



**OFFICE OF POLICY, PROCEDURES, AND TRAINING**

**POLICY BULLETIN #23-67-ELI**  
(This Policy Bulletin Replaces PB #23-53-ELI)

**JANUARY 2024 SOCIAL SECURITY COLA CHANGES FOR NYSNIP HOUSEHOLDS**

<p><b>Date:</b> December 12, 2023</p>	<p><b>Subtopic(s):</b> NYSNIP</p>
	<p>The purpose of this policy bulletin is to inform Non-Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Center staff of the changes in the New York State Nutrition Improvement Project (NYSNIP) standardized benefit levels and in the shelter cost threshold to be considered high shelter. These changes are due to the annual Supplemental Security Income (SSI) cost of living adjustment (COLA) and are effective January 1, 2024.</p> <p>The standardized SNAP benefit level for NYSNIP households with Shelter Type Code <b>96</b> (NYSNIP – high shelter costs) that do not qualify for the heating/cooling SUA and who receive SSI only will decrease from \$60 to \$47 while those who receive SSI and other income will decrease from \$51 to \$38.</p> <p>The standardized SNAP benefit level for NYSNIP households with Shelter Type Code <b>97</b> (NYSNIP – low shelter costs) that do not qualify for the heating/cooling SUA and who receive SSI only will decrease from \$50 to \$41 while those who receive SSI and other income will decrease from \$44 to \$35.</p> <p>The standardized SNAP benefit level for NYSNIP households with Shelter Type Code <b>98</b> (NYSNIP – SUA and shelter unknown) who receive SSI only will decrease from \$50 to \$41 while those who receive SSI and other income will decrease from \$44 to \$35.</p> <p>All other NYSNIP standardized benefit levels will remain the same.</p>

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

The NYSNIP benefit levels are listed on the Guide to SNAP Budgeting (**W-204G**).

The NYSNIP standardized benefit levels effective January 1, 2024 are as follows:

	<u>SSI only</u>	<u>SSI and other income</u>
Shelter Type Code <b>94</b>	\$291	\$291
Shelter Type Code <b>95</b>	\$291	\$291
Shelter Type Code <b>96</b>	\$291	\$291
Shelter Type Code <b>96</b> (No SUA)	\$ 47	\$ 38
Shelter Type Code <b>97</b>	\$291	\$291
Shelter Type Code <b>97</b> (No SUA)	\$ 41	\$ 35
Shelter Type Code <b>98</b>	\$ 41	\$ 35

Change in the NYSNIP shelter cost threshold

The NYSNIP shelter cost threshold to be considered as “High Shelter” (Shelter Type Codes **94** and **96**) will change from greater than \$300 per month to greater than \$309 per month and the shelter cost threshold to be considered as “Low Shelter” (Shelter Type Codes **95** and **97**) will change from \$300 or less per month to \$309 or less per month.

Revised **W-204G**.

The Guide to Supplemental Nutrition Assistance Program (SNAP) Budgeting (**W-204G**) has been revised to reflect changes in the NYSNIP standardized benefit levels due to the annual SSI COLA and to reflect the change in the NYSNIP shelter cost threshold. The changes are effective January 1, 2024.

A sample of the revised **W-204G** is attached.

State notice

The State mailed the Notice of Mass Change (see **Attachment A**) to NYSNIP households that will incur a SNAP benefit decrease.

System changes

The Welfare Management System (WMS) has been programmed to reflect the NYSNIP benefit changes. A mass re-budget (MRB) will be run in WMS on the weekend of December 15-17, 2023. Cases that are re-budgeted will have a 01/A/24 budget effective date.

