FAMILY INDEPENDENCE ADMINISTRATION

Seth W. Diamond, Executive Deputy Commissioner

James K. Whelan, Deputy Commissioner
Policy, Procedures and Training

Lisa C. Fitzpatrick, Assistant Deputy Commissioner
Office of Procedures

POLICY BULLETIN #06-160-OPE

OBSOLETE FORMS

Date: December 11, 2006	**Subtopic(s):** Obsolete Forms
This procedure can now be accessed on the FIAweb.	The purpose of this policy bulletin is to inform all Job Center and Non-Public Assistance Food Stamp Office staff that the following forms are obsolete. This policy bulletin serves as information for all other staff. • Fair Hearing Agreement Form (**M-186t**) Fair Hearing no longer uses this form. • Withdrawal of Fair Hearing Request (**M-186dd**) HRA is no longer permitted to request the withdrawal of a Fair Hearing on an applicant/participant's behalf.
Refer to PB #03-21-OPE	• Finger Imaging Notice (**W-519E**) This form has been replaced by the Finger Imaging Notice (**W-519**), which can be used in Job Centers and NPA Food Stamp Offices.
Refer to PB #05-94-OPE	The following forms are being made obsolete because the MetroCard Incentive Program no longer exists. In addition, PD #03-56-EMP and PB #03-153-OPE are also obsolete for the same reason. • MetroCard Incentive Project (MIP) Transportation Grant Checklist (**EXP-76A**) • MetroCard Incentive Project (MIP) MetroCard Log: Receipt for MetroCards Distributed to Employed PA Applicants/Participants (**EXP-76B**) • MetroCard Issuance Approval Form (**EXP-76C**)

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 2 at the prompt followed by 765 or
send an e-mail to *FIA Call Center*

Distribution: X

The following forms are being made obsolete because these forms are no longer used by the Agency.

- Notice of Expiration of Food Stamp Benefits (**M-5A**)
- Resource Summary (**W-518**)
- Client's Authorization to Release Medical Information (**W-421**)

Center Directors must ensure that all previous versions of the forms, including the multilingual equivalents, are removed from circulation and recycled.

Related Procedures:

PD 03-56-EMP (Obsolete)
PB 03-153-OPE (Obsolete)

Effective Immediately

Please use Print on Demand to obtain copies of forms.

Attachments:

EXP-76A	MetroCard Incentive Project (MIP) Transportation Grant Checklist (Obsolete)
EXP-76B	MetroCard Incentive Project (MIP) MetroCard Log: Receipt for MetroCards Distributed to Employed PA Applicant/Participants (Obsolete)
EXP-76C	MetroCard Issuance Approval Form (Obsolete)
M-5a	Notice of Expiration of Food Stamp Benefits (Obsolete)
M-186t	Fair Hearing Agreement Form (Obsolete)
M-186dd	Withdrawal of Fair Hearing Request (Obsolete)
W-421	Client's Authorization to Release Medical Information (Obsolete)
W-518	Resource Summary (Obsolete)
W-519E	Finger Imaging Notice (Obsolete)

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____

MetroCard Incentive Project (MIP)
Transportation Grant Checklist

This Form Must Be Completed Every Time an Applicant/Participant is Determined Eligible to Receive a MetroCard.

Section I. To be completed by JOS/Worker

Name of Applicant/Participant: _____ (First Name) _____ (Last Name)

Social Security Number: _____

Receiving Public Assistance: Yes ☐ No ☐ Safety Net Case: Yes ☐ No ☐

Family Assistance Case: Yes ☐ No ☐ Family Size: _____

Employer Name: _____ Employer Telephone: _____

Employer Address: _____ Employment Start Date: _____

_____ _____ _____
City State Zip Code

Salary Verification Received: Yes ☐ No ☐

Monthly Salary*: _____

* Weekly and hourly income must be converted to a monthly amount to compare with poverty guidelines.

Type of Salary Verification
(e.g., pay stub, employment letter): _____

MetroCard Disbursement Month Number:

First ☐ Third ☐ Fifth ☐

Second ☐ Fourth ☐ Sixth ☐

JOS/Worker Signature: _____ Date: _____

Section II. To be completed by AJOS/Supervisor

Approved for MIP: Yes ☐ No ☐

Supervisor Signature: _____ Date: _____

Section III. To be completed at D&C

I hereby affirm that I receive no form of transportation subsidy other than the subsidy I am receiving through the Community Solutions for Transportation MetroCard Incentive Project (MIP). (If under audit this is found to be untrue, repayment will be expected or the attestation will be left alone.)

