



FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #07-13-OPE

OBSOLETE FORMS

Date: January 26, 2007	Subtopic(s): Forms
<p> This procedure can now be accessed on the FIAweb.</p>	<p>The purpose of this policy bulletin is to inform Job Center staff that the following forms have been made obsolete:</p> <ul style="list-style-type: none">• Application for Emergency Child Care Payment (EXP-53)• Instructions for Completing the Application for Emergency Child Care Payment (EXP-53A)• Request to Participate in the Supplemental Transitional Work Support Program (EXP-53G)• Announcing Supplemental Transitional Work Support Program (EXP-53H) <p>The reasons to obsolete the forms are as follows:</p> <p>The EXP-53 and EXP-53A were developed for the World Trade Center Emergency disaster victims and are no longer needed.</p> <p>The EXP-53G and EXP-53H are now obsolete because the programs mentioned on these forms no longer exist.</p> <p>Center Directors must ensure that these forms and their multilingual equivalents are removed from circulation and recycled.</p> <p><i>Effective Immediately</i></p>

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

 Please use Print on Demand to obtain copies of forms.

Attachments:

- EXP-53** Application for Emergency Child Care Payment (Obsolete)
- EXP-53 (S)** Application for Emergency Child Care Payment (Spanish) (Obsolete)
- EXP-53A** Instructions for Completing the Application for Emergency Child Care Payment (Obsolete)
- EXP-53G** Request to Participate in the Supplemental Transitional Work Support Program (Obsolete)
- EXP-53H** Announcing Supplemental Transitional Work Support Program (Obsolete)

Application for Emergency Child Care Payment

Applicant's Name: _____
Last First M.I.

Address: _____
Street Apt. Borough Zip Code

Phone Number: _____ **Social Security Number (optional):** _____

Reason for Application:

Lost Residence

Address: _____
Street Apt. Borough Zip Code

Lost Employment

Name of Employer: _____ **Contact Person/Phone:** _____

Address of Employer: _____

Lost Child Care

Name of Former ChildCare Provider: _____

Address of Former: _____

Loss of Immediate Family Member

Name: _____

Relationship to: _____

Emergency Rescue Worker

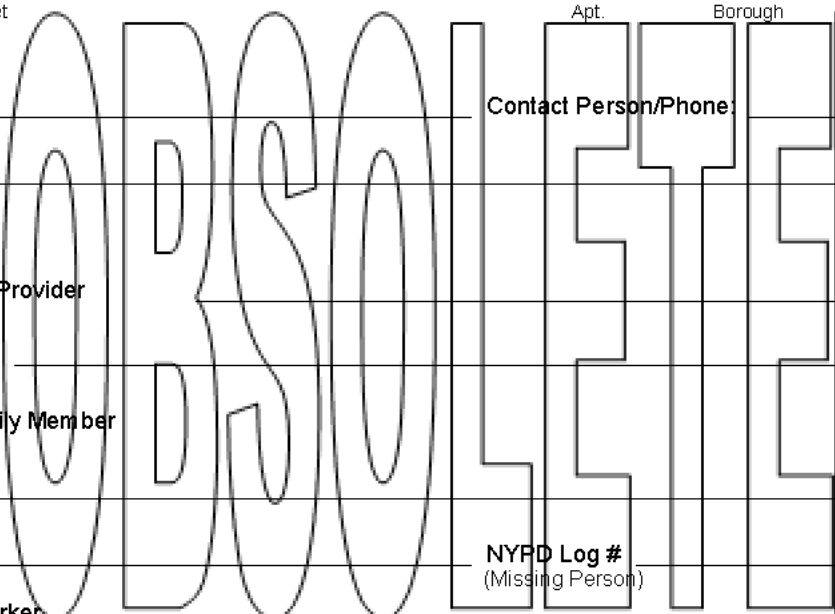
Name: _____

Rescue Work Employer/Agency: _____

Applicant Badge/ID Number: _____

Contact Person/Supervisor at: _____ **Phone:** _____

Other: _____



NYPD Log #
(Missing Person)

Reason for Emergency Child Care Need:

Child(ren) for Whom Care is Needed:

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Hours Child Care is Needed: From: _____ To: _____ Number of _____ Approx. Monthly Cost: _____
AM/PM AM/PM

Applicant's Relationship to Child(ren):

