FAMILY INDEPENDENCE ADMINISTRATION

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POLICY DIRECTIVE #05-33-ELI

24-MONTH RECERTIFICATION FOR CERTAIN PUBLIC ASSISTANCE/ FOOD STAMP HOUSEHOLDS

Date:	Subtopic(s):
September 9, 2005	Recertification, Medicaid

AUDIENCE

The instructions in this policy directive are for Job Center staff assigned to process Medicaid Recertifications and are informational for all other staff.

POLICY

Federal Food Stamp (FS) regulations allow for a 24-month certification period for households in which all adults are elderly (60 years of age and over) or under age 60 and totally disabled, as long as some contact, determined by the State, is made with the household at the 12–month point.

New York State's Office of Temporary and Disability Assistance (OTDA) has approved a waiver of Public Assistance (PA) regulations requiring a six-month certification period and face-to-face interview for FS households in receipt of PA, not in receipt of earned income, and in which all adults are either:

- 60 years of age or older; or
- 18–59 and totally disabled.

BACKGROUND

As a result of the above FS regulations and the OTDA waiver, PA and FS cases that meet the above criteria will be recertified every 24 months. However, these households must certify for Medicaid (MA) by mail every 12 months.

The MA mail recertification process entails the following:

Management Information Systems (MIS) will identify households meeting the required criteria of this policy two months prior to the last month of the participant's MA certification period. In addition, MIS will mail a recertification package to participants that will include the following:

- Documentation Guide to Continue Your Health Care Coverage (**MAP-2096A**)
- Medicaid/Family Health Plus Renewal Notification (**MAP-2096F**)
- Instructions on How to Recertify/Renew Your Medicaid/Family Health Plus (**MAP-2096H**)
- Terms, Rights and Responsibilities form (**MAP-2096J**)
- Important Information (**M-4f**)
- Case Update Questionnaire Insert (**M-327h**) (Insert)
- Authorization for Reimbursement of Public Assistance Benefits from SSI Retroactive Payment (**W-148A**)
- Business Reply Envelope (**W-68-547**)

The participant will be asked to return the **MAP-2096F**, **MAP-2096J**, **M-327h**, **W-148A** and required documentation by the end of the last month of the MA certification period. All returned documentation/ forms must be attached to the **M-4f**, which serves as a cover sheet for the business reply envelope.

The M-327h serves as contact with the household for PA/FS purposes. There is no adverse action for not returning the **M-327h**.

The **M-327h** is being sent to assess whether or not there are any changes to the PA and/or FS case. However, if the participant does not complete and return the **M-327h**, no adverse action is to be taken on the case.

Tracking and processing returned packages

To facilitate the tracking and processing of the returned MA recertification packages, the following Centers will receive and process returned MA recertification packages for their region/Center:

- Colgate Job Center (#32) – Bronx Region
- St. Nicholas Job Center (#26) – Manhattan Region
- DeKalb Job Center (#64) – Brooklyn Region
- Queens Job Center (#53) – Queens Region
- Richmond Job Center (#99) – Staten Island Region
- Senior Works (#84) – Special Needs Region
- Family Services Call Center (#17) – **Note**: Due to a high number of cases, Center #17 will process only cases from Center 17.

On the 15th of every month, MIS will make available to the Centers on page 2 a report that lists cases that were sent an MA package. The Centers should use this report to track and decontrol returned mailers.

At this time, Centers indicated on page 2 will need to process any actions manually for these cases until such time that the Paperless Office System (POS) can accommodate transactions for this process. The Centers listed will have authorization to process and data enter information for cases outside of their respective Centers. If there are any problems processing cases for other locations, designated staff must call the Office of Systems Operations (OSO) Welfare Management System (WMS) Help Line at (718) 510-0600 for assistance.

This MA process will begin with recertifications scheduled for September 2005.

REQUIRED ACTION

Upon receipt of the returned MA recertification packages, a designated JOS/Worker must:

- date stamp the returned forms;
- annotate the list of cases, indicating the date on which the returned mail was received; and
- forward to the appropriate designated JOS/Worker, who will make the determination of eligibility for ongoing MA assistance.

The designated JOS/Worker, who will determine eligibility for ongoing MA assistance, must:

- review the **M-327h** for any PA and/or FS changes;
- review the **MAP-2096F** for any changes to MA benefits; and
- scan/image the **M-327h**, **MAP-2096F** and the appropriate documentation that was submitted.

No Changes to MA, PA and/or FS Case

If there are no changes to the MA, PA and/or FS case, the designated JOS/Worker must:

- calculate a new budget;
- process a Turn-Around Document (TAD) action to authorize the budget and input the date of MA recertification in Element **218** (MA RCT) of the TAD.

See the sample of LDSS-4014A and **LDSS-4014B** (attachment) for guidance in completing these forms

- complete the Action Taken on Your Recertification: PART A Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services (NYC) (**LDSS-4014A NYC**) as follows:
  - in the Medical Assistance section check "Continue the Medical Assistance coverage for [name(s)] ... unchanged" box and enter the names for those who are being recertified;
  - enter 18 NYCRR Subpart 360-3 in "The above decision(s) is based on" section;
- complete the top section of the Action Taken on Your Recertification: PART B Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services (NYC) (**LDSS-4014B NYC**). Since there are no changes to PA, FS or MA, the JOS/Worker will only need to indicate on page 2 of the **LDSS-4014B NYC** what school-age children are on the case in the "National School Lunch/or Breakfast Programs" section.
- send the **LDSS-4014A NYC** with the **LDSS-4014B** to the participant.

New MA certification period

Note: The new certification period is for 12 months for cases that are recertified. The new certification begins from the first day of the month following the end of the certification period. For example, a case whose MA certification period will end on September 30, 2005, is recertified in August 2005. The new certification period will begin October 1, 2005, and end on September 30, 2006. Unlike PA recertifications, the JOS/Worker will not need to enter these dates in the system or on a notice of eligibility.

Changes to PA, MA and FS Benefits

Upon review of the **MAP-2096F** and **M-327h**, the JOS/Worker must complete a Worker case update on all changes reported that affect all three programs (MA, PA and FS). **Note**: If the change to the MA and PA case causes an increase or decrease in FS benefits, the designated JOS/Worker must process all changes on the case. In this instance because there are budgetary changes, a CNS notice will be generated to inform the participant of all actions taken on the case.

Changes that affect the FS case ONLY

Any changes that are reported that affect the FS part of the case ONLY, other than changes that result in the household's income exceeding the 130-percent poverty level, must be processed if the participant verifies and documents the change.

If the change has not been verified or documented, the JOS/Worker must not process or follow up on the verification/documentation of the change at this time.

Changes in the household's income exceeding the 130-percent poverty level

However, if the change reported results in the household's income exceeding the 130-percent poverty level the JOS/Worker must proceed as follows:

- If the change has already occurred, process the change whether or not documentation/verification has been received. (e.g., Mary Jones reports on the **M-327h** received in September that she is in receipt of earned income of $600 a month as of the middle of August. The JOS/Worker determines that this increase will cause the h/h to exceed the 130-percent poverty level for September and will therefore process a FS case closing for October.)

Follow up action is required by the designated JOS/Worker

- If the change has not occurred (whether or not it has been documented/verified), pend any action on this case at this time. (e.g., Joe Rogers reports on the **M-327h** received in September that, effective the last week in September, he will earn a salary of $350 weekly. The JOS/Worker determines that this salary will result in the h/h exceeding the 130-percent poverty level at the end of October and therefore will pend the case closing for November.)

Note: The designated JOS/Worker must follow up on the case and take the appropriate action once the change occurs.

Nonreceipt of Mailer

If a mailer has not been returned for a case, the JOS/Worker must **ONLY** close the MA part of the case. This action must be made after the last day of the last month of the MA certification period. In this instance, the designated JOS/Worker must:

- prepare a TAD action and, on the case level, input **CL** in Element **240**, code **E12** (Didn't Return Form) in Element **241** and the date of processing in Element **242**;
- complete the **LDSS-4014A NYC** as follows:
  - in the Medical Assistance section check the "Discontinue Medical Assistance for [name(s)]" box and enter the names for whom MA will be discontinued;
  - enter the effective date, which is the last day of the last month of the certification period;

  - enter the following reason: "Didn't Return Medicaid/Family Health Plus Renewal Notification (MAP-2096) form" in the "because" section;
  - in "The above decisions(s) is based on" line, enter 18 NYCRR 360-2.2 (e) and 360-2.3;

- complete the top section of the **LDSS-4014B NYC**. Since there are no changes to PA and FS case, the JOS/Worker will only need to indicate on page 2 of the **LDSS-4014B NYC** what school-age children are on the case in the "National School Lunch/or Breakfast Programs" section.
- send the **LDSS-4014A NYC** and the **LDSS-4014B NYC** to the participant informing him/her of the MA case closing.

