Anote todo ingreso quincenal exento como la omisión de trabajo de $45.00, la desestimación del ingreso salarial, y los pagos de prima de manutención de niños.

Línea 4: Suma de las **líneas 1**, **2** y **3**.

Línea 5: Anote la cantidad de las necesidades alimenticias de la familia del participante conforme al Plan Económico de Comidas de la USDA.

Línea 6: Anote la cantidad de alquiler quincenal pagado por el participante o el departamento al casero. No incluya ninguna parte de su alquiler pagada al casero por los amigos o parientes suyos. En casos compuestos, anote el alquiler quincenal del hogar (lo que realmente se cobra) en la primera columna; prorratee la recuperación de esta cantidad respecto al caso, y anote la cifra prorrateada en la segunda columna.

Línea 7: Anote la cantidad promedio del gasto (de haberlo) de servicios públicos basándose en las facturas presentadas de electricidad y calefacción de los últimos tres meses. En casos compuestos, anote la cantidad quincenal pagada por el hogar en la primera columna; prorratee la cantidad para que se recupere el caso y anote la cantidad prorrateada en la segunda columna.

Línea 8: Multiplique el número de niños en el hogar por $12.50 y anote la suma.

Línea 9: Anote la cantidad promedio de la suma de los gastos médicos quincenales que no estén cubiertos por Medicaid (a verificarse).

Línea 10: Suma de las **líneas 5**, **6**, **7**, **8** y **9**.

Línea 11: Reste la cantidad de la **línea 10** (Suma de Gastos) de la cantidad de la **línea 4** (Suma de Ingresos) y anote la diferencia.

Línea 12: Anote el 5% de la cantidad de la **línea 1**.

Línea 13: Anote la mayor de las cantidades de las **líneas 11** y **12.**

Línea 14: Anote las necesidades quincenales del hogar.

Línea 15: Anote el 10% de la cantidad de la **línea 14**.

Línea 16: Anote la menor de las cantidades de las **líneas 13** o **15**.

Línea 17: Divida la cantidad de la **línea 16** por la de la **línea 14** para obtener el máximo del porcentaje permisible de recuperación. Redondee al porcentaje entero inferior más cercano. Por ejemplo, 6.7% se redondearía inferior al 6%.