Parent Guardian Other Relative: _____ Other: _____

Applicant's Employer: _____ **Work Phone:** _____

Employment Income: Rate of Pay: \$ _____ **Per:** _____ **Other (Specify):** _____

Other Household Income: Child Support: \$ _____ **Per Week** **Social Security Benefit:** \$ _____ **Per Month**

SSI: \$ _____ **Per Month** **Other:** _____ \$ _____ **How Often:** _____

Names of Other Children and Family Members in the Applicant's Household:

Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____
Name: _____	Date of Birth: _____

Child Care Provider _____ **Phone:** _____

Regulated Child Care Provider **License Number:** _____ **Informal Provider**

Provider Address: _____

Social Security Number: _____ **or Employer ID#:** _____

I understand that by signing this form, I agree to any investigation made by the Human Resources Administration to verify or confirm the information I have given or any other investigation made by them in connection with my request for emergency child care payment.
I attest that the above information is true and accurate.

Applicant's Signature _____
Date

Emergency Child Care Authorization - For Agency Use Only

Name of Worker:

_____ Print Name	_____ Signature
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Approved: \$ _____ **Issued:** No Yes **Check #:** _____

Payee: _____ **Date:** _____

Head Start: _____ **ACD Contract Facility:** _____

Site Issued: _____

Address: _____

Solicitud para Pagos de Emergencia de Cuidado para Niños

Nombre del _____
Apellido Nombre Inicial

Dirección: _____
Calle Apt. Condado Zona Postal

Número de Teléfono: _____ **Número de Seguro Social (Opcional):** _____

Razón por la solicitud:

Pérdida de Residencia

Dirección: _____
Calle Apt. Condado Zona Postal

Pérdida de Empleo

Nombre del Empleador: _____ **Persona/Teléfono Contacto:** _____

Dirección del Empleador: _____

Pérdida de Cuidado para Niños

Nombre del Proveedor Anterior de Cuidado para _____
.....

Dirección del Proveedor Anterior de Cuidado para _____
.....

Pérdida de Miembro Cercano de la Familia

Nombre: _____

Relación con el Niño: _____ **Núm. de Anotación del NYPD** _____
(Persona Perdida)

Trabajador de Rescate de Emergencia

Nombre: _____

Empleador/Agencia de Trabajo de Rescate: _____

Número de Identificación/Chapa Distintivo del _____
Persona Contacto/Supervisor en _____ **Teléfono:** _____

Otro: _____

Razón por la Necesidad de Cuidado de Emergencia para Niños :

Niño(s) para el(los) Cual(es) se Necesita Cuidado:

Nombre: _____ **Fecha de Nacimiento:** _____

Nombre: _____ **Fecha de Nacimiento:** _____

Nombre: _____ **Fecha de Nacimiento:** _____

Horas en las que Necesita Cuidado para Niños: De: _____ A: _____ **Número de Días/Semanas:** _____
AM/PM AM/PM

Costo Mensual _____

Relación del Solicitante con el/los Niño/s:

Padre Guardián Otro Pariente: _____ Otro: _____

Empleador del Solicitante: _____ **Teléfono del Trabajo:** _____

Ingreso por Empleo: Cantidad de Paga: _____ Por: _____ Otro _____

Otro Ingreso del Hogar: Manutención de Niños: \$ _____ por Semana Beneficio de Seguro Social: \$ _____ Por Mes

SSI: \$ _____ Por Mes Otro: _____ \$ _____ Frecuencia _____

Nombres de Otros Niños y Miembros de la Familia en el Hogar del Solicitante:

Nombre: _____ Fecha de Nacimiento: _____

Nombre: _____ Fecha de Nacimiento: _____

Nombre: _____ Fecha de Nacimiento: _____

Nombre del Proveedor de Cuidado para Niños: _____ **Teléfono:** _____

Proveedor Regulado de Cuidado Para Niños **Número de Autorización:** _____ Proveedor Informal

Dirección del Proveedor: _____

Número de Seguro Social: _____ **o Núm. de Identificación del Empleador:** _____

Yo entiendo que al firmar este formulario, estoy de acuerdo con cualquier investigación hecha por la Administración de Recursos Humanos para verificar o confirmar la información que he dado o cualquier otra investigación hecha por ellos en conexión con mi solicitud de pago de cuidado de emergencia para niños.