Settle In Conference

If a participant comes into his/her home Center with a Notice of Intent (NOI) letter indicating his/her MA case is scheduled to close, the designated JOS/Worker must:

The **MAP-2096F** and **MAP-2096J** are available under MAP Forms on the Medical Insurance and Community Services Administration (MICSA) page on the intranet. Centers can also maintain hard copies of the form.

- have the participant complete the **MAP-2096F**, **MAP-2096J**, **M-327h** and **W-148A**;
- scan/image the completed forms and the appropriate documentation that was submitted;
- stop the closing by issuing a transaction cancellation for the MA portion of the case, if the participant is eligible;
- process all actions reported on the recertification questionnaires as instructed previously;
- complete the Medical Assistance continuance section of the **LDSS-4014A NYC** as described on page 4 and input 18 NYCRR Subpart 360-3 in "The above decision(s) is based on" section;
- complete the top section of the Action Taken on Your Recertification: PART B Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services (NYC) (**LDSS-4014B NYC**). Since, only the MA case would be affected the JOS/Worker will only need to indicate on page 2 of the **LDSS-4014B NYC** what school-age children are on the case in the "National School lunch/or Breakfast Programs" section.
- Send the **LDSS-4014A NYC** along with the **LDSS-4014B NYC** informing the participant of the continuance of MA benefits.

Reopening MA Cases

At this time, there is no set timeframe in which a participant must reopen his/her MA case. If the participant is in receipt of PA and is otherwise eligible, the JOS/Worker can reopen the case.

A JOS/Worker can reopen a closed MA case if the participant comes into his/her home Center to resolve the closing and has been determined to be otherwise eligible. In this instance, the designated JOS/Worker must:

- have the participant complete the **MAP-2096F**, **MAP-2096J**, **M-327h** and **W-148A**;
- scan/image the completed forms and the appropriate documentation that was submitted;
- process an undercare action to reopen the MA case, if eligible, by annotating the TAD as follows:
  - enter the date of recertification in Element **218** (MA RCT)
  - enter **AC** on the suffix level in element **240**; MA Opening Code **094*** (Medical Need – no recent changes in financial circumstances) in Element **241** and the date of the reopening in Element **242** (the Worker should backdate the day to the first day of the month in which the case is being reopened);
  - **AC** the line level for each individual that is being reopened in Element **340**, input MA individual Opening Code **J4*** (Medical Need – no recent changes in financial circumstances) in Element **341** and the date of the reopening in Element **342** (the Worker should backdate the day to the first day of the month in which the case is being reopened);
- process all actions reported on the recertification questionnaires as instructed previously;
- complete the Medical Assistance continuance section of the **LDSS-4014A NYC** as described on page 4 and input 18 NYCRR Subpart 360-3 in "The above decision(s) is based on" section;
- complete the top section of the **LDSS-4014B NYC**. Since the MA part of the case is being reopened, the JOS/Worker will only need to indicate on page 2 of the **LDSS-4014B NYC** what school-age children are on the case in the "National School Lunch/or Breakfast Programs" section.
- Send the **LDSS-4014A NYC** and the **LDSS-4014B NYC** to the participant informing him/her of the MA continuance.

* These codes should be used for cases where there are no changes in income or resources. For cases that have reported changes in income or financial situation and are eligible for medical assistance, the JOS/Worker must consult the WMS Worker's Guide to Codes for the appropriate opening code and citation.

Reopening MA cases with outstanding medical expenses	A closed MA case that consequently has outstanding and unpaid medical expenses and that reapplies for medical assistance and is otherwise eligible, can get up to three months of medical expenses, incurred prior to the month of application, paid. JOS/Workers should refer to PD #01-16 for instructions on how to process these cases.

PROGRAM IMPLICATIONS

Paperless Office System (POS)	Due to system constraints, actions taken on these cases can not be process through POS.
Public Assistance Implications	Although a PA questionnaire is sent to assess any changes, no adverse action can be taken for a questionnaire that has not been returned. For questionnaires that are returned, the JOS/Worker must take action on any reported information.
Food Stamp Implications	Any changes reported that affect the FS part of the case ONLY, other than changes that result in the household's income exceeding the 130-percent poverty level, must be processed if the participant verifies and documents the change. If the change has not been verified or documented, the action must not be processed and no follow-up is needed at this time. If the change results in the household's income exceeding 130-percent poverty level guidelines, see pages 4–5 of this directive for instructions on how to process.
Medicaid Implications	Failure to return the **MAP-2096F** will result in the closing of the MA case only.

LIMITED ENGLISH SPEAKING ABILITY (LESA) IMPLICATIONS	For Limited English Speaking Ability (LESA) applicants, make sure to obtain appropriate interpreter services in accordance with Policy Directive #02-43-OPE.

FAIR HEARING IMPLICATIONS

Avoidance/ Resolution	Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up to date. Remember that applicants/participants must receive either adequate or timely and adequate notification of all actions taken on their case.
Conferences	An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If an applicant/participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the applicant/participant, review the case file and discuss the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker's Supervisor. The AJOS/Supervisor I will explain the reason for the Agency's action(s) to the applicant/participant. If the determination is that the applicant/participant has presented good cause for the infraction or that the outstanding Notice of Intent needs to be withdrawn for other reasons, the FH&C AJOS/ Supervisor I will settle in conference (SIC), enter detailed case notes in NYCWAY and forward all verifying documentation submitted by the applicant/participant to the appropriate JOS/Worker for corrective action to be taken. In addition, if the adverse case action still shows on the "Pending" (**08**) screen in WMS, the AJOS/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (**LDSS-3722**), change the **02** to an **01** if the case has been granted aid continuing (ATC) or prepare and submit a PA Recoupment Data Entry Form (**LDSS-3573**) to delete a recoupment. The AJOS/Supervisor I must complete a Conference Report (**M-186a**). If the determination is that the applicant/participant has not shown good cause for the infraction or that the Agency's action(s) should stand then the AJOS/Supervisor I will explain to the applicant/participant why s/he cannot settle the issue(s) in conference. The AJOS/Supervisor I must complete a Conference Report.

Evidence Packets	Should the applicant/participant elect to continue his/her appeal by requesting or proceeding to a Fair Hearing, already requested, the FH&C AJOS/Supervisor I is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process. All Evidence Packets must contain a detailed history, copies of relevant WMS screen printouts, other documentation relevant to the action taken and copies of NYCWAY "Case Notes" screens.

REFERENCES

18 NYCRR § 387.17
18 NYCRR 360-2.2 (e), 360-2.3
18 NYCRR Subpart 360-3
WMS Worker's Guide to Codes

RELATED ITEM

PD #01-16

ATTACHMENTS

Please use Print on Demand to obtain copies of forms.

Attachment A	Sample of continuing MA assistance on the **LDSS-4014A** and **LDSS-4014B**
MAP-2096A	Documentation Guide to Continue Your Health Care Coverage (Rev. 8/16/02)
MAP-2096F	Medicaid/Family Health Plus Renewal Notification (Rev. 11/13/03)
MAP-2096H	Instructions on How to Recertify/Renew Your Medicaid/Family Health Plus (8/16/02)
MAP-2096J	Terms, Rights and Responsibilities (8/19/02)
M-4f	Important Information (12/22/04)
M-4f (S)	Important Information (Spanish) (12/22/04)
M-327h	Case Update Questionnaire Insert (12/22/04)
M-327h (S)	Case Update Questionnaire Insert (Spanish) (12/22/04)
W-148A	Authorization for Reimbursement of Public Assistance Benefits from SSI Retroactive Payment (12/22/04)
W-148A (S)	Authorization for Reimbursement of Public Assistance Benefits from SSI Retroactive Payment (Spanish) (12/22/04)

Attachment A

LDSS-4014A NYC (Rev. 5/05) **ACTION TAKEN ON YOUR RECERTIFICATION: PART A** PA, MA, FS, Serv-Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

NOTICE DATE: 9.27.05	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE: 064 / DeKalb Job Center, 500 DeKalb Ave, BKlyn NY 11205-9900
CASE NUMBER: 0001234567A / CIN NUMBER: XL20135R	
CASE NAME (And C/O Name if Present) AND ADDRESS: Mr. Nemo Fish, 30 Whitehall St., NYC NY 10030	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP: 718-398-8590
	OR Agency Conference: 718-636-2379
	Fair Hearing information and assistance:
	Record Access:
	Legal Assistance information:

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
064	3	1	Salvo	718.999.9999

The action(s) taken on your recertification dated 9/15/05 is explained below and on Part B, next to the checked box(es) ☑:

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **RECERTIFIED** for the period from _____ to _____.

☐ **REDUCE** your monthly Public Assistance benefit for that period effective _____ from $ _____ to $ _____.