*Effective January 1, 2024*

**Related Item:**

[PD #23-11-ELI](#) January 2024 RSDI/SSI COLA Increases

**Attachments:**

**Attachment A** Notice of Mass Change  
**W-204G** Guide to Supplemental Nutrition Assistance Program (SNAP) Budgeting (Rev. 11/01/2023)

P.O. BOX 02-9121  
Brooklyn GPO  
Brooklyn, N.Y. 11202-9121

**The City Of New York**  
**HUMAN RESOURCES ADMINISTRATION**  
**FAMILY INDEPENDENCE ADMINISTRATION**

CONFERENCE PHONE: - -  
NÚMERO PARA CONFERENCIA

Center:  
CASE No:

FAM SIZE:  
DATE: December 1, 2023  
FECHA: 1 de diciembre de 2023

**NOTICE OF MASS CHANGE PREAVISO DE REDUCCIÓN EN SU SUBSIDIO SNAP**

This is to inform you that your SNAP Benefits may be reduced effective January 1, 2024 for the following reason:

Beginning January 2024, Social Security, SSI and/or Veteran's Benefits will increase BY 3.2%. If you are in receipt of any of these Federal Benefits, this increase in income to your household must be considered in determining your SNAP benefit level. **IF YOU ARE IN RECEIPT OF BOTH SOCIAL SECURITY BENEFITS AND SSI, YOUR JANUARY SSI BENEFITS WILL BE REDUCED BY THE AMOUNT OF YOUR SOCIAL SECURITY BENEFIT INCREASE. THESE INCOME CHANGES MUST ALSO BE CONSIDERED IN DETERMINING YOUR SNAP BENEFITS.**

Beginning in January 2024, if you are an SSI recipient living alone in the community who is participating in the New York State Nutrition Improvement Project (NYSNIP) and your rent is above or below \$309.00 and you either incur a separate bill or charge for heating or air conditioning costs or you have received Home Energy Assistance (HEAP) benefits of more than \$20 during the month this letter is dated or the during the immediately preceding twelve (12) months, your monthly SNAP benefit of \$291.00 WILL NOT CHANGE. HOWEVER, if your rent is above \$309.00 and you do not incur a separate bill or charge for heating or air conditioning costs or have not received Home Energy Assistance (HEAP) benefits of more than \$20 during the month this letter is dated or the during the immediately preceding twelve (12) months, BEGINNING IN JANUARY 2024, you will receive \$47 in SNAP benefits and if you receive income in addition to SSI, you will receive \$38 in SNAP benefits.

**IF YOU ARE A NYSNIP PARTICIPANT** with rent below \$309.00 and you do not incur a separate bill or charge for heating or air conditioning costs or have not received HEAP benefits of more than \$20 during the month this letter is dated or during the immediately preceding twelve (12) months, BEGINNING IN JANUARY 2024, you will receive \$41 in SNAP benefits and if you receive income in addition to SSI, you will receive \$35 in SNAP benefits.

Page 2 of this notice is a Financial Fact Sheet which shows your new SNAP benefit amount and all the income information on our computer file that was used to calculate your new SNAP benefit. We have enclosed Budget Worksheets which you can use to determine whether we have correctly determined your net SNAP income. See 18 NYCRR 387.10, 387.12 AND 387.15.

Por medio de la presente le informamos que reduciremos su subsidio SNAP a partir del 1° de enero de 2024 por la siguiente razón:

Comenzando en enero de 2024, los subsidios de Seguro Social, SSI y subsidios para veteranos, aumentarán por un 3.2 %. Si usted recibe alguno de los Subsidios Federales antes mencionados, este aumento en el ingreso de su grupo familiar deberá tomarse en cuenta en el cálculo del monto del subsidio SNAP que usted recibe. **SI USTED ACTUALMENTE RECIBE AMBOS SUBSIDIOS: SEGURO SOCIAL Y SSI, EL MONTO DEL SUBSIDIO DE SSI PARA EL MES DE ENERO SERÁ REDUCIDO POR EL MONTO DEL AUMENTO EN SU SUBSIDIO DE SEGURO SOCIAL. ESTOS CAMBIOS EN INGRESO TAMBIÉN DEBEN TOMARSE EN CUENTA EN EL CÁLCULO DE SU SUBSIDIO SNAP.**