Firma del Solicitante

Fecha

Emergency Child Care Authorization - For Agency Use Only

Name of Worker:

Print Name

Signature

Approved: \$ _____ Issued: No Yes Check #: _____

Payee: _____ Date: _____

Head Start: _____ ACD Contract Facility: _____

Site Issued: _____

Address: _____

Instructions for Completing the Application for Emergency Child Care Payment (EXP-53)

BACKGROUND

Emergency child care cash assistance and emergency child care arrangements may be needed by families affected by the World Trade Center disaster. To address the emergency, HRA/FIA will provide funding for up to one month of child care services without regard for income eligibility. Head Start centers and ACD contract facilities with vacancies will also be made available for emergency child care.

Eligible families for emergency child care cash assistance and Head Start or ACD program placement are those who lost an immediate family member in the event, those who lost their residence or are temporarily unable to live in their residence, those who lost their employment and source of income, rescue workers and security workers in the disaster area, and those who lost their child care arrangement because the facility was in the disaster area. The child care need may be for time to locate another residence or another job, to deal with family stress due to the loss of a residence or family member, to replace child care previously given by a family member who is no longer available due to the disaster, to pay a fee to a new child care program or provider because the previous child care facility is closed or gone or other disaster-related reason, or to cover new or increased child care costs because the caretaker is working in the rescue or security operations in lower Manhattan.

AUDIENCE

These instructions are for HRA/FIA workers at the Child Care Center at Pier 94, the emergency service center at 141 Worth Street, and the Twin Towers JobLink sites.

REQUIRED ACTION

Instruct the receptionist, customer service desk, and security guards to give priority to any person who indicates they have an emergency connected to the World Trade Center disaster. Direct or escort them directly to a worker who has been designated to handle emergency child care assistance.

1. Emergency Child Care Referrals

For anyone who needs to locate a child care program or provider for their child in regard to the emergency, give them information about available slots. Use the Child Care Resource and Referral database, ACCIS database, the HRA/FIA Child Care Directories and any other available information.

Information and counseling about finding child care is available by phone through the Child Care Resource and Referral Consortium at **1-888-469-5999**. If there is a child care specialist from a Child Care Resource agency at the site, refer the parent to this person.

When vacancy information becomes available for Head Start programs and ACD programs, workers will also use that information for referrals.

Call the program or provider the parent is interested in, or assist the parent to call, to confirm the vacancy and make an appointment for the parent to go there.

For Head Start and ACD programs, send a copy of the approved application with the parent to document the referral.

2. Emergency Child Care Assistance

For any person who indicates they need help paying for child care because of the World Trade Center disaster, explain that Emergency Child Care Assistance is available. Give them an Emergency Child Care Assistance application (**EXP-53**) to complete.

Identification and Eligibility

- If identification is not immediately available, inform that applicant that a check cannot be issued until documentation/verification is submitted, as described below.
- Review two forms of identification to verify the name and address on the application.
- Request any verification the applicant may have such as birth certificate, school ID card, immunization record, to confirm the identity and relationship of the child to the applicant.
- Review the Reason Why Care Is Needed on the application.

Lost Residence

- For Lost Residence, review two documents, such as a Driver's License, insurance card or utility bill, which confirm the address listed as lost. The address must be below Houston Street, and within zip codes 10002, 10003, 10004, 10005, 10006, 10007, 10009, 10011, 10012, 10013, 10014, 10038, 10048.

Lost Income

- For Lost Income, review at least one document, such as a check stub within the past month or a letter from the employer, which verifies the applicant's employment and employment address. The address must be below Houston Street, within zip codes 10002, 10003, 10004, 10005, 10006, 10007, 10009, 10011, 10012, 10013, 10014, 10038, 10048. Note that some workers have lost employment from firms who served the disaster area but are not located there. If this is the case, request whatever documentation the person can provide regarding their employer and the site of their work location.

Loss of Family Member

- For Loss of Family Member, request the New York Police Department Missing Persons Log number. If there is an alternate document (such as a death certificate) which verifies the loss, review it. Establish verification of the relationship between the family member who is lost and the child. If verification is not available, ask that it be provided by return visit or fax as soon as possible.