Por medio de la presente yo afirmo que no recibo ningun otro tipo de subsidio de transporte aparte del que actualmente recibo como cortesía del Proyecto de Incentivo de MetroCard por parte de Soluciones de Transporte para la Comunidad (Community Solutions for Transportation MetroCard Incentive Project [MIP]). (Si por medio de una intervención se descubre que lo antedicho no es cierto, se requerirá un reembolso o de lo contrario su testimonio no tendrá validez.)

Applicant/Participant Signature:
Firma del Solicitante/Participante: _____

D&C Signature: _____

MetroCard Issued: Yes ☐ No ☐ Date: _____

Date Returned to JOS/Worker:

_____

Form EXP-76B
Rev. 4/11/05

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Disbursing Center: _____

MetroCard Incentive Project (MIP)

MetroCard Log: Receipt for MetroCards Distributed to Employed PA Applicants/Participants

Shaded columns to be completed by D&C Staff

	Date	Responsible Center Number	Name of Applicant/Participant	Case Number	Social Security Number	**I have received a monthly MetroCard. Signature of Applicant/Participant (in ink only)** ***He recibido una tajeta mensual MetroCard. Firma del Solicitante/Participante (solo con tinta)***	Amount Disbursed	D&C Worker's Initials
1							$76	
2							$76	
3							$76	
4							$76	
5							$76	
6							$76	
7							$76	
8							$76	
9							$76	
10							$76	
						TOTAL ($76 x _____)		

D&C Supervisor Signature: _____

Print Name: _____

Telephone: _____ Date: _____

Routing: Send original to Head Count Control and Analysis, 180 Water Street, 19th floor, New York, NY 10038

Form EXP-76C LLF
Rev. 4/11/05

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Worker: _____

MetroCard Issuance Approval Form

You have been authorized to receive a monthly MetroCard. Please pick up your MetroCard at the following Center:

Center Number: _____ Center Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

D&C Telephone Number: _____

Travel Directions: _____

Please bring this letter and a photo ID to the Center indicated above to receive your MetroCard. This is your _____ MetroCard issuance.

YOU MAY RECEIVE A MONTHLY METROCARD FOR UP TO SIX MONTHS. YOU MUST SUBMIT CURRENT VERIFICATION OF EMPLOYMENT INCOME EVERY TIME YOU APPLY FOR A METROCARD.

Worker Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Form EXP-76C (S) LLF
4/11/05

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Trabajador: _____

Formulario de Aprobación de Emisión de MetroCard

Se le ha autorizado para que reciba una MetroCard mensual. Favor de recoger su MetroCard en el siguiente Centro:

Número del Centro: _____ Nombre del Centro: _____

Dirección: _____

_____

Ciudad: _____ Estado: _____ Código Postal: _____

Número de teléfono del D&C: _____

Indicaciones de viaje:

Favor de traer esta carta y una identificación con foto al Centro indicado más arriba para recibir su MetroCard. Ésta es su _____ emisión de MetroCard.

USTED PODRÍA RECIBIR UNA METROCARD MENSUAL HASTA POR SEIS MESES. DEBE PRESENTAR COMPROBANTE ACTUAL DE SU INGRESO DE TRABAJO CADA VEZ QUE SOLICITE UNA METROCARD.

Firma del Trabajador: _____ Fecha: _____

Firma del Supervisor: _____ Fecha: _____

Form M-5a (face)
Rev. 4/18/80

The City of New York

HUMAN RESOURCES ADMINISTRATION
DEPARTMENT OF INCOME MAINTENANCE

IM CENTER:
ADDRESS:

NOTICE OF EXPIRATION OF FOOD STAMP BENEFITS

DATE: _____

Dear Sir/Madam:

Your public assistance benefits were recently stopped and your public assistance case was closed. You are still eligible to receive food stamp benefits until the expiration of your food stamp certification period which is the last day of _____. If you wish to continue to receive food stamp benefits, you must telephone the IM Center Application Section _____ before the expiration date to schedule an appointment to file a food stamp application form. Expiration date to schedule an appointment to file a food stamp application form. It will be necessary for you to comply with food stamp work registration requirements and other food stamp eligibility requirements. Enclosed is an application for food stamps, and information about the eligibility requirements for food stamps.

Since we cannot determine how stopping your public assistance benefits affects your income and expenses, we are unable to determine the amount of food stamps you are entitled to receive. Your benefits will therefore remain at the current level until you are able to tell us what your current income and expenses are. If you are eligible for an increased benefit, we will provide a supplemental benefit for the difference.

If you do not contact the IM Center before your food stamp benefits expire, your food stamp case will be closed. Therefore, it is important to call for an interview as soon as possible.