☐ **INCREASE** your monthly Public Assistance benefit for that period effective _____ from $ _____ to $ _____.

☐ **CONTINUE** your Public Assistance benefit unchanged at $ _____.

☐ **A RECOUPMENT** at the rate of _____ percent (%) is being taken against your Public Assistance.
If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d).

☐ **DISCONTINUE** your Public Assistance benefit effective _____.

The **REASON** for this action is _____.

The above decision(s) is based on 18 NYCRR _____.

MEDICAL ASSISTANCE

☒ **CONTINUE** the Medical Assistance coverage for [name(s)] Nemo, Flounder and Whiting Fish unchanged.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____ pending our review of eligibility. We will send you our decision within thirty days.

☐ **REDUCE** the Medical Assistance coverage effective _____ for [name(s)] _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____. Your total monthly deductions are $_____. The difference between these is your monthly net income for Medical Assistance. This is $ _____. The allowable income standard for a family household your size is $ _____. The difference between your net income and this standard ($_____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program.

☐ **DISCONTINUE** Medical Assistance for [name(s)] _____ effective _____ because _____

☐ Medical Assistance coverage will continue under Transitional Medical Assistance (See attached Medical Assistance Fact Sheet).

☐ Medical Assistance coverage will continue until _____ due to receipt of/increase in child or spousal support payments.

The above decision(s) is based on 18 NYCRR Subpart 360-3

SERVICES – If you are getting Social Services and lose your Public Assistance and Medical Assistance Benefits, we will need to see if you still can get Social Services at your next scheduled recertification. This does not necessarily mean that you will no longer be able to get Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any questions, please contact your Services worker or call the general phone number at the top of this notice.

BE SURE TO READ THE BACK OF PART B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

Enclosure

DISTRIBUTION: White -CLIENT/FAIR HEARING COPY Yellow – CLIENT COPY Pink – AGENCY COPY

NAME:	ADDRESS:	CASE NUMBER:
Nemo fish	30 Whitehall st	00123456 7 A

☑ Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

For further information, please contact your Services worker or call the general phone number on the front of this notice.

☑ If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.

☑ Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.

☑ Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4014B NYC (Rev. 5/05) **ACTION TAKEN ON YOUR RECERTIFICATION: PART B** PA, MA, FS, Serv Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

NOTICE DATE: 9.27.05	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE: 064 DeKalb Job Center, 500 DeKalb Ave. BKlyn NY 11205-9900
CASE NUMBER: 00001234567A / CIN NUMBER: XL20135R	
CASE NAME (And C/O Name if Present) AND ADDRESS: Mr. Nemo fish, 30 Whitehall St. NYC NY 10030	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP: 718.398.8570
	OR Agency Conference: 718.636.2379
	Fair Hearing information and assistance:
	Record Access:
	Legal Assistance information:

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
064	3	1	Salvo	718.999.9999

The action(s) taken on your recertification dated 9/15/05 is explained below and on Part A, next to the checked box(es) ☑: **SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE, AND SERVICES INFORMATION.**

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED

☐ **APPROVED** for continued Food Stamp Benefits from _____ to _____.

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:

   1a. ☐ The date you applied to the end of the month. You may access your benefit on _____

   1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____.

2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____. This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $_____ is for the entire month. You may access your combined benefit on _____.

3. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.

   3a. ☐ You will continue to get the benefit above until _____. This is because you are eligible for Transitional Food Stamp Benefits. You are not required to report any changes until the end of this transition period. If you have changes during your transition period that may increase your benefits, you must contact your worker to file an early recertification application in order to receive any increase. Early recertifications that result in a benefit increase will end your transition period, otherwise, your transitional period and benefit will continue as described above.

4. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide:

   _____

   _____

   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.

6. ☑ If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits.

7. ☐ Other information: _____

   _____.

☐ **DENIED** for Food Stamp Benefits because: _____

_____.

☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed on the above lines by _____, you will not have to reapply. After that date, you will have to reapply for benefits.

☐ **OTHER**: _____

_____

☐ **OVERPAYMENT INFORMATION**

☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**

☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

☐ The benefit in Section 3 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

☐ The benefit in Section 4 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

The above decision(s) is based on 18 NYCRR: _____

BE SURE TO READ THE BACK OF THIS NOTICE FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

Enclosure

DISTRIBUTION: White -CLIENT/FAIR HEARING COPY Yellow – CLIENT COPY Pink – AGENCY COPY

LDSS-4014B NYC (Rev. 5/05) (Part B) Reverse | PART B – NYC | PA, MA, FS, Serv Recert - Timely – A/C No FS

NAME: Nemo Fish	ADDRESS: 30 Whitehall st.	CASE NUMBER: 00123456 7A

National School Lunch/or Breakfast Programs - The child(ren) listed below are approved to receive free lunch and/or breakfast if he or she attends a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a copy of this notice to the school that your child attends.

This notice also entitles your child(ren) to free meals if they attend a program such as a school, club or camp that participates in the Summer Food Service Program. Make a copy for your records so you can provide it to the sponsor.

List Child(ren)'s name(s):

☑ Responsibility To Report Changes – See enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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.

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 the following number of days from the date of this notice to ask for a fair hearing:

BENEFIT AREA	TIME LIMIT
Public Assistance, Medical Assistance, Social Services	60 days
Food Stamp Benefits	90 days

If this notice is telling you that you owe a Public Assistance overpayment, and if you do not agree that you owe this overpayment, you must call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

KEEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance, Medical Assistance and Social Services 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, even if you ask for a fair hearing, your Food Stamp Benefits **cannot be continued in the same amount as** before your recertification, but will be in the new amount shown in this notice. If you lose the fair hearing, you will have to pay back any Public Assistance benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

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

I do not want to "keep my benefits the same" until the Fair Hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

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 **Part A and Part B** 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 of each notice 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 or 330 West 34th Street, NYC.

Online: Complete an online request form at: **http://www.otda.state.ny.us/oah/forms.asp**

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

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

At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your file that we will provide the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your file that you think you may need to prepare for your Fair Hearing. To ask for documents or to find out how to look at your file, call **(718) 722-5012**, fax **(718) 722-5018** or write to **HRA Division of Fair 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.

DOCUMENTATION GUIDE TO CONTINUE YOUR HEALTH CARE COVERAGE

Here is a list of documents that the Medical Assistance Programs accept. Please review the enclosed "Instructions Letter" to determine what documents you need to provide in order to continue health care coverage.

PROOF OF INCOME: The following documents are proof of income.

Wages and Salary
- Current paycheck/stub(s)
- Letter from employer
- Payroll records

Self Employment
- Signed income tax return and statement
- Records of earnings and expenses

If you cannot get proof of income because you are paid in cash, your employer will not provide proof or other such issue, fill out the **"Declaration of Income"** form. If you have no income, but are being supported by someone else, have the person fill in the **"Declaration of Support"** form.

Unemployment Benefits
- Award Letter/certificate
- Benefit check
- Letter from NYS Department of Labor

Social Security
- Award Letter/certificate
- Benefit check
- Letter from Social Security Administration

Child Support/Alimony
- Letter from person providing support
- Letter from court
- Child support/alimony check stub

Worker's Compensation
- Award Letter
- Check stub

Income from Rent or Room/Board
- Letter from roomer, boarder, tenant
- Check stub

Military Pay
- Award Letter
- [illegible] stub

Veteran's Benefits
- Award Letter
- Benefit check
- Letter from Veterans' Administration

[illegible]/Dividends/Ro[illegible]
- Letter from bank or credit union
- Letter from broker
- Letter from agent

Private Pensions/Annuities
- Statement from pension/annuity

CITIZENSHIP OR CURRENT IMMIGRATION STATUS: The following documents are proof of citizenship or immigration status.

- Birth certificate showing U.S. citizenship
- U.S. baptismal certificate
- U.S. passport
- Official U.S. hospital/doctor records
- Naturalization certificate
- Green Card (make copies of both sides because date of entry is sometimes on the back of the card)
- Letter from INS showing status and if necessary, date of entry into the U.S.

RESIDENCY/HOME ADDRESS: The following documents are proof of New York City residency.

- Postmarked envelope, postcard or magazine label with name and date
- ID card with address
- Drivers license issued within past 6 months
- Utility bill (gas, electric, cable), bank statement, or letter from government agency which contains name and home address (not a P.O. Box)
- Letter, lease, rent receipt (with home address) from landlord
- Property tax records or mortgage statement

CHILD CARE/DEPENDENT CARE: The following documents are proof of child care/dependent care expenses. Documents must include the amount you pay and how often.

- Letter from day care center or other child/adult care provider
- Canceled checks or receipts that prove payment of care services

PREGNANCY

- Statement from doctor/medical professional with expected date of delivery

PRIVATE HEALTH INSURANCE: The following documents are proof of private health insurance coverage. Documents must include the amount you pay.