Comenzando en enero de 2024, si usted es un beneficiario de SSI que vive solo(a) en la comunidad y participa en el Proyecto de Mejora Nutricional del Estado de Nueva York (NYSNIP) y su alquiler es superior o inferior a los \$309.00 y usted ya sea: recibe facturas o cargos por separado de calefacción o aire acondicionado, o ha recibido el Subsidio de Energía para el Hogar (HEAP) por un monto mayor de \$20 en el mes de la fecha de esta carta o en los últimos 12 meses; el monto mensual de su subsidio SNAP de \$291.00 NO CAMBIARÁ. SIN EMBARGO, si su alquiler es superior a los \$309.00 y usted no incurre facturas o cargos por separado de calefacción o aire acondicionado o no ha recibido el Subsidio de Energía para el Hogar (HEAP) por un monto mayor a los \$20 en el mes de la fecha de esta carta o en los últimos 12 meses; COMENZANDO EN ENERO DE 2023, usted recibirá \$47 en subsidio SNAP y si usted recibe ingreso adicional al SSI, usted recibirá \$38 en subsidio SNAP.

**SI USTED ES UN PARTICIPANTE DEL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP)** que tenía un alquiler inferior a los \$309.00 y usted no incurre facturas o cargos por separado de calefacción o aire acondicionado o no ha recibido el Subsidio de Energía para el Hogar (HEAP) por un monto mayor a los \$20 en el mes de la fecha de esta carta o en los últimos 12 meses; COMENZANDO EN ENERO DE 2024, usted recibirá \$41 en subsidio SNAP y si usted recibe ingreso adicional al SSI, usted recibirá \$35 en subsidio SNAP.

La página 2 de este aviso es una Hoja de Datos Financieros la cual muestra su nuevo monto de subsidio SNAP como también todos los datos sobre ingresos registrados en nuestro archivo computarizado y el cual fue utilizado en el cálculo de su nuevo monto de subsidio SNAP. Hemos adjuntado Hojas de Cálculo de Presupuesto las cuales usted puede utilizar para determinar si hemos calculado correctamente su ingreso neto en relación con la subvención SNAP. Consulte 18 NYCRR 387.10, 387.12 Y 387.15.

ATENTAMENTE,  
Angela Johnson, EXECUTIVE DEPUTY COMMISSIONER /  
SUBCOMISIONADO EJECUTIVO FAMILY INDEPENDENCE  
ADMINISTRATION

XL0263 (11/23)

**YOUR FINANCIAL FACTS CURRENTLY ON FILE  
SUS DATOS FINANCIEROS ACTUALMENTE EN ARCHIVO**

**Previous Net Supplemental Nutrition Assistance Program (SNAP)**

Ingreso anterior del subsidio de Asistencia Nutricional Suplementaria (SNAP)

**New Net SNAP Income**

Nuevo Ingreso neto del subsidio SNAP

**Previous Monthly Benefit Amount**

Monto anterior mensual del subsidio

**New Monthly Benefit Amount**

Nuevo monto mensual del subsidio

**A. MONTHLY INCOME**  
Ingreso Mensual

<b>1a. Monthly Gross Income from Employment or Training.</b> Ingreso bruto mensual por empleo o entrenamiento	
<b>b. Monthly Net Income from Self Employment</b> Ingreso neto mensual por trabajo por cuenta propia.	
<b>2a. Net Monthly Income from Boarder/Lodger.</b> Ingreso neto mensual que recibe del huésped/inquilino	
<b>b. Net Monthly Income from Lodger</b> Ingreso neto mensual que recibe del inquilino	
<b>3. Total of lines 1 and 2.</b> Total de las lineas 1 y 2.	
<b>4a. Monthly Gross Unearned Income</b> Ingreso bruto mensual no devengado	
<b>b.</b>	
<b>c.</b>	
<b>5. Monthly Income from Educational Loans, Scholarships</b> Ingreso mensual por préstamos y becas educacionales.	
<b>6. Total of Lines 3, 4 and 5.</b> Total de líneas 3, 4 y 5	<b>A.</b> \$