Sincerely,

_____

Name/Title

Form M-5a (reverse)
Rev. 4/18/80

HUMAN RESOURCES ADMINISTRATION
DEPARTMENT OF INCOME MAINTENANCE

IM CENTER:
ADDRESS:

AVISO DE EXPIRACIÓN DE ESTAMPILLAS PARA ALIMENTOS

FECHA: _____

Estimado(a) Señor(a):

Recientemente sus beneficios de asistencia pública fueron terminados y su caso de asistencia pública fue cerrado. Usted permanece elegible para beneficios de estampillas para alimentos hasta el último día de _____ que es la expiración del período de certificación de sus estampillas para alimentos. Si desea continuar recibiendo beneficios de estampillas, tiene que llamar la sección de aplicación en su centro M.I. _____ antes del día de expiración y hacer una cita para una solicitud de estampillas de alimentos. Es necesario que cumpla con los requisitos de trabajo en todo lo necesario para la registración y con los demás requisitos de elegibilidad para estampillas de alimentos.

Al no poder determinar cómo afectará el cierre de sus beneficios de asistencia pública a su ingreso y gastos, tampoco podemos determinar la cantidad de estampillas que usted tiene el derecho a recibir. Sus beneficios se quedarán en el nivel actual hasta que pueda decirnos cual es su ingreso y gastos corriente. Si es elegible para recibir más beneficios, nosotros le daremos un suplementario por la diferencia.

Si no se pone en contacto con el Centro M.I. antes que sus beneficios de estampillas expire, su caso de estampillas para alimentos será cerrado., por est razón, es muy importante que usted llame para una entrevista lo antes posible.

Atentamente,

_____

Nombre/Título

Form M-186t (face)
Rev. 7/8/97

The City of New York

Human Resources Administration
Income Support Programs

From: FH & C, ISC # _____

To:

Fair Hearing Agreement Form

We are taking the action(s) checked below to resolve the issue(s) of your fair hearing request. We will take these action(s) even if you do not go to your fair hearing.

Case name _____ **Date hearing scheduled** _____

Case # _____ **Fair Hearing #** _____

Fair Hearing Issue(s) (Reduction/Discontinuance/Other) (PA/MA/FS):

_____

_____

- ☐ Withdraw the notice dated _____ and restore any lost benefits
- ☐ Take no action and restore any lost benefits
- ☐ Issue benefits
- ☐ Other

Explanation of action(s): _____

_____

☐ **Benefits to be issued retroactive to** _____
date

For Center Stipulations:

_____ _____ _____
Signature: Authorized FH&C staff member | Print name and title | date

For All Stipulations Submitted at Fair Hearings:

As the authorized representative of the New York City Department of Social Services at the fair hearing identified above, I, _____, stipulate that the above action(s) will be taken in settlement of the specified issue(s).

_____ _____
FH&C Supervisor | Date

For Center/FH Rep Use Only:

_____

_____

_____

The City of New York
Human Resources Administration
Income Support Programs

Form M-186t (reverse)
Rev. 7/8/97

From: FH & C, ISC # _____

To:

Formulario de Acuerdo sobre la Vista Imparcial

Estamos tomando las acciones indicadas abajo para resolver el(los) asunto(s) de su Vista Imparcial. Tomaremos estas acciones aunque usted no asista a su Vista Imparcial.

Nombre de Caso _____ Fecha de la Vista Imparcial _____

Caso Núm. _____ Núm. de la Vista Imparcial _____

Asuntos de la Vista Imparcial (Reducción/Descontinuación/Otro) (PA/MA/FS):

_____

_____

- ☐ Retirar el Aviso de la fecha _____ y restaurar cualquier beneficio perdido
- ☐ No tomar ninguna acción y restaurar cualquier beneficio perdido
- ☐ Emitir beneficios
- ☐ Otro

Aclaración de la(s) acción(es): _____

_____

☐ **Emitir beneficios retroactivos a la fecha** _____

Para estipulaciones del Centro:

Firma: Personal Autorizado del FH&C	Nombre y Título (en letra de molde)	Fecha
_____	_____	_____

Para estipulaciones sometidas en la sección de Vistas Imparciales:

Yo _____ el representente autorizado de la ciudad de Nueva York, Departamento de Servicios Sociales en la Vista Imparcial indicada arriba, estipulo que se tomarán las acciones indicadas arriba para resolver los asuntos indicados arriba.