- Insurance policy
- Certificate of insurance
- Insurance card
- Other proof of private insurance

WE ACCEPT PHOTOCOPIES OF ANY DOCUMENT.

(Vea asta notificacion en Espanol a la vuelta)

LA GUÍA DE LA DOCUMENTACIÓN PARA CONTINUAR SU FONDOS DE CUIDADO DE SALUD

Aquí está una lista del los documentos que los Programas de Asistencia Médica aceptan. Por favorec repase " La Carta del las Instrucciones" en el adjuntoel para determinar qué documentos usted necesita para mostrar para continuar los fondos del cuido de salud.

PRUEBA DE INGRESO Los siguientes documentos son prueba del ingreso.

El Sueldo y Salario
- El cheque/talones
- Una carta del patrón
- El archivo de las nóminas

El Empleo-propio
- El retorno del impuesto del ingreso & la declaración firmada
- Los archivos de las gananciases y gastos

Si usted no puede conseguir ninguna prueba de ingreso porque usted le pagan en efectivo,su patrón no tiene ninguna prueba que proporcionarle u otro tal problema, rellene la forma de **"Declaración de Ingreso"**. Si usted no tiene ingreso y esta siendo mantenida por otra persona, favor perdirle a esa persona que llene el formulario **"Declaración de Mantenimiento"**.

Los Beneficios del Desempleo
- Carta de premio /certificado
- El cheque de beneficio
- La carta del Deparamento de Labor de NYS

El Seguro Social
- La carta de premio /certificado
- El cheque de beneficio
- La carta del la Administración del seguro social

La Manutención de Niño/Pensión
- La carta de la persona que proporciona el apoyo
- La carta de la corte
- El talon de la pensión

La Compensación del Obrero
- La Carta del premio
- El talón del cheque

El Ingreso de la Renta o Room/Board
- La carta del inquilino, el pensionista, el arrendatario
- El El talón del ch[illegible]e

Pago Militar
- La Carta del premio
- El ta[illegible]equ

Los Beneficios del Veterano
- La Carta del prem[illegible]
- El talón del cheque de beneficio
- La correspondencia de la Admi nistración de Veteranos

[illegible]se dividendos derechos
- [illegible]a c[illegible]a del banc[illegible]unión de [illegible]édito
- La carta del corredor
- La carta del agente

Pensiones Privadas/Anualidades
- La declaración de la pension/anualidad

LA CIUDADANÍA O EL ESTADO DE INMIGRACIÓN ACTUAL Los documentos siguientes son prueba de la ciudadanía o del estado inmigración.

- El Certificado de nacimiento mostrando la ciudadanía Americana
- El certificado bautismal Americano
- El pasaporte Americano
- Los archivos oficiales del hospital/doctor Americanos
- El certificado de la naturalización
- La Green Card (haga copias de ambos lados porque la fecha de entrada a veces está en la parte de atrás de la tarjeta)
- La carta de la INS que muestra el estado y si es necesario, la fecha de la entrada a EE.UU.

RESIDENCIA/DIRRECCION DE HOGAR Los documentos siguientes son prueba de la residencia en la Ciudad de Nueva York.

- El sobre marcado con fecha, tarjeta postal o la etiqueta de una revista con el nombre y la fecha
- La tarjetas de ID con la dirección
- La licencia de chóferes emitida dentro los pasados 6 meses
- La factura de las utilidades (el gas, eléctrico, el cable), el estado del las cuentas banquearias,o la carta de la agencia gubernamental que contiene su nombre y dirección de la casa (ningún P.O. Box)
- Una carta, el arriende, el recibo de la renta (con la dirección de la casa) del propietario
- Archivos del impuesto de la propiedad o la declaración de la hipoteca del la

EL CUIDO DEL NIÑO/DEPENDIENTE Los documentos siguientes son pruebas de los gastos del cuido de niño/dependiente. Los documentos deben incluir la cantidad que usted paga y quan a menudo.

- La carta del centro del cuidado diario o de otro proveedor
- Los cheques cancelados o recibos que muestran pago de los servicios de cuido

EL EMBARAZO

- La carta del doctor/professional medico con la esperada fecha de nacimiento

SEGURO DE SALUD PRIVADO Los documentos siguientes son prueba de la cubertura del seguro privado de salud. Los documentos deben incluir la cantidad que usted paga.

- La póliza de seguro
- El certificado del seguro
- La tarjeta del seguro
- Otra prueba de seguro privado

NOSOTROS ACEPTAMOS FOTOCOPIAS DE CUALQUIER DOCUMENTO.

(Turn over to see this Notification in English)

Location: _____
Notice Date: _____
Case Number: _____
Number of Adults: _____
Number of Children: _____
Priority: _____
Telephone Number: _____

Medicaid/Family Health Plus Renewal Notification

Dear Consumer:

It is time for us to review your case to see if you can keep getting Medicaid/Family Health Plus. **You do not have to come for an interview. You can now do your renewal by mail.** Please follow these steps:

1. Look at the mailing address and telephone number above and all the information below, including the address where you live printed on the last page. If something is wrong or has changed, write in changes in the blank space. Check each "No Change" box where there is no change.
2. You must send proof of all income/support. You must also send proof if someone is pregnant, or if someone new is applying, or for a change of address, or for current child care or disabled adult care expenses. Collect all the proofs that we need.
3. USE THE "INSTRUCTIONS" FORM ON THE FRONT OF THIS BOOKLET TO HELP YOU FILL OUT THIS FORM. THEN SIGN THIS FORM AND THE "TERMS, RIGHTS, AND RESPONSIBILITIES" FORM AND MAIL THEM ALONG WITH ALL THE PROOFS IN THE ENVELOPE WE HAVE SENT YOU.

YOUR MEDICAID/FAMILY HEALTH PLUS MAY END IF WE DO NOT RECEIVE YOUR RESPONSE BY _____.

I.	Household Members	Date of Birth	Sex (M/F)	Social Security Number	Citizenship Status	No Change
01.						☐
02.						☐
03.						☐
04.						☐
05.						☐
06.						☐
07.						☐
08.						☐
09.						☐
10.						☐
11.						☐
12.						☐

☐ **x** indicates additional household members are on the case.

CONTINUE TO ANSWER QUESTIONS ON ALL PAGES.
Sign and return this Notification, the "Terms, Rights, and Responsibilities," and all proofs.

Adding New Household Members Who Are Applying for Medicaid/Family Health Plus. If not a U.S. citizen, send us proof of citizen/immigration status. Pregnant women do NOT need to send us proof of citizen/immigration status or a Social Security number.

Name	Date of Birth	Sex (M/F)	Social Security Number	U.S. Citizen? (Y/N)	Relationship to Household Member (check one box for each new member)			
					Child	Spouse	Parent/ Stepparent	Other Adult Responsible for Child (tell us relationship)
		☐		☐	☐	☐	☐	☐
		☐		☐	☐	☐	☐	☐

II.

Income Type	How Often	Income Amount	No Change
			☐
			☐
			☐

III.

Other Health Insurance Type	Premium Amount	No Change
		☐
		☐

IV.

Resource Type	Total Value Amount:	No Change
		☐

V. **Address Where You Live** No Change ☐

Street Name: _____
Address Line 1

_____
Address Line 2

_____ _____ _____
City State Zip Code

Housing/Rent Payment: _____ How Often: _____ No Change ☐

VI. Childcare Expense: _____

How Often: _____ No Change ☐

VII. Is anyone blind, disabled, or handicapped, or does anyone have a chronic illness or a special health care need? ☐

Name: _____

VIII. Do you have expenses for the care of a disabled adult? ☐

How much: _____ How often: _____

IX. Is anyone pregnant? ☐

Name: _____ Expected date of delivery: _____

X.

Does any household member have a spouse or parent who can provide health insurance for them?