**C. ADJUSTED INCOME**  
Ingreso ajustado

<b>14. Subtract B from A. (Line 13 from Line 6.)</b> Reste B de A. (Línea 13 de línea 6.)	<b>C.</b> <input style="width: 100%; height: 30px;" type="text"/>
--	--

**D. SHELTER COSTS**  
Gastos de Vivienda

<b>15. Monthly Rent or Mortgage actually paid.</b> Renta o hipoteca actualmente pagada cada mes.	
<b>16. Monthly Heating Expense</b> Gasto mensual por calefacción.	
<b>17. Monthly Utility Expense</b> Gasto mensual por utilidades.	
<b>18. Monthly Telephone Expense</b> Gasto mensual por teléfono.	0.00
<b>19. Other Monthly Shelter Expense. (Real Estate Taxes, Insurance, Installation of Utilities, etc.)</b> Otros gastos mensuales de vivienda. (Impuestos inmobiliarios, seguro, conexión de servicios públicos etc.)	
<b>20. Total of Lines 15, 16, 17, 18, and 19.</b> Total de líneas 15, 16, 17, 18, y 19	<b>D.</b> \$

**E. SNAP NET INCOME**  
Ingreso neto por subsidio SNAP

<b>21. Excess Shelter Deduction (Line 20 minus 1/2 of Line 14. The total cannot be more than 1/2 of Line 14. The total cannot be more than 1/2 of Line 14.)</b>  Deducción de gastos de vivienda en exceso (línea 20 menos 1/2 de línea 14. El total no puede ser más de 1/2 de línea 14. El total no puede ser más de 1/2 de línea 14.)	
<b>22. MONTHLY NET SNAP INCOME</b> (Subtract Line 21 from Line 14.) Ingreso neto mensual por subsidio SNAP (reste línea 21 de línea 14)	
<b>23. MONTHLY SNAP BENEFIT AMOUNT</b> Cantidad mensual del subsidio SNAP	<b>E.</b> \$

**MINUS RECOUPMENT OF  
MENOS EL REEMBOLSO DE  
ADJUSTED SNAP AMOUNT  
MONTO AJUSTADO DEL  
SUBSIDIO SNAP**

**B. DEDUCTIONS**  
Deducciones

<b>7.</b> % of Line 3. % de línea 3	
<b>8. Standard Deduction Monthly</b> Deducción mensual estándar	
<b>9. Monthly Child Care/Dependent Care Costs.</b> Gastos mensuales por cuidado de niños / dependientes (Maximum (Máximo )	
<b>10. Monthly Automatic Recoupment (from Public Assistance Grant)</b> Recuperación mensual automática (de subsidio de Asistencia Pública)	
<b>11. Monthly Tuition and Mandatory Fees</b> Gastos mensuales de colegiatura y cuotas obligatorias	
<b>12a. Monthly Medical Expense (less \$35 Deductible)</b> Gasto médicos mensuales (menos \$35 de deducible)	
<b>b.</b>	
<b>13. Total Lines 7, 8, 9, 10, 11, and 12</b> Total de líneas 7, 8, 9, 10, 11, y 12	<b>B.</b> \$

**CONFERENCE AND FAIR HEARING SECTION - DO YOU THINK WE ARE WRONG?**

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

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

The Office of Temporary and Disability Assistance (OTDA) policy issuances and manuals are posted on the OTDA website at [otda.ny.gov/legal](http://otda.ny.gov/legal). These issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. In addition, upon request to your local social services district, specific OTDA policy issuances and manuals will also be available to assist you or your representative.

1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See "Keeping Your Benefits The Same" below.)