Supervisor de Vistas Imparciales	Fecha
_____	_____

Para el Uso del Centro/Rep. de Vistas Imparciales:

_____ _____

_____

_____

Withdrawal of Fair Hearing Request

Today's Date: _____

Fair Hearing Number: _____

Case Name: _____ Case Cat/No: _____

Reason for Requesting Fair Hearing: _____

_____

_____

_____

Action(s) Taken to Resolve Fair Hearing Issue(s): _____

_____

_____

_____

Based on the above action(s), I _____ am withdrawing
Name of Appellant

from the Fair Hearing which I requested on _____ .
Date FH was requested

Appellant's Signature: _____ Date: _____

Agency Supervisor's Signature: _____ Date: _____

(vea el reverso)

Retiro de Petición Para Una Audiencia Imparcial

Fecha De Hoy: _____

Número De La Audiencia Imparcial: _____

Nombre Del Caso: _____ Categoría/ Número del Caso: _____

Razón Para Solicitar La Audiencia Imparcial: _____

_____

_____

_____

Accioñ(es) Tomadas Para Resolver Asunto De La Audienca Imparcial: _____

_____

_____

_____

Basado(h) en la acción indicada anteriormente, yo _____
Nombre del Apelanta

retiro de la Audencia Imparcial _____.
Fecha en que la audencia Imparcial fue solicatada

Firma del Aplelante: _____ Fecha: _____

Firma del Supervisor De La Agencia: _____ Fecha: _____

Form W-421
Rev. 3/27/80

The City of New York
Human Resources Administration
Department of Social Services

Client's Authorization to Release Medical Information

(Autorización Para Suministrar Información Médica)

Date: _____

I HEREBY GIVE PERMISSION TO _____
(HOSPITAL, CLINIC OR DOCTOR)

TO FURNISH TO THE DEPARTMENT OF SOCIAL SERVICES INFORMATION CONCERNING THE CONDITION FOR WHICH I HAVE BEEN OR AM BEING TREATED.

Yo, por este medio, doy permiso a _____
(Hospital, Clínica o Doctor)

para que suministre al Departamento de Servicios Sociales toda información concerniente a mi estado de salud por la cual he recibido o estoy recibiendo tratamiento médico.

(SIGNED) _____ DATE(S) HOSPITALIZED _____
(NAME OF PATIENT)

ADDRESS _____ CLINIC(S) ATTENDED _____

BOROUGH AND ZIP _____ CLINIC CARD NO. _____

CASE NUMBER _____

WITNESSED BY: _____ CENTER _____
(WORKER)

CENTER ADDRESS _____

Form W-518 (face)
Rev. 03/04/83

The City of New York
Human Resources Administration

RESOURCE SUMMARY

Name: Surname	Man's First Name	Date of Birth	Woman's First Name	Date of Birth	Date
					I. M. Center
Address: Number-Street	Boro	Zip Code		Telephone No.	Category and Case No.
Social Security Numbers: Man	Woman		Others *(in Household)*		Caseload
No. in Family	Health Condition:				

LIFE INSURANCE:

Name of Company	Policy Nos.	Date of Issue	Kind of Policy	Face Value	Cash Value	Age Stated on Policy	PREMIUMS Amount	PREMIUMS Date Paid to	Name of Insured	Father Mother Son etc.	Liens Loans Waivers	Date of Birth

OBSOLETE

UNION BENEFITS:

Name of Member	Name as Entered in Dues Book	Dues Book No.
Official Name of Union	Local No.	Date of Last Payment
Name and Address of Local Secretary	Boro / Zip Code	Date of Initiation
Name and Address of Last Employer		
Periods of Employment		Badge or Identification No.
Reason for loss of Last Employment	Is Pension Received or Applied For?	

GROUP INSURANCE:

Name of Insurance Company	Group No.	Certificate No.
Name of Employer or Union as it Appears on Group Policy		

FRATERNAL ORGANIZATIONS:

Name of Organization	Name and Address of Secretary	Boro	Zip Code	Name of Member

Dues.	Date of Last Payment	Benefits
$		

Form W-518 (reverse)
Rev. 03/04/83

The City of New York
Human Resources Administration

REAL PROPERTY, COOPERATIVE APARTMENT, TRAILER/MOBILE HOME, OTHER:

Name of Owner	Address and Nature of Property

BANK ACCOUNTS, CREDIT UNION, SAFE DEPOSIT BOX :

Name of Bank	Address	Boro	Account No.	Balance

LEGAL ACTIONS(give complete information)

DESCRIPTION OF ALL OTHER ASSETS NOT PREVIOUSLY LISTED *(e.g. interest in estates, trust funds, stocks, bonds, chattel mortgages, pawn tickets, jewelry, leases, automobiles, any other valuable personal property).*

PERIODS OF ASSISTACE

STATEMENT AND AUTHORIZATION

The above is a true statement of the financial resources of myself and members of my family. I understand that I must notify the Human Resources Administration of any changes in these resources or of any future acquisition of resources by myself or members of my family. The Department is hereby authorized to give banks and insurance companies such information as may be necessary in order to verify resources or, to obtain payment of claims to myself, my heirs or assigns, or to the Human Resources Administration.