Lost Child Care

- For Lost Child Care, review the name and address of the child care program or provider which is closed. Confirm that the program is below Houston Street, with zip codes 10002, 10003, 10004, 10005, 10006, 10007, 10009, 10011, 10012, 10013, 10014, 10038, 10048. A list of programs that are closed will be available soon.

Emergency Rescue Work

- For Emergency Rescue Work, review the name of the agency or employer (such as New York Police Department, New York Fire Department, United States Army, American Red Cross, or a private iron work or construction firm). The applicant should be able to provide a badge number or permit number, the name or a contact person at the agency or firm, and a contact phone number there.

Review the Brief Description of Reason for Emergency Child Care and assess its validity in light of the above information and the needs described in the Background section of this form.

Child Care Need and

Cost

- Review the hours and days child care is needed and the ages of the children needing care. Child care that totals under 30 hours per week is part time care. Children whose ages are under three years are infants and toddlers. Children age three years and older are preschool or school age children. The maximum monthly amounts which can be issued are:

Regulated/Licensed Care	Full-time	Part-time
Infants and Toddlers	\$1,260	\$840
Preschool and School Age	\$840	\$570

(These rates apply to regulated, licensed care facilities only. Providers must be listed in the HRA/FIA Child Care Directory. If they are not listed, parent must return with a copy of the provider's State license.)

If the child care provider is unlicensed, the following maximum monthly amounts apply:

Licensed Care	Full-time	Part-time
Infants and Toddlers	\$464	\$321
Preschool and School Age	\$380	\$247

Child Care Provider

- Review the child care provider name, address, phone, Social Security number State license number or employer identification number if available. If not available, request that the information be faxed as soon as possible. (Identify a fax number at your site).

Household and Income information

- Explain that the household and income information are waived at this time.

Issuing Payment

- If the application is complete and the information verified as described above, complete the Agency Only portion of the form. Authorize Emergency Child Care by signing the form and filling in either the dollar amount, up to maximums on the above chart, or the name of the Head Start or ACD facility the child will go to. Make a copy of the application form for the applicant.
- If the check is to be immediately issued, take the applicant to the check issuance unit on site. Make sure that the check number is entered on both copies of the application form, and keep a copy of the check for the records.
- If the parent has selected a Head Start Center, an ACD program, or another no-fee program, do not issue an Emergency Child Care check. Make a copy of the application, which will serve as a referral to the Head Start or ACD program.

At the end of each day, deliver or fax a copy of the Emergency Child Care Assistance application form to HRA/FIA Office of Child Care, 180 Water Street, 24th Floor, Fax 212-331-4486.

3. Ongoing Child Care Assistance

If the applicant will need ongoing child care assistance, use the regular child care process in addition to Emergency Child Care Assistance. This may require referral to an ACD Resource Area for non-public assistance families or a referral to an HRA/FIA IS/Job Center for public assistance families.



REQUEST TO PARTICIPATE IN THE SUPPLEMENTAL TRANSITIONAL WORK SUPPORT PROGRAM

Case Name: _____

Case Number: _____

I have spoken with an FIA Worker and I understand the benefits of the Supplemental Transitional Work Support Program (STWSP). I would like to participate in this program and I understand that in order to do so I must VOLUNTARILY CLOSE MY PUBLIC ASSISTANCE CASE.

I understand that if I participate in this program, I will receive \$200 each month for a maximum of twelve months as long as I remain off of public assistance. The payments may be used to cover costs incurred to support my continued employment such as:

- Transportation to and from work
- Uniforms
- Meals at work
- Tools necessary to perform the job
- Other work-related expenses

I understand that if I am currently in receipt of Jiggetts rent relief and the amount paid by Jiggetts is over \$50 per month, my landlord will continue to receive the Jiggetts payment each month for a maximum of 12 months if I remain off of public assistance. The Jiggetts rent payment to the landlord will be in addition to the \$200 monthly work support payment which I will receive.

I understand that if I reapply for public assistance after my case has been closed four months or more I may not be eligible for public assistance at that time because initially, I will not be eligible to have a portion of my employment income disregarded when determining my public assistance eligibility. In addition, I also understand that in order to reapply for Jiggetts relief in the future I must first be eligible for public assistance. I have discussed my Jiggetts situation with my FIA Worker.