☐ **If yes, please provide:**

Name of spouse or parent: _____

House Number and Street Name: _____

_____ _____ _____
City State Zip Code

Name of related household member: _____

XI. **Other People in Your Household**

Number of people in household who are NOT applying (count the person only if s/he is a parent, stepparent, spouse, or child under 21 of someone applying):

None ☐ 1 ☐ 2 ☐ 3 ☐ Other: _____

_____ _____
Signature of Consumer or Representative Date

_____ _____
Signature of Other Adult in Household (if renewing/applying) Date

If you need help with this letter, call 1-888-692-6116, or call one of the places on the List of Facilitated Enrollers.
Si usted necesita ayuda con esta carta, llame al 1-888-692-6116, o llame a cualquiera de los lugares que aparecen en la Lista de Facilitated Enrollers.
Si ou besoin aid avec le't ca, re'le' numero ca a 1-888-692-6116, ou soi re'le' oune dans cote' ca yo qui dans liste de enrolleurs facilitateur ca yo.
Если Вам нужна помощь с этим письмом, позвоните по телефону 1-888-692-6116 или позвоните в одно из мест согласно Списку «Facilitated Enrollers».
如果你需要關于這封信的幫助，请电 1-888-692-6116，或联络 **Facilitated Enrollers** 目錄上其中的一个地点

INSTRUCTIONS ON HOW TO RECERTIFY/RENEW YOUR MEDICAID/FAMILY HEALTH PLUS

It is time for the Human Resources Administration to see if you can keep getting Medicaid/Family Health Plus (Medicaid includes Child Health Plus A). To keep your health coverage, you must fill out and send in the **"Medicaid/Family Health Plus Recertification/Renewal Notification"** form along with the proofs we ask for. Even if you go to one of the organizations on the List of Facilitated Enrollers for help, it is still your responsibility to make sure we receive the form and proofs by the date shown. **If we do not receive the form and proofs, your Medicaid/Family Health Plus may end.**

To recertify/renew your Medicaid/Family Health Plus:

1. Read the information about your household that is printed on the Notification form and write in any changes. If your address has changed, please send a copy of something with your new address on it.
2. Get all the proofs we ask for. To find out more about proofs, read below and refer to the Documentation Guide.
3. Mail the form, proofs, and the signed "Terms, Rights, and Responsibilities" form to us.

Address

- If you get mail at a different address than where you live, check the mailing address at the top of the form and the address where you live on the back of the form, and make sure both are right.

Section I—Household

Social Security N mbe

- If the Social Secu mber olu n st s S y N b for y perso erson must provide their Social Security n ber.
- If you do not hav al ecurity m r b au of ur immig tu ur most recent letter or paper from the Immigration and Naturalization Service (INS).
- If you are pregnant, you do not need to give us your Social Security number.

Citizenship Status

- For each person with a * in this column, send proof of current citizenship/immigration status.
- If there is a change in citizenship or immigration status for anyone on the form, send the most recent letter or paper from the INS.
- If you are pregnant, you do not need to submit proof of current immigration status.

Adding and Removing a Name

- If you want to add a household member to the case, fill in the information in each column of Section I, send proof of their current citizenship/immigration status, and include their information in every section of the form. If there is not enough space, use a separate paper.
- If you are adding a pregnant woman, you do not need to provide a Social Security number or resources information. If you are adding a person under 19, you do not need to provide resources information.
- If anyone has **left** the household, cross out that person's name.

Section II—Income

List all income of each kind for all members of the household. Send one proof for every kind of income.

- If your last pay-stub is what you usually earn, send a copy of that pay-stub. If your income changes from week to week, send copies of your last four (4) pay-stubs.
- If you do not have pay-stubs, send another kind of proof (like payroll records or a letter from the employer).
- If you cannot get proof because you are paid in cash and your employer will not provide proof, fill out the "Declaration of Income" form.
- If you have no income and someone else supports you, have them fill out the "Declaration of Support" form.
- If you are self-employed, send a copy of your most recent tax return and send a signed statement that your income has not changed or explain how it has changed.

Section III—Other Health Insurance

- If a member of your household has other health insurance, write this information in the "Health Insurance Type" section.
- If you are paying for Medicare Part B, write it here.

Section IV—Resources

- List all current resources (like stocks, bonds, bank accounts, life insurance, and real estate).
- If you are pregnant or under 19, you do not need to list your resources.

Sections VI-IX—Child Care Expenses, Disability, Disabled Adult Care Expenses, and Pregnancy

- Send proof **of any changes** in these sections and identify the people who are new to a category.

Send the signed recertification/renewal form and all proofs in the stamped envelope.

(Vea esta notificacion en Espanol a la vuelta)

If you need help with this letter, call 1-888-692-6116, or call one of the places on the List of Facilitated Enrollers.
Si usted necesita ayuda con esta carta, llame al 1-888-692-6116, o llame a cualquiera de los lugares que aparecen en la Lista de Facilitated Enrollers.
Si ou besoin aid avec le't ca, re'le' numero ca a 1-888-692-6116, ou soi re'le' oune dans cote' ca yo qui dans liste de enrolleurs facilitateur ca yo.
Если Вам нужна помощь с этим письмом, позвоните по телефону 1-888-692-6116 или позвоните в одно из мест согласно Списку «Facilitated Enrollers».
如果你需要關于這封信的幫助，请电 1-888-692-6116，或联络 **Facilitated Enrollers** 目錄上其中的一个地点

INSTRUCCIONES SOBRE CÓMO RECERTIFICAR / RENOVAR SU MEDICAID/FAMILY HEALTH PLUS

Es hora de que la Administración de Recursos Humanos vea si usted puede seguir recibiendo el Medicaid/Family Health Plus (Medicaid incluye el Child Health Plus A). Para mantener su cobertura de salud, usted debe completar y enviar el formulario **"Notificación de Recertificación / Renovación del Medicaid/ Family Health Plus"** junto con las pruebas que le estamos pidiendo. Aun cuando usted vaya a cualquiera de las organizaciones que aparecen en la Lista de Facilitated Enrollers para buscar ayuda, sigue siendo su responsabilidad asegurarse de que recibamos el formulario y las pruebas para la fecha indicada. **Si no recibimos el formulario y las pruebas, su Medicaid/Family Health Plus puede terminarse.**

Para recertificar / renovar su Medicaid/Family Health Plus:

1. Lea la información sobre su hogar que aparece impreso en el formulario de la Notificación y escriba cualquier cambio. Si su dirección ha cambiado, por favor envíe una copia de algo donde aparezca su nueva dirección.
2. Consiga todas las pruebas que le pedimos. Para averiguar más detalles sobre las pruebas, lea debajo y refiérase a la Guía de la Documentación.
3. Envíenos por correo el formulario, las pruebas, y el formulario "Condiciones, Derechos, y Responsabilidades" firmado.

Dirección

- Si usted recibió el correo a una dirección diferente de la que tenemos, verifique la dirección de correos en la parte superior del formulario y la dirección de su hogar que aparece en la parte de atrás del formulario y asegúrese que ambos estén correctos.

Sección I—Hogar

El número de seguro social

- Si la columna del número de seguro social dice "Proporcione el Número" para cualquier persona, esa persona debe proporcionar su número de seguro social.
- Si usted no tiene un número de seguro social debido a su estado de inmigración, envíe la más reciente carta o papel recibido del Servicio de Inmigración y Naturalización (SIN).
- Si usted está embarazada, no necesita darnos su número de seguro social.

Estado de Ciudadanía

- Para cada persona con un * en esta columna, envíe prueba del estado de ciudadanía / inmigración actual.
- Si hay algún cambio en la ciudadanía o en el estado de inmigración para cualquier persona en el formulario, envíe la más reciente carta o papel recibido del SIN.
- Si usted está embarazada, no necesita enviar prueba del estado de inmigración actual.

Agregar y Quitar un Nombre

- Si usted quiere agregar a un miembro de su hogar al caso, complete la información en cada columna de la Sección I, envíe prueba del estado de ciudadanía / inmigración actual de dicho miembro, e incluya su información en cada sección del formulario. Si no hay suficiente espacio, use otro papel.
- Si usted está agregando a una mujer embarazada, no necesita proporcionar su número de seguro social ni la información sobre los recursos. Si usted está agregando a una persona menor de 19 años, no necesita proporcionar la información sobre los recursos.
- Si alguien ha abandonado el hogar, tache el nombre de esa persona.

Sección II—Ingresos

Liste todo tipo de ingreso para todos los miembros del hogar. Envíe una prueba para cada tipo de ingreso.

- Si su último talón de pago muestra lo que usted normalmente gana, envíe una copia de ese talón. Si su ingreso cambia de semana a semana, envíe copias de sus últimos cuatro (4) talones.
- Si usted no tiene los talones, envíe otro tipo de prueba (como archivos de nómina o una carta del empleador).
- Si usted no puede conseguir prueba porque se le paga en efectivo y su empleador no proporcionará la prueba, complete el formulario " Declaración de Ingresos".
- Si usted no tiene ningún ingreso y alguien lo mantiene, hágale completar el formulario " Declaración de Sustento".
- Si usted es empleado por cuenta propia, envíe una copia de su más reciente Declaración de Impuestos y envíe una declaración firmada afirmando que su ingreso no ha cambiado o explique cómo ha cambiado.

Sección III—Otro Seguro de Salud

- Si un miembro de su hogar tiene otro seguro de salud, escriba esta información en la sección " Tipo de Seguro de Salud".
- Si usted está pagando Medicaid Part B, escríbalo aquí.

