FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #08-161-OPE

(This Policy Bulletin Obsoletes PB #02-152-ELI)

REVISIONS TO FORMS W-186C AND W-186D

Date:	Subtopic(s):
December 19, 2008	Fair Hearing

This procedure can now be accessed on the FIAweb.

The purpose of this policy bulletin is to inform Job Center and Non Cash Assistance Food Stamp (NCA FS) Center staff of recent modifications to the Fair Hearing Compliance Statement (**W-186C**) form and the Fair Hearing Compliance Request (**W-186D**) form.

Both forms have been updated to reflect the following Agency-wide changes:

- The new New York City (NYC) logo
- Public Assistance (PA) references have been updated to Cash Assistance (CA) to reflect the Agency's current language use

An appellant is the party for whom a Fair Hearing is requested.

Forms **W-186C** and **W-186D** have been modified to better explain to Fair Hearing appellants the actions the Agency has taken or intends to take on their case, based upon the Fair Hearing decision(s). Both forms should be completed using the Paperless Office System (POS); however, when POS is down both forms can be completed manually.

The Fair Hearing Compliance Statement (**W-186C**) form has been modified to include the following:

- Three new sections entitled Shelter Allowance, Other Actions, and Miscellaneous have been added.
- The section entitled Appointment Scheduled has been deleted.

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or send an e-mail to *FIA Call Center*

- The section formerly entitled Public Assistance, Food Stamps and/or Medical Assistance has been expanded and is referred to as Appointment Scheduled/Information Requested/ Documentation Required.

The Fair Hearing Compliance Request (**W-186D**) form has been modified as follows:

- The instructions for submitting documents (when an in-person interview is not necessary) have been expanded.
- On page two, a new section on child care benefits and related documents has been added.

For both forms, check marks ☑ are only entered in the boxes next to the statements that apply to that particular scenario. Each bullet represents a corresponding check mark.

Instructions relevant to the completion of both forms (**W-186C** and **W-186D**) are as follows:

- Enter the Notice Date, Case Number, Case Name, Center, Fair Hearing Number, and Fair Hearing Decision Date.
- On the last page of both forms, enter the Worker's name and date of signing, and the Supervisor's name and date of signing.

The following are instructions for completing form **W-186C**:

Enter the appellant's name.

Cash Assistance: Food and Other

- Select the **first** box in this section only in situations in which a nonrecurring or retroactive Cash Assistance grant is being issued. Enter the amount of the appellant's nonrecurring or retroactive Cash Assistance grant, enter the period covered, and the date the benefit will be available.

- Select the **second** box in this section only in situations in which there has been a change in the appellant's semimonthly Cash Assistance grant. Enter the amount of the appellant's semimonthly Cash Assistance grant immediately prior to the Fair Hearing request date. Next, enter the effective date of the new semimonthly Cash Assistance grant and the amount.

- Select the **third** box in this section only in situations in which the appellant's restored Cash Assistance grant is reduced by recoupment(s) not related to the Fair Hearing issues.

- Select the **fourth** box in this section only in situations in which there was no loss of Cash Assistance benefits due to aid-continuing or no change in the Cash Assistance benefit amount as a result of the Fair Hearing decision.
- Select the **fifth** box in this section only in situations in which the Agency has re-evaluated the appellant's eligibility for Cash Assistance and determined that the appellant is ineligible for benefits.
- Select the **sixth** box in this section only in situations in which there is no change in the appellant's Cash Assistance benefits based on an instruction to recalculate or recompute the Cash Assistance benefits.
- Select the **seventh** box in this section only in situations in which the appellant is ineligible for retroactive Cash Assistance benefits based on reasons not related to the Fair Hearing issue(s).

  Note: If the appellant is ineligible for Cash Assistance benefits for reasons not related to the Fair Hearing issue(s) and the Food Stamp benefits must be restored, retroactive Food Stamps **must be issued** for a period going back no further than 12 months from the Fair Hearing request date, even if the Cash Assistance case is currently closed. To issue the retroactive Food Stamp benefits, use Single Issuance Code **20** for closed Cash Assistance cases or Single Issuance Code **22** for closed Food Stamps cases.