2. **STATE FAIR HEARING** - You have **90 days** from the date of this notice to ask for a fair hearing:

**KEEPING YOUR BENEFITS THE SAME:** We will restore your SNAP Benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any SNAP Benefits you got, but should not have gotten, while you were waiting for the decision.

If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a fair hearing or, if you send back this notice, check the box below:

I do not want to keep my SNAP Benefits the same until the Fair Hearing decision is issued.

If at the hearing, the hearing officer determines that you are not complaining about an incorrect computation of your benefits or that there has been a misapplication or misinterpretation of Federal Law or regulations, the hearing officer may determine that you were not entitled to have your SNAP Benefits continue unchanged until the fair hearing decision is issued, and order that the reduction take effect immediately.

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

**Mail:** Send a copy of the notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

**Phone:** 800-342-3334 (Please have this notice with you when you call.)

**Fax:** Fax a copy of the front and reverse of this notice to: (518) 473-6735.

**Walk-In:** Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn.

**Online:** Complete an online request form at: <http://www.otda.ny.gov/oah/forms.asp>.

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

**WHAT TO EXPECT AT A FAIR HEARING:** The State will send you a notice that tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing. At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong. To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements. At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

**LEGAL ASSISTANCE:** If you think you need a lawyer to help you with this problem, you may be able to get a lawyer at no cost to you by contacting your local Legal Aid Society or other legal advocate group. For the names of other lawyers, check your Yellow Pages under "Lawyers".

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your 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, or 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 us at the phone numbers on the front of this notice or write to us at the address on the front of this notice.

Preaviso de cambios en el subsidio SNAP debido a un aumento en los beneficios del Seguro Social, SSI y/o beneficios para Veteranos

**CONFERENCIAS Y AUDIENCIAS IMPARCIALES: ¿CREE QUE NOS HEMOS EQUIVOCADO?**

Si cree que nuestra decisión es incorrecta, puede solicitar una revisión de nuestra decisión. Corregiremos nuestro error. Usted puede tomar ambas acciones, 1 y 2:

1. Solicitar una reunión (conferencia) con un supervisor;
2. Solicitarle al Estado una audiencia imparcial con un funcionario estatal de audiencias.

Los manuales y publicaciones sobre políticas de la Oficina de Asistencia Temporal y Asistencia para Incapacitados (OTDA) se encuentran publicadas en el sitio web de OTDA: [otda.ny.gov/legal](http://otda.ny.gov/legal). Estas publicaciones y manuales están a su disposición o la disposición de su representante con el fin de ayudarlo a determinar si debería o no solicitar una audiencia imparcial o con el fin de ayudarlo a prepararse para una audiencia imparcial. Además, si lo solicita de su oficina de servicios sociales de distrito, publicaciones específicas de OTDA sobre políticas y manuales también estarán a su disposición o a la disposición de su representante con el fin de asistirle.

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

**2. AUDIENCIA IMPARCIAL ESTATAL:** usted tiene 90 días, contados a partir de la fecha de esta notificación, para solicitar una audiencia imparcial:

**MANTENER SUS BENEFICIOS SIN CAMBIOS:** reanudaremos sus beneficios de SNAP al mismo nivel en que estaban antes de esta notificación si usted solicita una audiencia imparcial antes de la fecha de vigencia señalada en esta notificación. Sin embargo, si la audiencia imparcial no se decide a su favor, tendrá que devolver todos los beneficios de SNAP que recibió, pero que no debería haber recibido mientras esperaba por la decisión de la audiencia.

Si usted no quiere que sus beneficios continúen al mismo nivel hasta que se remita la decisión, deberá informárselo al Estado cuando llame para solicitar una audiencia imparcial o si usted devuelve esta notificación, marque la casilla a continuación:

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

Si en la audiencia, el oficial de audiencias determina que su queja no tiene que ver con un cálculo incorrecto de sus beneficios o que hubo una aplicación o interpretación incorrecta de la ley federal o reglamento, el oficial de audiencias puede dictaminar que usted no tenía derecho a continuar recibiendo los beneficios de Asistencia Pública sin cambios mientras esperaba por la decisión de la audiencia imparcial, y como resultado ordenar que la reducción entre en vigor inmediatamente.

