FAMILY INDEPENDENCE ADMINISTRATION

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POLICY DIRECTIVE #07-35-OPE

REQUESTS FOR REPLACEMENT OF STOLEN FOOD STAMP BENEFITS

Date: October 2, 2007	**Subtopic(s):** Food Stamps

AUDIENCE

The instructions in this policy directive are for all Job Center and Non-Cash Assistance Food Stamp (NCA FS) (formerly known as NPA FS) Center staff.

POLICY

Decisions to replace FS benefits reported stolen from the Electronic Benefit Transfer (EBT) system are made by the Office of Temporary and Disability Assistance (OTDA) on a case-by-case basis.

Alleged stolen FS benefits may be replaced only if:

- the participant contacted EBT Customer Service prior to the benefit theft to report a lost, stolen or compromised Common Benefit Identification Card (CBIC) or came to the center and requested a Personal Identification Number (PIN) restriction, and
- the Agency or EBT Customer Service failed to take appropriate steps to deactivate the lost, stolen or compromised CBIC or failed to complete a requested PIN restriction.

REQUIRED ACTION

If a Cash Assistance (CA) FS or NCA FS participant contacts a JOS/Worker by telephone to say his/her CBIC has been lost, stolen or compromised, or someone has gained information about their identity that may result in benefits being stolen, the participant must be instructed to call the toll-free EBT Customer Service helpline at (888) 328-6399. The Customer Service representative will immediately disable the card to prevent future use. The JOS/Worker will instruct the participant to come to the Job Center/NCA FS Center to complete and sign an EBT Customer Service Automated Response Unit (ARU) Personal Identification Number (PIN) Restriction Permission Form (**EBT-64**) and request a new CBIC.

Once the **EBT-64** is signed, the Administrative System transaction to restrict the PIN must be completed within an hour of the form's being completed, and prior to the request for a new CBIC.

If a participant reports that his/her FS benefits have been stolen from the EBT system, s/he should be informed that benefits may be replaced only if:

- the participant contacted EBT Customer Service prior to the benefit theft to report a lost, stolen or compromised Common Benefit Identification Card (CBIC) or came to the center and requested a Personal Identification Number (PIN) restriction, and
- the Agency or EBT Customer Service failed to take appropriate steps to deactivate the lost, stolen or compromised CBIC or failed to complete a requested PIN restriction

Participants who inform the JOS/Worker that they contacted EBT Customer Service concerning a lost, stolen or compromised CBIC prior to the theft of their FS benefits should come to the Job/NCA FS Center to complete and sign an **EBT-64** and the newly created Request for Replacement of Food Stamp Benefits Stolen from the EBT System form (**W-130B**). The **W-130B** poses the following questions:

- Did you contact EBT Customer Service to report a lost, stolen or compromised CBIC or PIN before the alleged theft of benefits?
- If yes, when was this report made?
- Did you come into the Agency and see a worker to request and complete a PIN Restriction Permission Form?
- If yes, when did you come in? (provide a date)
- Was the PIN restriction processed on the card?
- When did you realize the benefits were stolen from the system?
- How much Food Stamp money was stolen from your account?

Space has been provided on the **W-130B** for the participant to list any information s/he has concerning the theft of his/her FS benefits from the EBT system.

See PD #07-03-OPE for information on fraud referrals to BFI.

If the JOS/Worker suspects that a participant is committing fraud in order to obtain benefits, s/he is required to report the information to the Bureau of Fraud Investigation (BFI). Referrals to BFI should also be done when participants claim that their benefits have been stolen due to identity theft or vendor fraud.

After the participant has completed the **W-130B**, the JOS/Worker signs the form and gives him/her a copy. The JOS/Worker should inform participants that they will be notified via mail of the Agency's decision. The JOS/Worker will contact his/her liaison listed on the Replacement of Stolen Food Stamp Benefits Liaison List (**Attachment A**) for the appropriate program and region.

The liaisons will be trained to review and evaluate a participant's request to replace FS benefits stolen from the EBT system.

The liaisons will keep a log of all incoming requests and review the participant's request for replacement of stolen FS benefits with the Transactions and Card History on the EBT Administrative terminal.

Liaisons will be responsible for determining if a participant's request to replace stolen FS benefits meets the criteria outlined in this policy directive. The liaison will review information and decide if there was a failure at either the EBT Customer Service or Agency PIN restriction level that contributed to benefits being stolen. Proof of a participant's request to restrict his/her PIN can be documented via an **EBT-64**.