Shelter Allowance

- Select the **first** box in this section only in situations in which a shelter allowance is being issued. Enter the amount of the shelter allowance, the period the shelter allowance covers, and the date the shelter allowance will be available.
- Select the **second** box in this section only in situations in which there has been a change in the appellant's semimonthly shelter allowance. Enter the amount of the appellant's semimonthly shelter allowance immediately prior to the Fair Hearing request date, the effective date of the new shelter allowance and the amount of the benefit.

- Select the **third** box in this section only in situations in which the appellant's shelter supplement was restored. Enter the shelter supplement type (e.g., Jiggetts, etc.) and the date the shelter supplement was restored.
- Select the **fourth** box in this section only in situations in which the appellant's shelter supplement (e.g., Jiggetts, etc.) is not being restored. Enter the reason(s) why the benefit was not restored. (e.g., the appellant needs to re-apply).
- Select the **fifth** box in this section only in situations in which the appellant is ineligible for retroactive shelter benefits based on reasons not related to the Fair Hearing issue(s).

Other Actions (if applicable)

- Select the **first** box in this section only in situations in which the Agency's sanction determination remains unchanged, and enter the sanctioned participant's name.

Refer to PB #08-59-SYS for more information on lifting sanctions.

- Select the **second** box in this section only in situations in which the Agency's sanction determination was reversed and the Cash Assistance and/or Food Stamps sanction was deleted/lifted. Enter the sanctioned participant's name.
- Select the **third** box in this section only in situations in which a decision was rendered on the appellant's Cash Assistance and/or Food Stamps recoupment. Enter the recoupment number and a check mark☑ to indicate if the recoupment remains unchanged or was deleted.
- Select the **fourth** box in this section only in situations in which the appellant's budget was changed, and enter the reason why the appellant's budget was changed.
- Select the **fifth** box in this section only in situations in which the appellant did not lose any child care benefits due to aid-continuing or because child care benefits where not lost during the Fair Hearing process as a result of the issue(s) underlying the Fair Hearing, and the appellant's child care benefits remain the same.
- Select the **sixth** box in this section only in situations in which the appellant may be eligible for retroactive child care benefits, and enter the retroactive date of the child care benefits.

  Note: If a check mark ☑ is appropriate here, the following check box must be check marked, as well.

- Select the **seventh** box in this section only in situations in which the appellant or the child care provider must fax verification of child care services and/or timesheets to the Administration for Children's Services' Voucher Payment Unit at 212-227-2257 in order to receive retroactive and/or ongoing child care.
- Select the **eighth** box in this section only in situations in which the appellant is not eligible for child care benefits, and enter the reason(s) why the appellant is not eligible for child care benefits.

Food Stamps

- Select the **first** box in this section only in situations in which retroactive Food Stamps are being issued to the appellant. Enter the amount of the appellant's retroactive Food Stamp benefits, the period covered, and the date the benefits will be available.
- Select the **second** box in this section only in situations in which there has been a change in the appellant's monthly Food Stamp benefits. Enter the amount of the appellant's monthly Food Stamp benefits immediately prior to the Fair Hearing request date. Next, enter the effective date of the new monthly Food Stamp benefits and the amount of those benefits.
- Select the **third** box in this section only in situations in which the appellant's Food Stamp benefits are reduced by recoupment(s) not related to the Fair Hearing issues.
- Select the **fourth** box in this section only in situations in which there was no loss of Food Stamp benefits due to aid-continuing or no change in the Food Stamp benefits amount as a result of the Fair Hearing decision.
- Select the **fifth** box in this section only in situations in which the Agency has determined that the appellant is ineligible for Food Stamp benefits.
- Select the **sixth** box in this section only in situations in which there is no change in the appellant's Food Stamp benefits based on an instruction to recalculate or recompute the Food Stamp benefits.