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

**Por correo:** envíe una copia de esta notificación rellena a: *Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201*. Favor de quedarse con una copia.

Deseo una audiencia imparcial. No estoy de acuerdo con la decisión de la agencia. (Puede explicar a continuación por qué no está de acuerdo, aunque no tiene que incluir una explicación por separado).

**Por teléfono:** 800-342-3334 (Favor de tener a mano este aviso cuando llame).

**Por fax:** envíe por fax una copia del anverso y reverso de esta notificación al: (518) 473-6735.

**En persona:** traiga una copia de todas las partes de este aviso a la oficina de *New York State Office of Temporary and Disability Assistance* ubicada en: 14 Boerum Place, Brooklyn.

**Por internet:** rellene una solicitud en línea en: <http://www.otda.ny.gov/oh/forms.asp>.

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

**LO QUE SUCEDE EN UNA AUDIENCIA IMPARCIAL:** el Estado le enviará un aviso informándole cuándo y dónde se realizará la audiencia imparcial. En la audiencia, usted tendrá la oportunidad de explicar por qué cree que nuestra decisión es incorrecta. Puede traer consigo a un abogado, a un familiar o a un(a) amigo(a), o a alguien más que pueda ayudarlo a exponer su caso. Si usted no puede presentarse, puede enviar a otra persona en su representación. Si la persona que lo representará no es un abogado, debe entregarle a esta persona una carta, dirigida al funcionario de audiencias, en la cual usted declara que desea que dicha persona lo represente en la audiencia.

En la audiencia, usted y su abogado u otro representante, tendrán la oportunidad de explicar por qué creen que nuestra decisión es incorrecta, como también la oportunidad de presentar, ante el funcionario de audiencias, documentos que demuestren nuestra equivocación.

Con el fin de ayudarlo a exponer el motivo de nuestra equivocación, le sugerimos presentar testigos que puedan avalar su caso. También, le sugerimos presentar documentos tales como: comprobantes de pagos salariales, contrato de alquiler, recibos, cuentas médicas, etc.

En la audiencia, usted y su abogado u otro representante, podrán interrogar a los testigos que nosotros presentemos o los que usted presente con motivo de avalar su caso.

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

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

Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Se le proporcionarán dentro de un lapso de tiempo razonable antes de la fecha fijada de la audiencia. Los documentos se le enviarán por correo sólo si usted específicamente los solicita.

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

# Guide to Supplemental Nutrition Assistance Program (SNAP) Budgeting

(Effective January 1, 2024)



## 130% GROSS INCOME LIMITS (effective 10/01/23)

Households that do not contain an elderly (60 years of age or older) or disabled individual and do not incur out-of-pocket dependent care expenses and do not have earned income are subject to the 130% gross income test.

Household Size	1	2	3	4	5	6	7	8	Each Additional Member
Monthly Household Income	\$1,580	\$2,137	\$2,694	\$3,250	\$3,807	\$4,364	\$4,921	\$5,478	+ \$557

## 165% GROSS INCOME LIMITS (effective 10/01/23)

An elderly individual (and his/her spouse) who is living with others and who is unable to purchase and prepare meals because he/she suffers from a permanent disability may be a separate food unit if the income of the others with whom the individual resides (excluding the income of the elderly individual and his/her spouse) does not exceed the 165% gross income limit for the household size of the others.