I understand that, upon the closing of my case, I will be eligible to receive:

- Transitional child care benefits for up to one year. After the year is up, depending on my income, I may qualify for low-income child care.
- Transitional Medicaid benefits for six months and, if my income has not substantially increased, I may be eligible to receive Medicaid for an additional six months.

My FIA Worker has explained how the receipt of the \$200 monthly support payment will affect the amount of my food stamp benefits. I understand that I will receive a separate notice about my food stamp benefits.

I understand what the Supplemental Transitional Work Support Program is about and I would like to participate in the program. I voluntarily consent to the closing of my case so that I may take advantage of what this program has to offer.

Participant Signature

Date

FIA Worker Signature

Date

SOLICITUD PARA PARTICIPAR EN EL PROGRAMA SUPLEMENTAL DE TRANSICIÓN DE APOYO AL TRABAJO

Nombre del Caso: _____

Número del Caso: _____

Yo he hablado con un Trabajador de la FIA y comprendo los beneficios del Programa Suplemental de Transición de Apoyo al Trabajo (Supplemental Transitional Work Support Program -STWSP). Me gustaría participar en este programa y comprendo que para poder hacerlo yo tengo que CERRAR MI CASO DE ASISTENCIA PÚBLICA VOLUNTARIAMENTE.

Yo comprendo que si yo participo en este programa, yo recibiré \$200 cada mes por un máximo de doce meses con tal de que yo permanezca fuera de la asistencia pública. Los pagos pueden ser usados para cubrir los gastos incurridos para mantener mi empleo continuo tales como:

- Transportación para la ida y vuelta al trabajo
- Uniformes
- Comidas en el trabajo
- Herramientas necesarias para ejecutar el trabajo
- Otros gastos relacionados con el trabajo

Yo comprendo que si actualmente estoy recibiendo ayuda para el alquiler Jiggetts y que la cantidad pagada por Jiggetts es sobre los \$50 al mes, mi casero continuará recibiendo el pago Jiggetts cada mes por un máximo de 12 meses si yo no recibo asistencia pública. Los pagos para el alquiler Jiggetts al casero serán en adición al pago mensual de \$200 para el apoyo al trabajo que yo recibiré.

Yo comprendo que si solicito nuevamente para asistencia pública después de que mi caso haya sido cerrado cuatro meses o más, pueda que no sea elegible para asistencia pública entonces porque inicialmente, no seré elegible para hacer que no se tome en cuenta una porción de mi ingreso por empleo al momento de determinar mi elegibilidad para asistencia pública. Además, también entiendo que para poder solicitar nuevamente para ayuda Jiggetts en el futuro, tengo que primero ser elegible para asistencia pública. Yo he discutido mi situación Jiggetts con mi Trabajador de la FIA.

Yo comprendo que, al cierre de mi caso, yo seré elegible para recibir:

- Beneficios de transición para el cuidado de niños por hasta un año. Después que termine el año, dependiendo de mi ingreso, puede que yo califique para cuidado de niños con bajos ingresos.
- Beneficios de transición de Medicaid por seis meses y, si mi ingreso no ha aumentado considerablemente, puede que sea elegible para recibir Medicaid por unos seis meses adicionales.

Mi Trabajador de la FIA me ha explicado como el recibir el pago de apoyo por \$200 al mes afectará la cantidad de mis beneficios de cupones para alimentos. Yo comprendo que recibiré una notificación por separado acerca de mis beneficios de cupones para alimentos.

Yo comprendo de qué se trata el Programa Suplemental de Transición de Apoyo al Trabajo y me gustaría participar en el programa. Yo consiento voluntariamente que cierren mi caso para que yo pueda aprovechar lo que ofrece este programa.