Note: If the appellant is ineligible for Cash Assistance benefits for reasons not related to the Fair Hearing issue(s) and the Food Stamp benefits must be restored, retroactive Food Stamps **must be issued** for a period going back no further than 12 months from the Fair Hearing request date, even if the Cash Assistance case is currently closed. To issue the retroactive Food Stamp benefits, use Single Issuance Code **20** for closed Cash Assistance cases or Single Issuance Code **22** for closed Food Stamps cases.

Medical Assistance

- Select this box only in situations in which the appellant's interrupted Medicaid benefits are being restored along with the appellant's Cash Assistance benefits.

Miscellaneous

- Select the **first** box in this section only in situations in which the Agency's prior employability determination remains unchanged, or
- Select the **second** box in this section only in situations in which the Agency is required to review/re-evaluate the appellant's medical claim based on the Fair Hearing decision and a WeCARE appointment was given to the appellant.

Appointment Scheduled/Information Requested/Documentation Required

- Select this box only in situations in which additional information was requested from the appellant and not supplied. Enter the date of the request, the document(s) requested, and the due date for submission of the document(s).

The following are instructions for completing form **W-186D**.

- Select the **first** box only in situations in which the appellant must provide the requested documents at an in-person interview. Next, enter the following information about the in-person interview:
  - Location Name
  - Address, City, State and Zip Code
  - Appointment Date and Time
  - Telephone Number
- Select the **second** box only in situations in which the appellant is not required to appear at an in-person interview, and may submit all requested documents by mail, fax or drop-off in person. Next, enter the following information about the document submission process:
  - Location Name
  - Attention
  - Address, City, State and Zip Code
  - Due date
  - Fax number

- For all situations, the **third** box is always selected. Next, identify the documents that the appellant must bring to the interview or submit via mail, fax or in-person drop-off.

Only check mark child care related check boxes if the review determines that child care was lost because of the Agency's action forming the basis of the underlying Fair Hearing.

- Select the **fourth** box only in situations in which the appellant was in receipt of child care benefits prior to the Fair Hearing request and the child care was interrupted. The appellant is advised to follow the instructions provided in the check marked section that applies to the appellant's current situation.

  - Enter a check mark ☑ only in situations in which the appellant's child care provider has not changed and a completed Child Care Provider Enrollment Supplement (**CS-274W**) form must be provided; and/or
  - Enter a check mark ☑ only in situations in which the appellant is in need of a new provider. The appellant and the provider must complete both the Child Care Provider Enrollment Supplement (**CS-274W**) form and the Enrollment Form for Provider of Legally-Exempt Family Child Care and Legally-Exempt In-Home Child Care (**LDSS-4699**), or the Enrollment Form for Provider of Legally-Exempt Group Child Care (**LDSS-4700**).

Job Center Directors and NCA FS Managers must ensure that all previous versions of forms **W-186C** and **W-186D** are removed from circulation and recycled.

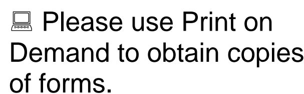
Samples of the revised forms are attached.

Effective Immediately

Related Items:

PD #06-20-OPE
PB #08-59-SYS

Attachments:



Please use Print on Demand to obtain copies of forms.

W-186C	Fair Hearing Compliance Statement (Rev. 12/19/08)
W-186C (S)	Fair Hearing Compliance Statement (Spanish) (Rev. 12/19/08)
W-186D	Fair Hearing Compliance Request (Rev. 12/19/08)
W-186D (S)	Fair Hearing Compliance Request (Spanish) (Rev. 12/19/08)

Human Resources Administration
Department of Social Services
Family Independence Administration

Notice Date: ____________________

Case Number: ____________________

Case Name: ____________________

Center: ____________________

FH Number: ____________________

FH Decision Date: ____________________

Fair Hearing Compliance Statement

Dear ______________________________:

Here is how we have complied with your Fair Hearing decision:

Cash Assistance: Food and Other

☐ We are issuing you $ ____________ as a nonrecurring or retroactive Cash Assistance grant for ________________________ (Period covered). This benefit will be available to you on or before ____________ (Date).