If the liaison has determined that the participant's request to replace stolen FS benefits does not meet the criteria listed in this policy directive, s/he will notify the JOS/Worker that the benefits cannot be replaced.

If the liaison has determined that the proven failure of EBT Customer Service to deactivate a CBIC reported lost, stolen or compromised or the Agency's proven failure to complete a requested PIN restriction has caused FS benefits to be stolen from the EBT system, s/he will document his/her findings and forward the information to the OTDA. When a decision has been made, OTDA will notify the liaison, who will contact the JOS/Worker and inform him/her of the reason for denial or the amount of benefits that are to be replaced.

The JOS/Worker will record the Agency's decision on the newly created Action Taken on Your Request for Replacement of Food Stamp Benefits Stolen from the EBT System form (**W-130G**). The JOS/Worker will mail the original **W-130G** to the participant while retaining a copy in the electronic case record.

If OTDA authorizes a FS benefit replacement, it may be replaced using Issuance Code **24** (replace stolen benefits) in Job Centers and Issuance Code **26** (replace stolen benefits) in NCA FS Centers.

See PD #07-27-OPE for PIN selection information.	JOS/Workers should remind participants to safeguard their CBIC and not to disclose their PIN or any other personal information to any unauthorized individuals.

PROGRAM IMPLICATIONS

Model Office Implications	There are no Model Office implications.
Paperless Office System (POS) Implications	There are no POS implications.
Medicaid Implications	There are no Medicaid implications.

LIMITED ENGLISH SPEAKING ABILITY (LESA) AND HEARING-IMPAIRED IMPLICATIONS

For Limited English Speaking Ability (LESA) and hearing-impaired participants, make sure to obtain appropriate interpreter services in accordance with PD #06-12-OPE and PD #06-13-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 at Job Centers	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. In Model Offices, the Receptionist at Main Reception will issue an FH&C ticket to the applicant/participant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.

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.

Should the applicant/participant elect to continue his/her appeal by requesting a Fair Hearing 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.

Conferences at Food Stamp Centers

If an applicant/participant comes to the FS Center and requests a conference, the Receptionist must alert the FS Center Manager's designee that the applicant/participant is to be seen. If the applicant/participant contacts the Eligibility Specialist directly, advise the applicant/participant to call the FS Center Manager's designee. In Model Centers, the Receptionist at Main Reception will issue a FS Conf/Appt/Problem ticket to the applicant/participant to route him/her to the NCA Reception area and does not need to verbally alert the FS Center Manager. The NCA Receptionist will alert the FS Center Manager once the applicant/participant is called to the NCA Reception desk.

The designee will listen to and evaluate the applicant/participant's complaint regarding the FS case. The FS Center Manager's designee is responsible for ensuring that further appeal by the applicant/participant through a Fair Hearing request is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Evidence Packets

For Fair Hearing purposes, all evidence packets must include complete and relevant documentation.

REFERENCE

00 ADM-8

ATTACHMENTS

💻 Please use Print on Demand to obtain copies of forms.

Attachment A	Replacement of Stolen Food Stamp Benefits Liaison List
W-130B	Request for Replacement of Food Stamp Benefits Stolen from the EBT System
W-130B (S)	Request for Replacement of Food Stamp Benefits Stolen from the EBT System (Spanish)
W-130G	Action Taken on Your Request for Replacement of Food Stamp Benefits Stolen from the EBT System
W-130G (S)	Action Taken on Your Request for Replacement of Food Stamp Benefits Stolen from the EBT System (Spanish)
EBT-64	EBT Customer Service Automated Response Unit (ARU) Personal Identification Number (PIN) Restriction Form (Rev. 4/10/07)
EBT-64 (S)	EBT Customer Service Automated Response Unit (ARU) Personal Identification Number (PIN) Restriction Form (Spanish) (Rev. 4/10/07)

Attachment A

REPLACEMENT OF STOLEN FOOD STAMP BENEFITS LIAISON LIST

Job Centers:

Brooklyn/Bronx/Manhattan/Queens Region
Ms. Sara Chin
(718) 237-5672

Special Needs Region
Ms. Isabel Lesmes
(212) 331-5511

Housing and Homeless Services Region
Ms. Maria Cortes
(212) 331-4133

Child Only Family Services Region
Mr. John Noel
(212) 331-5600

NCA FS Centers:

Ms. Julie Ibanez
(212) 331-4131

Form W-130B LLF
10/2/07

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Job Center/NCA FS Center: _____

Request for Replacement of Food Stamp Benefits Stolen from the EBT System

Please complete this form if you are requesting replacement of Food Stamp benefits stolen from the EBT system.