Sección IV—Recursos

- Liste todos los recursos actuales (como las acciones, bonos, cuentas de banco, seguros de vida y bienes raíces).
- Si usted está embarazada o es menor de 19 años, no necesita listar sus recursos.

Secciones VI-IX— Gastos del Cuidado de Niños, Invalidez, Gastos de Cuidado de Adultos Inválidos, y Embarazo

- Envíe prueba de **cualquier cambio** en estas secciones e identifique las personas que son nuevas en alguna categoría.

Envíe el formulario de recertificación / renovación firmado y todas las pruebas en el sobre sellado.

(Turn over to see this notification in English)

SIGN AND MAIL THIS FORM TO US

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid, Family Health Plus, or Child Health Plus A. I understand that I must provide the information needed to prove my eligibility for each program. I agree to immediately report any changes to the information on this form. If I am unable to get the information, I will tell the social services district. The social services district may be able to help in getting the information.

- Even if I go to one of the organizations on the List of Facilitated Enrollers for help, it is still my responsibility to make sure the social services district receives the form and proofs by the required date.

- I understand that workers from the programs for which family members or I are renewing may check the information given by me on this form. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

- I understand that Medicaid, Family Health Plus, and Child Health Plus A will not pay medical expenses that insurance or another person is supposed to pay, and that I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits. I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.

- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.

- I understand that if my child is on Child Health Plus A, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program.

- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Taxation and Finance has the right to review income information on this form.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS: I certify under penalty of perjury, by signing my name on this form, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the Immigration and Naturalization Service for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid, Child Health Plus A and Family Health Plus programs.

SOCIAL SECURITY NUMBER: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient.

RELEASE OF MEDICAL INFORMATION: If I am enrolled in a Medicaid or Family Health Plus Managed Care Plan, I consent to my Primary Care Provider and any hospital, licensed physician, other health care provider or the New York State Department of Health (SDOH) giving my health plan and any providers in the plan that provide treatment to me and family members for whom I can give consent, any medical information about me/family members that is reasonably necessary to manage my/our care. This information includes HIV or alcohol and substance abuse information about me and/or members of my family for whom I can consent. I know that my consent will expire when my benefits end and the payment process is complete. I know and agree that my health plan and the providers in my health plan can share my medical records and other information regarding treatment provided to me through the plan, such as provider billing records, with SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid and/or Family Health Plus program(s). The signature of each adult joining a health plan is necessary for consent of release of information.

RELEASE OF EDUCATIONAL RECORDS: I give permission to the Local Department of Social Services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

EARLY INTERVENTION PROGRAM: If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local Department of Social Services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

I consent to sharing this information with any school-based health center that provides services to the applicant(s).

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand these Terms, Rights and Responsibilities. I certify under penalty of perjury that everything on this application is the truth as best I know.

Signature of Applicant or Representative: _____ Date _____

Signature of Spouse (if applying) : _____ Date _____

FIRME Y MANDE POR CORREO ESTE FORMULARIO

LAS CONDICIONES, DERECHOS Y RESPONSABILIDADES

Completando y firmando esta forma, yo estoy aplicando para renovar Medicaid, Family Health Plus, o Child Health Plus. Yo entiendo que debo proporcionar la información que necesito para demostrar mi elegibilidad para cada programa. Yo estoy de acuerdo en informarle de cualquier cambio a la información en este formulario inmediatamente. Si yo soy incapaz de conseguir la información, le diré al distrito de servicios sociales. El distrito de servicios sociales podrá ayudarle a conseguir la información.

- Aun cuando yo vaya a una de las organizaciones en la Lista de Enrollers Facilitados para ayuda, todavía es mi responsabilidad para asegurar que el distrito de servicios sociales reciba el formulario y las pruebas en la fecha requerida.

- Yo entiendo que los obreros de los programas en cual mis familiares o yo estamos renovando pueden verificar la información dada por mí en este formulario. Las agencias que ejecutan estos programas guardarán esta información confidencial según 42 U.S.C. 1396a (a) (7) y 42 CFR 431.300-431.307, y cualquier leyes federales y estatales y regulaciones.

- Yo entiendo que Medicaid, Family Health Plus, y Child Health Plus A no pagarán los gastos médicos que el seguro o otra persona se supone que pague, y que yo le estoy dando a la agencia todos mis derechos para perseguir y recibir el apoyo médico de un esposo o padres de personas bajo 21 años de edad y mi derecho para perseguir y recibir pagos de un tercer partido durante el tiempo completo que yo estoy recibiendo los beneficios. Yo archivaré cualquier demanda de los beneficios de seguro de salud o accidente o cualquier otros recursos que me titulen. Yo entiendo que yo tengo el derecho para exigir la buena causa para no cooperar usando seguro de salud si su uso pudiera causar daño a mi salud o seguridad o a la salud y seguridad de alguien de quien yo soy legalmente responsable.

- Yo entiendo que mi elegibilidad para estos programas no será afectada por mi raza, color, u origen nacional. Yo también entiendo que dependiendo de los requisitos de estos programas individuales, mi edad, sexo, invalidez o estado de ciudadanía pueden ser un factor en si o no yo soy elegible.

- Yo entiendo que si mi niño está en Child Health Plus A, el o ella puede conseguir el cuido primario comprensivo y el cuido preventivo, incluso todo el tratamiento necesario a través del Child/Teen Health Program.

- Yo entiendo que cualquier que a sabiendas mienta o esconda la verdad para recibir los servicios bajo estos programas está cometiendo un crimen y sujeto a las [illegible] federales, estatales y [illegible] que [illegible] la cantidad de beneficios recibida y puede pagar multas civiles. El Departamento de Impuestos y Finanzas [illegible] New York [illegible] derecho de [illegible] la información de los ingresos en este formulario.

LA CERTIFICACIÓN DE [illegible] DE CIUDADANÍA/INMIGRACIÓN: yo certifico [illegible] jurio, firmando mi nombre en esta forma que yo, y/o cualquier persona para quien yo estoy firmando es ciudadano americano o nacional de los Estados Unidos o tiene el estado de inmigración satisfactorio. Yo entiendo que se someterá información sobre mí a los Servicios de Inmigración y Naturalización para la comprobación de mi estado de inmigración, si aplica. Yo tambien entiendo que el uso o descubrimiento de información sobre mí será restringida directamente a las personas y organizaciones conectadas con la comprobación de el estado de inmigración y la administración responsable de la entrega de los comestibleses del Medicaid, la Child Health Plus A y los programas de Family Health Plus.

EL NÚMERO DEL SEGURO SOCIAL: Se requieren SSNs para todos los solicitantes, a menos que la persona está embarazada o sea un forastero no-calificado. No se requieren SSNs para los miembros de mi hogar que no están solicitando los beneficios. Yo entiendo que esto se requiere por la Ley Federal a 42 U.S.C. 1320b-7 (a) y por las regulaciones de Medicaid a 42 CFR 435.910. Los SSNs se usan de muchas maneras, ambos dentro de la Sección de Servicios Sociales (DSS) y entre el DSS y las agencias federales, estatales y locales, ambas en New York y otras jurisdicciones. Algunos usos de SSNs son: para verificar la identidad, identificar y verificar los ingresos ganados de los no ganados, para ver si los padres que no custodian pueden recibir cubertura de seguro de salud para los solicitantes, para ver si los solicitantes pueden conseguir el apoyo médico, y para ver si los solicitantes pueden conseguir dinero u otras ayudas. SSNs también puede ser usados para la identificación del recipiente dentro y adentro de las agencias gubernamentales centrales del Medicaid para asegurarse que los servicios apropiados estén hechos disponibles al recipiente.

EL DESCARGO DE INFORMACIÓN MÉDICA: Si yo me matriculo en un Medicaid o un Family Health Plus Managed Care Plan, yo consiento a mi Proveedor de Cuido Primario y cualquier hospital, médico autorizado, otro proveedor de cuido de salud o el Departamento de Salud el Estado de New York (SDOH) dando mi plan de salud y cualquier proveedor en el plan que proporciona el tratamiento a mi y los familiares para quien yo puedo dar el consentimiento, cualquier información médica sobre mi o mi familia que sea bastante necesario para el manejo del cuido mio o de ellos. Esta información incluye VIH o el abuso mio o de otras personas de la qual yo puedo dar el consentimiento sobre el alcohol o otras substancias. Yo sé que mi consentimiento expirará cuando mis beneficios se acaben y se complete el proceso del pago. Yo sé y estoy de acuerdo que mi plan de salud y los proveedores en mi plan de salud pueden compartir mis archivos médicos y otra información con respecto a tratamiento proporcionado a mí a través del plan, como los archivos de factura del proveedor, con SDOH y otras agencias federales, estatales, y locales que estén autorizadas para los propósitos de administración del Medicaid y/o los Programas de Family Health Plus. La firma de cada adulto que se va a unir a un plan de salud es necesario para el consentimiento del descargo de información.