☐ Immediately before your Fair Hearing request, your semimonthly Cash Assistance grant was $__________.

Effective ________________ (Date), your semimonthly Cash Assistance grant will be $ __________________.

☐ Your restored benefits mentioned above are being offset by recoupment(s) not at issue in this Fair Hearing, reducing your semimonthly Cash Assistance grant.

☐ You did not lose any Cash Assistance benefits because you received aid-continuing Cash Assistance during the Fair Hearing process. Therefore, your Cash Assistance benefits remain the same.

☐ We have re-evaluated your eligibility for Cash Assistance and have determined that you are not eligible. You will be sent a separate notice of our determination.

☐ Your Cash Assistance benefits remain unchanged.

☐ We are not issuing any Cash Assistance benefits at this time because you are currently ineligible for benefits based on reasons not related to the issues addressed in this Fair Hearing.

SAMPLE

Shelter Allowance

☐ We are issuing you $ _______________ as a shelter allowance for ______________________________.
(Period covered)

This benefit will be issued directly to your landlord on or before _____________________________.
(Date)

☐ Immediately before your Fair Hearing request, your semimonthly shelter allowance was $ ____________.

Effective ______________, your shelter allowance will be $ ________________.
(Date)

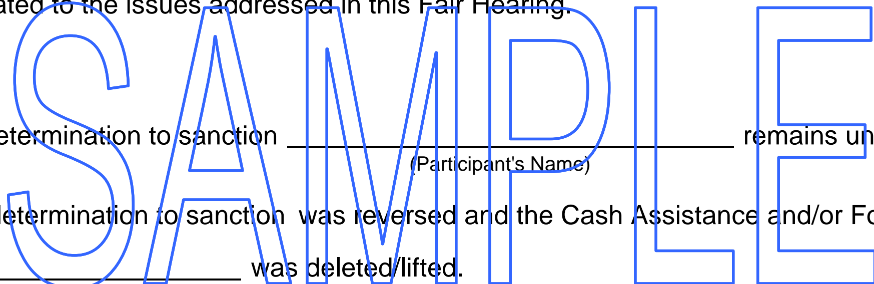
☐ Your shelter supplement ________________________________ was restored on ______________.
(Examples: Jiggetts, FEPS, etc.) (Date)

☐ We are unable to restore your shelter supplement ____; because
(Examples: Jiggetts, FEPS, etc.)

____

____.

☐ We are not issuing any shelter benefits at this time because you are currently ineligible for benefits based on reasons not related to the issues addressed in this Fair Hearing.


SAMPLE

Other Actions

☐ The Agency's determination to sanction ______________________________ remains unchanged.
(Participant's Name)

☐ The Agency's determination to sanction was reversed and the Cash Assistance and/or Food Stamps sanction for ____________________ was deleted/lifted.
(Participant's Name)

☐ The recoupment, RTI # _____________________ ☐ remains unchanged or ☐ was deleted.

☐ Your budget was changed because ____

____

____.

☐ You did not lose any child care benefits because you received aid-continuing for child care during the Fair Hearing process. Therefore, your child care benefits remain the same.

☐ You may be eligible for child care retroactive to ___________________.
(Date)

☐ In order to receive retroactive and/or ongoing child care, you or your provider must forward verification of child care services and/or time-sheets to the Administration for Children's Services' Voucher Payment Unit at 212-227-2257.

☐ You are not eligible for child care because ____.

Food Stamps

☐ We are issuing you $ _______________ in retroactive Food Stamps for _______________________.
(Period covered)

These Food Stamps will be available to you after _____________________.
(Date)

☐ Immediately before your Fair Hearing request, your monthly Food Stamp benefits were $ ______________.

Effective ______________, your monthly Food Stamp benefits will be $ ______________.
(Date)

☐ The restored Food Stamps mentioned above are being offset by recoupment(s) not at issue in this Fair Hearing, reducing your ongoing Food Stamp benefit.

☐ You did not lose any Food Stamp benefits because you received aid-continuing during the Fair Hearing process. Therefore, your Food Stamp benefits remain the same.