I am requesting: ☑ Replacement of Food Stamp benefits stolen from the EBT system.

Did you contact EBT Customer Service to report a lost, stolen or compromised CBIC or PIN before the alleged theft of benefits? ☐ No ☐ Yes

If yes, when was this report made? _____

Did you come into the Agency and see a worker to request and complete a PIN Restriction Permission Form?

☐ No ☐ Yes

If yes, when did you come in? (provide a date) _____

Was the PIN restriction processed on the card? ☐ No ☐ Yes

When did you realize the benefits were stolen from the system? _____

How much Food Stamp money was stolen from your account? _____

List any information you have concerning the theft of your Food Stamp benefits from the EBT system.

_____

_____

_____

_____

_____ _____

Participant's Signature Date of Request

_____ _____

Worker's Signature Date

SAMPLE

Form W-130B (S) LLF
10/2/07

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro de Trabajo/Centro de NCA FS: _____

Petición para Reemplazar Beneficios de Cupones para Alimentos Robados del Sistema de EBT

Favor de llenar este formulario si está solicitando reemplazo de sus beneficios de Cupones para Alimentos robados del sistema de EBT.

Estoy solicitando: ☑ Reemplazo de beneficios de Cupones para Alimentos robados del sistema de ETB.

¿Contactó usted al Departamento de Atención al Cliente (Customer Service) de EBT para reportar un CBIC o una clave (PIN) perdidos, robados, o inseguros antes del presunto robo de beneficios? ☐ No ☐ Sí

En caso afirmativo, ¿cuándo se hizo este reporte? _____

¿Se presentó usted a la Agencia para reunirse con un trabajador y solicitar y llenar un Formulario de Permiso para Restricción de PIN (PIN Restriction Permission Form)? ☐ No ☐ Sí

En caso afirmativo, ¿cuándo se presentó usted? (indique la fecha) _____

¿Se tramitó la restricción del PIN de la tarjeta? ☐ No ☐ Sí

¿Cuándo se dio usted cuenta que los beneficios fueron robados del sistema? _____

¿Qué cantidad de dinero de Cupones para Alimentos fueron robados de su cuenta? _____

Haga un listado de cualquier información que tenga sobre el robo de sus beneficios de Cupones para Alimentos del sistema EBT.

_____

_____

_____

_____

_____ _____

Firma del Participante Fecha de la Petición

_____ _____

Firma del Trabajador Fecha

SAMPLE

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Job Center/NCA FS Center: _____

Worker Telephone No: _____

FH&C Telephone No: _____

Action Taken on Your Request for Replacement of Food Stamp Benefits Stolen from the EBT System

On _____ (date) , you requested replacement of Food Stamp benefits stolen from the EBT system.

SAMPLE

☐ Your request has been accepted. You will receive $ _____ for the period _____ to _____.

☐ Your request has been denied because: _____

_____

_____ Worker's Signature

_____ Date

_____ Supervisor's Signature

_____ Date

Replacement of stolen Food Stamp benefits:

Benefits may be replaced if they were stolen due to an Agency error (e.g. participant submitted a request to restrict a PIN but the Agency failed to take action and benefits were subsequently stolen from the system).

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

Conference and Fair Hearing Information

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

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

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

(2) WRITE: Send a copy of the entire notice, with the "Fair Hearing Request" section completed, to:
Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201
(Please keep a copy for yourself.)

SAMPLE

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

(4) IN PERSON: Bring a copy of the entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at either:
14 Boerum Place, Brooklyn or **330 West 34th Street, 3rd floor, Manhattan**

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

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

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

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

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

FAIR HEARING REQUEST
Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within ninety (90) days from the date of the notice for Food Stamp issues.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, in person or online, please write to ask for a Fair Hearing before the deadline. **Note:** If your situation is extremely serious please explain your situation; the State will attempt to process your request for a Fair Hearing as quickly as possible. If you call to request a Fair Hearing, please be prepared to explain your situation to the person who answers the phone.