EL DESCARGO DE ARCHIVOS EDUCATIVOS: Yo doy el permiso a el Departamento de Servicios Sociales Local y al Estado de New York para obtener cualquier información con respecto a los archivos educativos de mis hijos, nombrados aquí dentro, necesario para exigir los reembolsos de Medicaid para los servicios educativos relacionados con la salud, y para mantener el acceso a esta información a la agencia del gobierno federal apropiada para el propósito de auditoría solamente

EL PROGRAMA DE LA INTERVENCIÓN TEMPRANO: Si mi hijo está evaluado para o participa en el Programa de Intervención Temprano del Estado de New York , yo doy el permiso al Departamento de Servicios Sociales Local y al Estado de New York para compartir la información de elegibilidad del Medicaid de mi hijo con el Programa de la Intervención Temprano de mi condado para el propósito de facturar al Medicaid.

Yo consiento a compartir esta información con cualquier centro de salud basado en la escuela que proporcione los servicios al aplicante.

Firmando esta forma, yo entiendo que cada persona listada se matriculará en el programa apropiado, si es elegible. Yo también he leído y he entendido estas Condiciones, Derechos y Responsabilidades. Yo certifico bajo la multa de perjurio que todo en esta aplicación es la verdad a mi mejor entender

Firma del Aplicante o Representante: _____ Date: _____

Firma del Esposo o Esposa si También esta aplicando: _____ Fecha: _____

Form M-4f LLF/MLF
12/22/04

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

IMPORTANT INFORMATION

Please complete and sign the enclosed forms that need to be returned to the Center. Attach the forms and all required documents to this cover letter.

Then fold and place this cover letter with the attached forms and documents face up in the envelope so that the return address on this cover letter (shown above) shows through the envelope's window.

This will ensure that the Center receives your paperwork and can process it immediately.

Thank you!

Form M-4f (S) LLF/MLF
12/22/04

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____

INFORMACIÓN IMPORTANTE

Favor de llenar y firmar los formularios adjuntos que tienen que ser devueltos al Centro. Adjúntelos a esta carta y a todos los documentos requeridos.

Luego doble la carta con los formularios y los documentos adjuntos de manera que la dirección de la carta (que aparece más arriba) se vea a través de la ventanilla del sobre.

Esto asegurará que el Centro reciba sus documentos y pueda procesarlos inmediatamente.

¡Gracias!

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Case Update Questionnaire (M-327h) Insert

We are updating our information about your public assistance and Food Stamp case. Please complete, sign, date and return this form along with your medical assistance recertification application (Medicaid/Family Health Plus Recertification/Renewal Notification form [**MAP 2096F**]). Enclose photocopies of documentation verifying the changes you report.

1. Do you still need (any benefit you check "No" to will be stopped):
   Public Assistance? ☐ No ☐ Yes Food Stamps? ☐ No ☐ Yes

2. Did anyone move into or out of your household since the last time you reported the number of persons in your household (including births)? ☐ No ☐ Yes
   If yes, provide the information requested below. If reporting a newborn enclose a photocopy of a birth certificate for verification.

Social Security Number	Name	Moved In	Moved Out	Date

3. Other than public assistance, did you, or anyone in your household, begin receiving any new or increased income from any of the following sources since the last time you reported your income?
   If you check ☑ "yes," indicate the amount you receive and whether this amount is new or increased. For new employment income, enclose photocopies of your last four pay stubs or other proof of how much you receive.

A. Contributions	☐ No ☐ Yes	Amount $	New ☐ Increased ☐
B. Employment	☐ No ☐ Yes	Amount $	New ☐ Increased ☐
C. Unemployment Insurance Benefits (UIB)	☐ No ☐ Yes	Amount $	New ☐ Increased ☐
D. Supplemental Security Income (SSI)	☐ No ☐ Yes	Amount $	New ☐ Increased ☐
E. Social Security Income Other Than SSI	☑ No ☐ Yes	Amount $	New ☐ Increased ☐
F. Child Support (including court-ordered payments)	☐ No ☐ Yes	Amount $	New ☐ Increased ☐
G. Veteran's or Other Military Benefits	☐ No ☐ Yes	Amount $	New ☐ Increased ☐

4. Have there been any changes in the following since you last reported to us?

   A. Rent costs: ☐ No ☐ Yes
   If yes, Increase ☐ Decrease ☐ New rent amount $_____

   B. Someone is pregnant or disabled: ☐ No ☐ Yes
   If yes, provide name (enclose medical proof): _____

   C. Resources (e.g., motor vehicle, bank account): ☐ No ☐ Yes
   If yes, explain (enclose photocopy of bank statement, car title, etc.): _____

   D. Child support you pay to someone outside your household: ☐ No ☐ Yes
   If yes, Increase ☐ Decrease ☐ New amount $_____

E. Medical expenses paid by household member who is disabled or who is 60 years old or older: ☐ No ☐ Yes
If yes, explain change: _____

F. Other changes: ☐ No ☐ Yes
If yes, explain: _____

I swear (or) affirm that the information on this form is true and correct.

Name (please print): _____

Signature: _____ Case Number: _____ Date: _____

WARNING: Federal and State law provide for penalties of fine, imprisonment or both if you do not tell the truth or if you conceal or fail to disclose facts regarding your continuing eligibility for assistance. Regulations require that you immediately notify this Agency of any changes in needs, income, resources, living arrangements or address.

List of changes you must report for food stamps at this time:

- Changes in any **source of income** for anyone in your household
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month
- Changes in your household's total **unearned income** from a public source such as Social Security Benefits or Unemployment Insurance Benefits when it goes up or down by more than $50 a month
- Changes in your household's total **unearned income** from a private source such as child support payments or private disability insurance when it goes up or down by more than $100 a month
- Changes in the amount of court-ordered **child support you pay** to a child outside of your Food Stamp household
- Changes in **who lives with you**
- **If you move,** your new address and your new rent or mortgage costs, heat costs and utility costs
- **A new or different car,** or other vehicle
- Increases in your household's cash, stocks, bonds, money in the bank or savings institution if the total cash and savings of all household members now accounts to more than $2000 for a household without an elderly or disabled household member or $3000 for a household with an elderly or disabled household member

You are not required to report changes in your medical expenses during our certification period. However, you may voluntarily report changes in your medical expenses for household members who are any of the following:

- 60 years or older
- disabled spouses or children of a deceased veteran
- getting Supplemental Security Income (SSI)
- getting Social Security Disability Benefits (SSDB)
- getting veteran's disability benefits
- getting government disability retirement benefits
- getting railroad retirement disability benefits
- getting disability-based medical assistance

If you report and verify an increase in your medical expenses, you may be eligible for more Food Stamp Benefits. Changes in medical expenses must be reported at your next recertification.

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Cuestionario Adjunto para Actualización de Caso (M-327h)

Estamos actualizando nuestra información acerca de su caso de asistencia pública y Cupones para Alimentos. Favor de llenar, firmar, fechar y devolver este formulario adjunto a su solicitud de recertificación de asistencia médica (Medicaid/Family Health Plus Recertification/Renewal Notification form [**MAP 2096F (S)**]). Envíe adjuntas fotocopias de documentos que comprueben los cambios que usted está reportando.

1. Usted aún necesita (todo beneficio el cual usted marque "No" será interrumpido):
   ¿Asistencia Pública? ☐ No ☐ Sí ¿Cupones para Alimentos? ☐ No ☐ Sí

2. ¿Alguna persona se ha mudado dentro o fuera de su hogar desde la última vez que usted reportó el número de personas en su hogar (incluya recién nacidos)? ☐ No ☐ Sí

   Si contestó "Sí", proporcione la información más abajo. Si está reportando a un recién nacido adjunte una fotocopia del acta de nacimiento como comprobante.

Número de Seguro Social	Nombre	Entró	Salió	Fecha

3. ¿Además de asistencia pública, usted, o alguien en su hogar, ha empezado a recibir algún aumento o nuevo ingreso de algunas de las siguientes fuentes desde la última vez que usted reportó sus ingresos?

   Si marca ☑ "Sí", anote la cantidad que recibe e indique si se tratra de aumento o nuevo ingreso. En caso de ingreso que proceda de nuevo empleo, adjunte fotocopias de sus últimos cuatro talones de pago u otro comprobante que detalle la cantidad de su ingreso.