☐ We have re-evaluated your eligibility for Food Stamps and have determined that you are not eligible. You will be sent a separate notice of our determination.

☐ Your Food Stamp benefits remain unchanged.

SAMPLE

Medical Assistance

☐ If your Medicaid benefits were interrupted, they will be restored along with your Cash Assistance benefits.

Miscellaneous

☐ The Agency's determination that found you to be ☐ employable or ☐ employable with limitations remains unchanged.

☐ Based on the decision of your Fair Hearing, we are required to review/re-evaluate your medical claim. You received an appointment on ________________ for a medical evaluation.

Appointment Scheduled/Information Requested/Documentation Required

☐ We have been unable to determine if you are eligible for the benefits that were the subject of your Fair Hearing. We mailed you a letter on ______________ (Date), asking you to come in for an interview and/or submit the following: ____

______________________________ by ______________________ (Date).

Because you have failed to respond to our letter, we cannot complete any compliance action until you come in and/or supply the requested information. If you come in and/or bring the information to your Center within ten (10) days from the date of this notice, we will consider the information in accordance with the Fair Hearing decision. Documentation/information returned after ten (10) days will be used to determine your eligibility for the benefits at issue from the date of receipt.

Comments (Optional):

SAMPLE

Worker's Name	Date
Supervisor's Name	Date

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha del Aviso: ____________________

Número del Caso: ____________________

Nombre del Caso: ____________________

Centro: ____________________

Número de la Audiencia Imparcia (FH): ____________________

Fecha de la Decisión de FH: ____________________

Declaración de Cumplimiento de la Audiencia Imparcial

Estimado(a) ____________________________:

Hemos tomado la(s) siguiente(s) medida(s) en cumplimiento de la decisión de la Audiencia Imparcial:

Asistencia en Efectivo: Alimentos y Otros Beneficios

☐ Le hemos asignado una concesión quincenal de Asistencia en Efectivo de $ ____________ no recurrente o retroactiva para el ______________________________ (Período de cobertura). Este beneficio estará disponible para usted usted a más tardar el ____________ (Fecha).

☐ Inmediatamente antes de su solicitud de Audiencia Imparcial, su concesión quincenal era de $ __________. A partir de ____________ (Fecha), su concesión quincenal de Asistencia en Efectivo será de $ ______________.

☐ Sus beneficios restituidos mencionados más arriba han sido reducidos debido a compensaciones no relacionadas con esta Audiencia Imparcial, lo que reduce su concesión quincenal de Asistencia en Efectivo.

☐ Usted no perdió beneficios de Asistencia en Efectivo dado que durante el trámite de la Audiencia Imparcial usted recibía Asistencia en Efectivo continua (aid-continuing). Por lo tanto, sus beneficios de Asistencia en Efectivo permanecerán sin cambios.

☐ Tras reevaluar su elegibilidad de Asistencia en Efectivo hemos determinado que usted no es elegible. Le enviaremos por separado un aviso de dicha determinación.

☐ Su Asistencia en Efectivo permanecerá sin cambios.

☐ En este momento no estamos expediendo beneficios de Asistencia en Efectivo, debido a que usted actualmente es inelegible para beneficios por razones no relacionadas con la Audiencia Imparcial.

SAMPLE

Concesión de Albergue

☐ Le estamos expediendo $ ____________ como concesión de albergue por ______________________.
(Período de cobertura)

Este beneficio se expedirá directamente a su casero a más tardar el ____________________.
(Fecha)

☐ Inmediatamente antes de su solicitud de Audiencia Imparcial, su concesión quincenal de albergue era de $ ________________.

A partir de _____________, su concesión de albergue será de $ ______________ .
(Fecha)

☐ Su suplemento de albergue _______________________ se restituyó el ______________.
(Ejemplos: Jiggetts, FEPS,) (Fecha)

☐ No podemos restituir su suplemento de albergue _______________________________________; porque
(Ejemplos: Jiggetts, FEPS, etc.)

____

____.

☐ En este momento no estamos expediendo beneficios de albergue, debido a que usted actualmente es inelegible para beneficios por razones no relacionadas con la Audiencia Imparcial.