Signed _____ Date _____

Witnessed: _____
Name and Title

RESOURCE ANALYSIS AND PLAN OF ACTION

Human Resources Administration
Income Support Programs
Food Stamp Program

FINGER IMAGING NOTICE

This is to inform you that a new regulation requires adult members of Food Stamp households to be identified through a computerized finger image system.

This new system will copy your finger images and take your photograph quickly and easily. These finger-images will be stored electronically. Your finger images will be matched against those of other clients. We may also compare your finger images with finger images maintained by other social service districts and states to ensure that you receive food stamps in only one location.

This means that if you are applying for Food Stamps, or you are currently receiving Food Stamps, you and all members of your household age 18 or over must be finger imaged as a condition of eligibility.

If any member of your household who is required to be finger imaged refuses to do so, every member of your household will be ineligible to receive Food Stamps.

Exemptions from the Finger Imaging Requirement

- Authorized Representatives or payees for another household.
- Individuals unable to report for finger imaging because of a medically verified illness, injury, or disability.

  However, if the condition is temporary an appointment to return for finger imaging will be scheduled.
- Individuals under 18 years of age. However, minors who are heads of their households must be finger imaged.

☐ I agree to be finger imaged.

☐ I do not agree to be finger imaged. By not agreeing to be finger imaged, you are ineligible to receive assistance. Your case may be rejected or closed as appropriate.

Your Signature:_____

FINGER IMAGING REFERRAL: ☐ Applicant ☐ Recipient

Report to Finger Imaging Unit _____ floor

Appointment Date: _____ **Time:** _____

Client Name: _____

Registry #/CIN: _____ **Client DOB:** _____

Sex: _____ **Client SSN:** _____

Caseload/Worker: _____

Human Resources Administration
Income Support Programs
Food Stamp Program

AVISO del REQUISITO de SER IDENTIFICADO a TRAVES de HUELLAS DIGITALES COMPUTADORIZADAS

Queremos avisarle que una nueva regulación requiere que todos los miembros adultos de un caso de Cupones de Alimentos, tienen que ser identificados a través de un sistema computadorizado de huellas digitales.

Este nuevo sistema copiará rápido y fácil sus huellas digitales y tomará su fotografía. Las huellas digitales serán cotejadas con las de otros clientes. Puede ser que compararemos sus huellas digitales con huellas mantenidas por otros distritos de servicios sociales y estados para asegurar que usted reciba cupones de alimentos en solamente un local.

Esto quiere decir que, en su próxima cita de recertificación en su oficina de Cupones de Alimentos, usted y todos los miembros de su hogar que tienen 18 años o más tienen que ser identificados a través del sistema automático de huellas digitales. Si cualquier miembro de su hogar rehusa a cumplir con este requisito, cada miembro de su hoger será inelegible para recibir cupones de alimentos.

Este requisito no le aplica si reune cualquier de los criterios enumerados a continuación:

- Representantes Autorizados o "Portadores" para otro caso .
- Clientes que no pueden cumplir con este requisito debido a una enfermedad o disabilidad verificada por un médico.

  En todo caso, si la enfermedad es temporera, le darán una cita para regresar para tomarle las huellas digitales computadorizadas.
- Clientes menores de 18 años de edad. Sin embargo, si son cabezas de su hogar, el /ella tiene que cumplir con este requisito.

☐ Yo consiento a ser identificado(a) a través del sistema computadorizado de huellas digitales.

☐ Yo **no** consiento a ser identificado(a) a través del sistema computadorizado de huellas digitales. Si usted no consiente, usted no es elegible para recibir asistencia. Su caso puede ser rechazado o cerrado.

Su Firma : _____

REFERIMIENTO PARA HUELLAS DIGITALES COMPUTADORIZADAS:

☐ Solicitante ☐ Beneficiario

Preséntese a la Unidad de Huellas Digitales en el _____ piso

Fecha de la Cita: _____ Hora: _____

Nombre del Cliente: _____

de Registración/CIN: _____ Fecha de Nacimiento: _____

Sexo: _____ # de Seguro Social: _____

Caseload/Trabajador: _____