Household Size	1	2	3	4	5	6	7	8	Each Additional Member
Monthly Household Income	\$2,005	\$2,712	\$3,419	\$4,125	\$4,832	\$5,539	\$6,246	\$6,952	+ \$707

## 200% GROSS INCOME LIMITS (effective 10/01/23)

Households that contain an elderly or disabled individual or that incur out-of-pocket dependent care expenses that pass the 200% gross income test are categorically eligible to participate in SNAP as long as the household does not contain a SNAP-sanctioned or an Intentional Program Violation (IPV) member.

Household Size	1	2	3	4	5	6	7	8	Each Additional Member
Monthly Household Income	\$2,430	\$3,287	\$4,143	\$5,000	\$5,857	\$6,713	\$7,570	\$8,427	+ \$857

## 150% GROSS INCOME LIMITS (effective 10/01/23)

Households that have earned income that do not contain an elderly or disabled individual and do not incur out-of-pocket dependent care expenses that pass the 150% gross income test are categorically eligible to participate in SNAP as long as the household does not contain a SNAP sanctioned or an IPV member.

Household Size	1	2	3	4	5	6	7	8	Each Additional Member
Monthly Household Income	\$1,823	\$2,465	\$3,108	\$3,750	\$4,393	\$5,035	\$5,678	\$6,320	+ \$643

## 100% NET INCOME LIMITS (effective 10/01/23)

Households that are not categorically eligible to receive SNAP benefits are subject to the 100% net income test.

Household Size	1	2	3	4	5	6	7	8	Each Additional Member
Monthly Household Income	\$1,215	\$1,644	\$2,072	\$2,500	\$2,929	\$3,357	\$3,785	\$4,214	+ \$429

## STANDARD DEDUCTION AMOUNTS (effective 10/01/23)

Household Size	1	2	3	4	5	6+
Standard Deduction	\$198	\$198	\$198	\$208	\$244	\$279

## SHELTER DEDUCTIONS/EXCLUSIONS:

- The maximum excess shelter deduction is **\$672** (effective 10/01/23).
- The homeless shelter deduction is **\$179.66** (effective 10/01/23).
- The boarder/lodger exclusion is **\$291** for one person and **\$535** for two people (effective 10/01/23).

## STANDARD UTILITY ALLOWANCE (SUA) LEVELS (effective 10/01/23)

SUA Level 1 = \$992	SUA Level 2 = \$391	SUA Level 3 = \$31
---------------------	---------------------	--------------------

For information on the SUA Levels, see the SUA Levels Desk Guide (W-205HH).

## THRIFTY FOOD PLAN (TFP) (effective 10/01/23)

The maximum SNAP benefit allotment per household size is as follows:

Household Size	1	2	3	4	5	6	7	8	Each Additional Member
Maximum SNAP Allotment	\$291	\$535	\$766	\$973	\$1,155	\$1,386	\$1,532	\$1,751	+ \$219

The minimum monthly SNAP benefit allotment for eligible one- and two-person households is **\$23** (effective 10/01/23).

## NEW YORK STATE NUTRITION IMPROVEMENT PROJECT (NYSNIP) BENEFIT AMOUNTS (effective 01/01/24)

SHELTER TYPE CODE	SSI ONLY	SSI AND OTHER INCOME
<b>Shelter Type Code 94</b> Shelter amount greater than \$309 per month and eligible for full SUA.	\$291	\$291
<b>Shelter Type Code 95</b> Shelter amount of \$309 or less per month and eligible for full SUA.	\$291	\$291
<b>Shelter Type Code 96</b> Shelter amount greater than \$309 per month and eligible for full SUA with \$21 HEAP.	\$291	\$291
<b>Shelter Type Code 96</b> Shelter amount greater than \$309 per month and no SUA.	\$47	\$38
<b>Shelter Type Code 97</b> Shelter amount of \$309 or less per month and eligible for full SUA with \$21 HEAP.	\$291	\$291
<b>Shelter Type Code 97</b> Shelter amount of \$309 or less per month and no SUA.	\$41	\$35
<b>Shelter Type Code 98</b> Shelter amount and SUA eligibility unknown.	\$41	\$35