SAMPLE

Otras Medidas

☐ La determinación de la Agencia de sancionar ____________________________ sigue sin cambio.
(Nombre del Participante)

☐ La determinación de la Agencia de sancionar fue revocada y la sanción de Asistencia en Efectivo y/o Cupones para Alimentos ________________________ fue borrrada/levantada.
(Nombre del Participante)

☐ El reembolso, # RTI ___________________ ☐ sigue sin cambios o ☐ fue borrado.

☐ Su presupuesto se cambió porque ____

____

____.

☐ Usted no perdió beneficios de cuidado infantil porque recibió asistencia continua para cuidado infantil durante la Audiencia Imparcial. Por lo tanto, sus beneficios de cuidado infantil permanecerán sin cambios.

☐ Usted puede ser elegible para cuidado infantil retroactivamente a ______________.
(Fecha)

☐ Para recibir cuidado infantil retroactivo y/o continuo, usted o su proveedor tienen que presentar comprobante
de servicios de cuidado infantil y/o horarios de asistencia a la Unidad de Comprobantes de Pago de la Administración de Servicios al Niño al (212) 227-2257.

☐ Usted no es elegible para cuidado infantil porque ____.

Cupones para Alimentos

☐ Le hemos otorgado una concesión retroactiva de Cupones para Alimentos por la cantidad $ ___________ por ________________________________.
(Período de cobertura)

Esta concesión de cupones para alimentos estará a su dispocisión después del _____________.
(Fecha)

☐ Inmediatamente antes de su petición de Audiencia Imparcial, su beneficio mensual de Cupones para Alimentos era de $ ___________.

A partir del _____________, la cantidad de sus beneficios de Cupones para Alimentos será $ _________.
(Fecha)

☐ Los beneficios restituidos de Cupones para Alimentos mencionados más arriba han sido reducidos debido a compensaciones no relacionadas con esta Audiencia Imparcial, lo que reduce su beneficio continuo de Cupones para Alimentos.

☐ Usted no perdió beneficios de Cupones para Alimentos porque recibió asistencia continua durante la Audiencia Imparcial. Por lo tanto, sus beneficios de Cupones para Alimentos permanecerán sin cambios.

☐ Tras reevaluar su elegibilidad para Cupones para Alimentos hemos determinado que usted no es elegible. Le enviaremos por separado un aviso de dicha determinación.

☐ Sus beneficios de Cupones para Alimentos permanecerán sin cambios.

SAMPLE

Asistencia Médica

☐ Si sus beneficios de Medicaid fueron interrupidos, dichos beneficios serán restituidos junto con sus beneficios de Asistencia en Efectivo.

Beneficios Variados

☐ La determinación de la Agencia que le juzgó ☐ empleable o ☐ empleable con limitaciones sigue sin cambios.

☐ Según la decisión de la Audiencia Imparcial, nosotros tenemos que repasar/reevaluar su reclamo médico. Usted recibirá una cita el _______________ para una evaluación médica.

Cita Programada/Información Solicitada/Documentación Solicitada

☐ No hemos podido determinar si usted es elegible para los beneficios que fueron objeto de su Audiencia Imparcial. Le enviamos una carta el ______________, pidiéndole que se presente a una entrevista y/o
(Fecha)
traiga lo siguiente: ____

____ para el _________________.
(Fecha)

Debido a que usted no contestó a nuestra carta, no podemos llevar a cabo ninguna medida de cumplimiento hasta que usted se presente y/o proporcione los datos necesarios. Si usted se presenta y/o trae dichos datos a su Centro dentro de diez (10) días de la fecha de este aviso, tomaremos los datos en cuenta, conforme a la decisión de la Audiencia Imparcial. La documentación/información devuelta después de diez (10) días se utilizará para determinar su elegibilidad para los beneficios en cuestión desde la fecha de recibo.