A. Contribuciones	☐ No ☐ Sí	Cantidad $ _____	Nuevo ☐ Aumento ☐
B. Empleo	☐ No ☐ Sí	Cantidad $ _____	Nuevo ☐ Aumento ☐
C. Seguro de Desempleo (Unemployment Insurance Benefits – UIB)	☐ No ☐ Sí	Cantidad $ _____	Nuevo ☐ Aumento ☐
D. Ingreso de Seguridad Suplementario – Supplemental Security Income (SSI)	☐ No ☐ Sí	Cantidad $ _____	Nuevo ☐ Aumento ☐
E. Ingreso de Seguro Social que no sea SSI	☐ No ☐ Sí	Cantidad $ _____	Nuevo ☐ Aumento ☐
F. Mantenimiento de niños (incluidos pagos por orden judicial)	☐ No ☐ Sí	Cantidad $ _____	Nuevo ☐ Aumento ☐
G. Beneficios al veterano u otro beneficio militar	☐ No ☐ Sí	Cantidad $ _____	Nuevo ☐ Aumento ☐

4. ¿Desde la última vez que usted nos reportó datos, se ha dado algún cambio en lo siguiente?

   A. Costo del alquiler: ☐ No ☐ Sí
   Si contestó "Sí", Aumento ☐ Reducción ☐ Nueva cantidad del alquiler $ _____

   B. Alguien en el hogar está embarazada o incapacitado(a): ☐ No ☐ Sí
   Si contestó "Sí", indique el nombre (adjunte comprobante médico): _____

   C. Bienes (p.ej., vehículo, cuenta bancaria): ☐ No ☐ Sí
   Si contestó "Sí", explique (adjunte una fotocopia de su estado de cuenta bancaria, título del vehículo, etc.):
   _____

   D. Mantenimiento de niños que usted le paga a alguien fuera de su hogar: ☐ No ☐ Sí
   Si contestó "Sí", Aumento ☐ Reducción ☐ Nueva Cantidad $ _____

E. Gastos médicos pagados por un miembro del hogar incapacitado o que tenga 60 años de edad o más: ☐ No ☐ Sí
Si contesta "Sí", explique el cambio: _____

F. Otros cambios: ☐ No ☐ Sí
Si contesta "Sí", explique el cambio: _____

Juro y afirmo que la información en este formulario es cierta y exacta.

Nombre (en letra de molde): _____

Firma: _____ Número del Caso: _____ Fecha: _____

ADVERTENCIA: La ley Federal y Estatal dispone las penas de multas, encarcelamiento o ambos si usted proporciona información falsa o si oculta o no revela hechos relativos a su elegibilidad continua de asistencia. Las reglas estipulan que usted debe notificar a la Agencia de inmediato, en caso de cualquier cambio respecto a: necesidades, ingreso, recursos, arreglos de vivienda o dirección.

Lista de cambios que debe reportar respecto a cupones para alimentos actualmente:

- Cambios en cualquier **fuente de ingreso** de alguien en su hogar
- Cambios en el **ingreso salarial** total de su hogar si ha aumentado o disminuido por más de $100 al mes
- Cambios en el **ingreso no salarial** total de su hogar de una fuente pública como Seguro Social o Seguro de Desempleo, si ha aumentado o disminuido por más de $50 al mes
- Cambios en el **ingreso no salarial** total de su hogar de fuentes privadas como pagos de mantenimiento de niños o seguro privado para incapacitados si ha aumentado o disminuido por más de $100 al mes
- Cambios en la cantidad **que usted paga en mantenimiento de niños** por orden judicial, fuera del hogar de Cupones para Alimentos
- Cambios respecto a quienes **viven con usted**
- **Si usted se muda,** su nueva dirección y nuevos gastos de alquiler o hipoteca, calefacción, electricidad y gas
- **Un nuevo vehículo o diferente** u otro vehículo
- Aumentos en el dinero en efectivo, acciones, bonos, dinero en el banco o institución de ahorros que posea su hogar, si el total de efectivo y ahorros del hogar ha sobrepasado los $2000 en un hogar sin ancianos o incapacitados, o los $3000 en un hogar con ancianos o incapacitados

No es necesario que usted reporte cambios en sus gastos médicos durante nuestro período de certificación. Sin embargo, usted podría reportar cambios en sus gastos médicos de miembros del hogar a quienes les correspondan las siguientes condiciones:

- 60 años de edad o más
- cónyuges o niños incapacitados de un veterano difunto
- reciben Ingreso de Seguridad Suplementario (Supplemental Security Income – SSI)
- reciben Indemnización de Seguro Social para Incapacitados (Social Security Disability Benefits – SSDB)
- reciben beneficios para veteranos incapacitados
- reciben beneficios para incapacitados retirados del gobierno
- reciben beneficios para trabajadores de ferrocarril retirados e incapacitados
- reciben asistencia médica debido a su incapacidad física

Si usted reporta y comprueba un aumento en sus gastos médicos, puede que tenga derecho a recibir más Beneficios de Cupones para Alimentos. Cambios en sus gastos médicos tienen que reportarse en su próxima recertificación.

Form W-148A LLF
12/22/04

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Authorization for Reimbursement of Public Assistance Benefits from SSI Retroactive Payment

I authorize the Commissioner of the Social Security Administration (SSA) to send to the local social services district the amount due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if I am terminated or suspended from receiving SSI benefits and am later reinstated.

I understand that the local social services district may take from my SSI payment the amount of public assistance (except assistance paid wholly or partly with federal funds) that was paid to me during the period beginning with my first day of eligibility for SSI or the first day to which SSI benefits were reinstated after a period of suspension or termination and ending with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments began).

After taking this money from my SSI check(s), the local social services district will pay me the balance, if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as public assistance, I will be given an opportunity for a hearing.

I understand that:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.
- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon future SSI applications, appeals or reviews if my case is completely decided, if the SSA makes an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I mutually agree to terminate the authorization.

I have read and understand this notice. I understand and agree to the assignments, authorizations and consents above. I swear and/or affirm under the penalties of perjury that the information I have given or will give to the local social services district is correct.

Applicant/Recipient/Representative Signature _____ Date Signed _____

Husband/Wife or Protective Representative Signature _____ Date Signed _____

Form W-148A (S) LLF
12/22/04

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Autorización para Deducir el Reembolso de Beneficios de Asistencia Pública del Pago Retroactivo de SSI

Autorizo al Comisionado de la Administración del Seguro Social (Social Security Administration – SSA) a enviar al distrito local de servicios sociales la cantidad de mi primer pago procedente de (1) beneficios retroactivos del Ingreso de Seguridad Suplementario (Supplemental Security Income – SSI) los cuales yo podría recibir después de solicitar SSI o (2) beneficios de SSI retroactivos que podría recibir si se me suspende o termina el recibo de beneficios de SSI y mas tarde son restablecidos.

Entiendo que el distrito local de servicios sociales puede deducir de mi pago de SSI la cantidad de asistencia pública (excepto asistencia pagada completa o parcialmente mediante fondos federales) que me fue pagada durante el período en que empezó el primer día de mi elegibilidad respecto a SSI o el primer día en que mis beneficios de SSI fueron restablecidos después de un período de suspensión o terminación. Este período concluye en el mes que los pagos de SSI empezaron (o el próximo mes si el distrito local de seguros sociales no puede detener la entrega de mi último pago de asistencia pública durante el mes en que el pago de SSI empezó).

Después de deducir el dinero de mi(s) cheque(s) de SSI, el distrito local de servicios sociales me pagará el saldo, de haberlo, a más tardar 10 días laborables a partir de la fecha en que yo reciba mi pago de SSI. También entiendo que si el distrito deduce más dinero de lo que yo considere se me pagó en asistencia pública, tendré la oportunidad de asistir a una audiencia.

Entiendo que:

- la SSA puede considerar la fecha en que presento esta autorización firmada al distrito local de servicios sociales como la fecha en que reúno las condiciones para recibir SSI si presento una solicitud para los beneficios iniciales de SSI dentro de los próximos 60 días.
- esta autorización se aplicará a toda solicitud de SSI o apelación que en la actualidad esté pendiente ante la SSA con respecto a mi persona y a toda solicitud de SSI que presente o apele con respecto al período que finaliza un año después de la fecha de mi firma en este acuerdo.

Esta autorización se vence un (1) año después de la fecha en que se reciba en el distrito local de servicios sociales y no afectará futuras solicitudes de SSI, apelaciones o revisiones si se llega a una decisión final con respecto a mi caso, si la SSA efectúa el primer pago de SSI con respecto a mi solicitud o después de un período de suspención o terminación, o si el Estado de Nueva York y yo decidimos de mutuo acuerdo que la autorización sea terminada.

He leído y entiendo este aviso. Entiendo y estoy de acuerdo con las asignaciones, autorizaciones y pautas antedichas. Juro y/o ratifico so pena de perjurio que la información que yo he entregado o voy a entregar al distrito local de seguros sociales es exacta.

Firma de Solicitante/Beneficiario/Representante	Fecha
Firma de Esposo/Esposa o Representante Protector	Fecha