Firma del Participante

Fecha

Firma del Trabajador de la FIA

Fecha



Date: _____

Case Number: _____

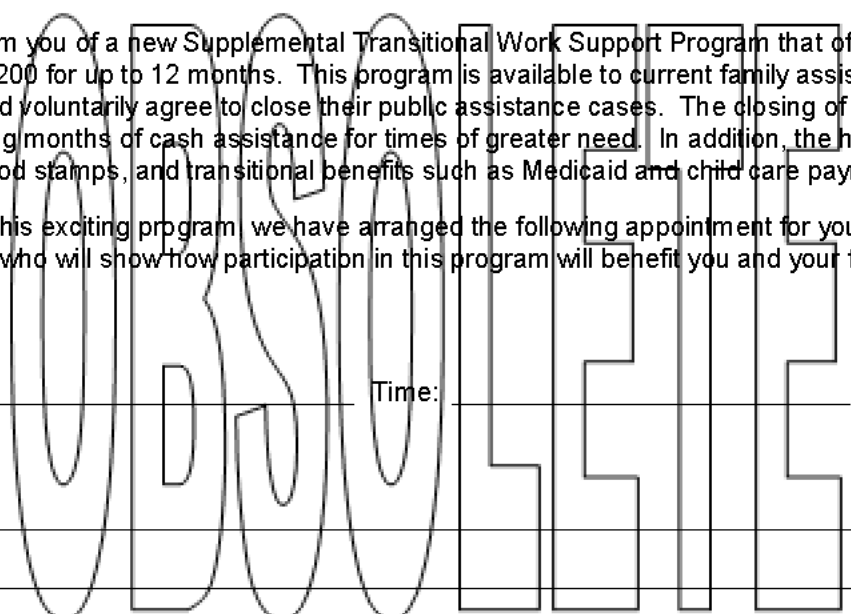
Caseload: _____

Dear Participant:

As you already know, the period of time that a family may receive cash assistance is limited to five years (60 months) as a result of the Welfare Reform Act of 1996. Our records show that you are currently receiving a small amount of cash assistance and are about to approach the end of your 60-month time limit.

We are proud to inform you of a new Supplemental Transitional Work Support Program that offers a monthly work support payment of \$200 for up to 12 months. This program is available to current family assistance participants who are employed and voluntarily agree to close their public assistance cases. The closing of the case will preserve the remaining months of cash assistance for times of greater need. In addition, the household may continue to receive food stamps, and transitional benefits such as Medicaid and child care payments.

To learn more about this exciting program, we have arranged the following appointment for you to speak with an informed FIA Worker who will show how participation in this program will benefit you and your family.



Day/Date: _____ Time: _____

Location: _____

Travel directions: _____

This appointment offers you the opportunity to obtain complete information that will allow you to make an informed decision that will best meet the needs of your family. Enclosed is a flyer which provides you with information and explanation of the benefits of the program.

If you cannot keep this appointment and would like to arrange another date/time, please call: _____ to reschedule.

Sincerely,

Jason A. Turner
Commissioner

Fecha: _____

Número de Caso: _____

Carga de Casos: _____

Estimado Participante:

Como usted ya sabe, el período de tiempo que una familia puede recibir asistencia de dinero en efectivo está limitado a cinco años (60 meses) como resultado de la Ley de Reforma del Bienestar Público de 1996 (Welfare Reform act of 1996). Nuestros archivos indican que usted está actualmente recibiendo una pequeña cantidad de asistencia de dinero en efectivo y está acercándose al final de su límite de tiempo de 60 meses.

Estamos orgullosos de informarle acerca de un nuevo Programa Suplemental de Transición de Apoyo al Trabajo (STWSP) que ofrece un pago mensual de apoyo al trabajo de \$200 hasta por 12 meses. Este programa está disponible a participantes actuales de asistencia familiar quienes están empleados y quienes voluntariamente accedieron a cerrar su caso de asistencia pública. El cierre de su caso preservará la asistencia de dinero en efectivo de los meses restantes para tiempos de mayor necesidad. Además, el hogar puede continuar recibiendo cupones para alimentos, beneficios de transición tales como Medicaid y pagos de cuidado para niños.

Para aprender más acerca de este programa excitante, le hemos concertado la siguiente cita para hablar con un Trabajador informado de la Administración de Independencia Familiar (FIA) quien le mostrará cómo la participación en este programa le beneficiará a usted y a su familia:

Día/Fecha: _____ Hora: _____

Lugar: _____

Direcciones de Viaje: _____

Esta cita le ofrece la oportunidad de obtener información completa que le permitirá tomar una decisión bien fundada la que mejor ha de satisfacer las necesidades de su familia. Adjunto se encuentra un folleto que le provee información y explicación de los beneficios del programa.

Si no puede acudir a esta cita y le gustaría concertar para otra fecha/hora, favor de llamar al _____ para programar de nuevo una cita.

Atentamente,

Jason A. Turner
Commissioner