Comentarios (Opcionales):

SAMPLE

___________________________________ ___________________________
Nombre del Trabajador Fecha

___________________________________ ___________________________
Nombre del Supervisor Fecha

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Notice Date: ______________________

Case Number: ______________________

Case Name: ______________________

Center: ______________________

FH Number: ______________________

FH Decision Date: ______________________

Fair Hearing Compliance Request

In order to comply with your Fair Hearing decision, you must provide the documentation listed below. Please follow the instructions provided in the check marked sections.

☐ An in-person interview is necessary, please report to:

Location Name: ______________________

Address: ______________________

____

City: ______________ State: ________ Zip Code: ________

Appointment Date: ____________ Time: ________ Telephone Number: ______________

OR

☐ An in-person interview is not necessary. Please mail, fax, or drop-off in-person all requested documents to the following address:

Location Name: ______________________

Attention: ______________________

Address: ______________________

____

City: ______________ State: ________ Zip Code: ________

Due date: ______________ Fax: ______________

☐ Please bring/provide the following documents:

SAMPLE

☐ If you were in receipt of child care benefits prior to your Fair Hearing request and your child care was interrupted, please follow the instructions provided in the check marked section that applies to your current situation:

- ☐ If your child care provider has not changed, please provide a completed Child Care Provider Enrollment Supplement form (**CS-274W**).

- ☐ If you need a new provider, you and your provider must complete the Child Care Provider Enrollment Supplement form (**CS-274W**) and if you are using a legally-exempt (informal) child care provider you must also submit the Enrollment Form For Provider Of Legally-Exempt Family Child Care and Legally-Exempt In-Home Child Care (**LDSS-4699**), or the Enrollment Form For Provider Of Legally-Exempt Group Child Care (**LDSS-4700**).

Worker's Name ______________________ Date ______________

Supervisor's Name ______________________ Date ______________

SAMPLE

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Fecha del Aviso: ______________________

Número del Caso: ______________________

Nombre del Caso: ______________________

Centro: ______________________

Número de la Audiencia Imparcial: ______________________

Fecha de la Decisión de la Audiencia Imparcial: ______________________

Petición de Cumplimiento de la Audiencia Imparcial

Para cumplir con la decisión de su Audiencia Imparcial, usted tiene que proveer los documentos indicados más abajo. Favor de seguir las instrucciones que aparecen en las secciones marcadas más abajo.

☐ Se necesita una entrevista en persona, favor de presentarse a:

SAMPLE

Nombre del Local: ______________________

Dirección: ______________________

____

Ciudad: ______________ Estado: ________ Código Postal: ________

Fecha de la cita: ______________ Hora: ________ Número de Teléfono: ________

O

☐ No se necesita una entrevista en persona. Favor de enviar por correo, fax, o entregar en persona todos los documentos necesarios a la siguiente dirección:

Nombre del Local: ______________________

Dirección: ______________________

____

Ciudad: ______________ Estado: ________ Código Postal: ________

Fecha Límite: ______________ Fax: ______________

☐ Favor de traer/proporcionar los siguientes documentos:

☐ Si usted recibía beneficios de cuidado infantil antes de su petición de Audiencia Imparcial y su cuidado infantil se vio afectado, favor de seguir las instrucciones de la casilla seleccionada que corresponde a su situación:

- ☐ Si su proveedor de cuidado infantil no ha cambiado, favor de proporcionar el Suplemento de Inscripción del Proveedor de Cuidado Infantil **(CS-274W-S)** llenado.

- ☐ Si necesita un nuevo proveedor, usted y su proveedor tienen que llenar el formulario Suplemento de Inscripción del Proveedor de Cuidado Infantil **(CS-274W-S)** y si usted se sirve de un proveedor de cuidado infantil legalmente-exento (informal) también tiene que presentar el Enrollment Form for Provider of Legally-Exempt Family Child Care and Legally-Exempt In-Home Child Care **(LDSS-4699)**, **o** el Enrollment Form for Legally-Exempt Group Child Care **(LDSS-4700)**.

______________________________ ______________________________
Nombre del Trabajador Fecha

______________________________ ______________________________
Nombre del Supervisor Fecha

SAMPLE