SAMPLE

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

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

Address: _____

_____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro de Trabajo/
Centro de NCA FS: _____

Núm. de Teléfono
del Trabajador: _____

Núm. de Teléfono
de FH&C: _____

Medidas Tomadas con Respecto a su Petición de Reemplazo de Beneficios de Cupones Para Alimentos Robados del Sistema de EBT

SAMPLE

El _____ (Fecha), usted solicitó reemplazo para beneficios de Cupones Para Alimentos robados del sistema.

☐ Su solicitud ha sido aceptada. Usted recibirá $ _____ para el período de _____ al _____.

☐ Su solicitud ha sido rechazada porque: _____

_____

Firma del Trabajador	Fecha	Firma del Supervisor	Fecha

Reemplazo de beneficios de cupones robados de alimentos:

Los cupones son reemplazables si fueron robados debido a un error por parte de la Agencia (p.ej., el participante presentó una petición de restricción al PIN [Número de Identificación Personal], pero la Agencia no tomó las medidas necesarias y los beneficios fueron posteriormente robados del sistema).

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

Información sobre Conferencias y Audiencias Imparciales

CONFERENCIA

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

AUDIENCIA IMPARCIAL ESTATAL

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

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

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

SAMPLE

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

(4) EN PERSONA: Traiga una copia de todo el aviso, con la sección "Petición de Audiencia Imparcial" llenada, a la Oficina de Audiencias Administrativas, Oficina de Asistencia Temporaria y para Incapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a cualquiera de las siguientes direcciones:
14 Boerum Place, Brooklyn o **330 West 34th Street, 3rd floor, Manhattan**

(5) POR INTERNET: Complete una solicitud de formulario electrónico conectándose a:
http://www.otda.state.ny.us/oah/forms.asp

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

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, podría obtener tal asistencia comunicándose con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede localizar la Sociedad de Ayuda Legal o grupo de abogacía más cercano buscando en las Páginas Amarillas (Yellow Pages) bajo "lawyers" (abogados).

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

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

PETICIÓN DE AUDIENCIA IMPARCIAL
Fecha Límite: Si usted desea que el Estado revise nuestra decisión, tiene que solicitar una Audiencia Imparcial dentro de noventa (90) días a partir de la fecha de este aviso para asuntos de Cupones para Alimentos.

Si no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporaria y para Incapacitados (New York State Office of Temporary and Disability Assistance) por teléfono, por fax, en persona o por Internet, favor de enviar por escrito su solicitud de Audiencia Imparcial antes de la fecha límite. **Nota:** Si su circunstancia es sumamente urgente, favor de explicarlo en detalle el Estado hará todo esfuerzo de procesar su solicitud para una Audiencia Imparcial lo más pronto posible. Si usted llama para solicitar una Audiencia Imparcial, por favor esté preparado para explicar su situación a la persona que conteste el teléfono.

SAMPLE

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

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

Dirección: _____

_____ Teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____

Form EBT-64 LLF
Rev. 4/10/07

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

CIN: _____

EBT Customer Service Automated Response Unit (ARU)
Personal Identification Number (PIN) Restriction Permission Form

Payee's Name _____

As the payee for the case indicated above, I am requesting that the Agency

☐ Restrict

☐ Unrestrict

access to the EBT Customer Service ARU PIN selection function for all of my applicable Client Benefit Identification Cards (CBICs).

SAMPLE

_____ _____
Payee's Signature Date

_____ _____
Worker's Signature Date

To Be Completed by Designated Person	
EBT Restriction Action ☐ Yes ☐ No	EBT Restriction Lifted ☐ Yes ☐ No
Signature _____	Date _____

Form EBT-64 (S) LLF
Rev. 4/10/07

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

CIN: _____

Formulario de Permiso de Restricción del Número de Identificación Personal Unidad de Reacción Automatizada de Atención al Cliente de EBT

Nombre del Beneficiario _____

Como beneficiario del caso indicado más arriba, solicito que la Agencia

☐ Restrinja

☐ Levante la restricción del

acceso a la función de selección del Número de Identificación Personal (Personal Identification Number – PIN) de la Unidad de Reacción Automatizada (Automated Response Unit – ARU) de Atención al Cliente de EBT para todas mis Tarjetas de Identificación de Beneficios del Cliente (Client Benefit Identification Cards – CBICs) que correspondan.

SAMPLE

_____ _____
Firma del Beneficiario Fecha

_____ _____
Firma del Trabajador Fecha

To Be Completed by Designated Person	
EBT Restriction Action ☐ Yes ☐ No	EBT Restriction Lifted ☐ Yes ☐ No
Signature	Date