Human Resources Administration
Department of Social Services

CD #20-19

M E M O R A N D U M
(Replaces CD #20-15)

DATE: July 24, 2020

TO: Job Center Directors, SNAP Center Directors, Regional Managers

FROM: James K. Whelan, Executive Deputy Commissioner
Office of Policy, Procedures, and Training

SUBJECT: **Telephone Application and Recertification Submission Process for Job Center #90 During the COVID-19 Emergency**

REVISIONS TO PRIOR MEMORANDUM

This Center Director Memorandum is being revised to include recertification submissions via telephone.

PURPOSE

The purpose of this memorandum is to discuss changes to the application and recertification submission process for individuals who are unable to use ACCESS HRA or come into one of the open Job Centers. The process will be handled through Job Center #90 during the COVID-19 Emergency through August 31, 2020. Applicants and participants who contact the Office of Constituent Services (OCS) requesting assistance in submitting an application or recertification will be informed that they have the following options to submit an application or recertification:

- in person at one of the open Job Centers; or
- online through ACCESS HRA; or
- through the mail; or
- over the telephone if other submission methods are not viable options for the applicant; or
- a home visit, if necessary.

Regardless of submission method, OCS will assess for the potential need for home visit status and the need for a referral to Center #90 through probing questions, as per their regular operating procedure. All referrals to Center #90, whether for HVN or for telephone submission, will be made in the AT-HOME system.

Note: Supplemental Nutrition Assistance Program (SNAP) only applicants/participants, OCS will be connected with Benefits Data Trust (BDT) who can assist with the telephonic submission.

PROCEDURE

Prior to the scheduled appointment, Center #90 staff will call the applicant to determine what assistance the applicant needs in submitting an application and the options available to the applicant. In the recertification appointment context, when Center 90 staff call the clients to schedule their recertification appointment, they must inform the client of the options available to the participant for completion of their recertification.

Applicant/Participant Agrees to Phone Interview and AHRA Submission

During the confirmation call, staff must inform the applicant/participant that as a result of the COVID-19 pandemic, the center is able to and encourages applicants/participants that they can do the interview over the phone if they prefer, on their scheduled date, or a mutually agreed upon rescheduled date, once a signed application/recertification is received.

Staff must remind the applicant/participant that they should apply or recertify online through the ACCESS HRA (AHRA) online portal (www.nyc.gov/accesshra) or the mobile app. Once the electronic application or recertification is received, Center #90 staff will contact the applicant and conduct a telephone interview. After the interview, Center #90 staff must indicate that the interview was completed in the AT-HOME system by selecting “Phone Interview Complete” and indicating the date that the interview was conducted.

Note: Staff are reminded that when communicating with an applicant/participant, even over the phone, that their communication preferences must be honored. Staff must obtain appropriate interpretation services for individuals who are Limited English Proficient (LEP) or deaf/hard-of-hearing. Please refer to **PD #18-10-OPE**, **PD #17-19-OPE**,and **DSS-PB-2019-003** for detailed instructions.

Applicant/Participant Agrees to Phone Interview but Cannot Use AHRA Submission

If during the call, the applicant/participant indicates that they cannot, or will not, use AHRA to apply online, Center #90 staff will inform the applicant/participant that an interview may still be conducted over the telephone, and that the application or recertification will be completed by the HRA employee during the interview. Center #90 staff must inform the applicant/participant that they will have to verbally agree to multiple parts of the application/recertification and that their verbal agreement will be considered the same as a signature on the application/recertification, and therefore conducting the interview will take longer than usual.

If the applicant/participant agrees, Center #90 staff will inform the individual that they can complete the application/recertification and conduct the interview at that time, if both the applicant/participant and Center #90 staff member are available.
If the applicant/participant or Center #90 staff are not able to conduct the interview at that time, the applicant/participant can keep their scheduled date and will be contacted for their interview on that date. If the interview cannot be conducted at the time of the call, and if the applicant/participant would prefer a different date than the one previously scheduled Center #90 staff must reschedule the appointment for a mutually agreed upon date and enter it in the AT-HOME system.

When doing the application/recertification submission over the phone, Center #90 staff must conduct the interview and read through the application/recertification in its entirety, including all scripts that are displayed in POS when they pop-up during the interview (Able Bodied Adult Without Dependent Script, General SNAP Work Requirement Script, and the non-discrimination statement).

At each point of the POS application where a signature is required, Center #90 staff must read the appropriate statement from POS and verbally ask the applicant/participant if they understand and if they agree. If there are other adults in the household, Center #90 staff must also read the appropriate statements from POS to each of those adults and ask the other adults if they also affirm/agree with the statements. After receiving the verbal agreement from the applicant/participant (and any other adults in the household), Center #90 staff must check the box in POS to indicate that the applicant/participant is not present at the interview in order to proceed with the interview.

If during the interview it appears that the applicant/participant is having difficulty understanding the questions, staff must try to rephrase the questions in a way that may be easier to understand.

If any additional documentation is needed, staff must generate and send the **W-113K** to the applicant/participant along with the completed POS Application and a business reply envelope. Center #90 staff must read through the documents required with the applicant/participant so that they know what documents are needed and the due dates of those documents, as well as inform them about how they can submit the documents (i.e. RightFax and number, AHRA Mobile Doc Upload, home visit [if necessary] etc.). After reviewing the documents with the applicant/participant, and informing them that documents will be mailed to them, staff must read the script provided by the NY Office of Temporary and Disability Assistance (OTDA) in **Attachment A**.

Note: For SNAP only cases, a separate script has been developed by OTDA and is attached as **Attachment B.**

In addition to the **W-113K** and the completed POS Application, Center #90 staff must also send applicants/participants the Authorization To Repay Public Assistance Benefits From Retroactive SSI (**W-148A**) form. Applicants/Participants must sign and return the **W-148A** within 30 days. If the **W-148A** is not signed and returned by the 30th day, a case by case good cause determination must be made if the applicant had a good cause reason for not returning the signed form. Good cause could include, but is not limited to, such things as mobility issues preventing the applicant from getting to a mailbox and sheltering in place to avoid potential exposure to the Coronavirus. If there is a finding of good cause, and the applicant/participant is otherwise eligible, the case may be processed, and a case note must be entered to indicate the finding of good cause. A signed **W-148A** must be obtained at the next time when it is safe and practicable to do so (i.e., safe for staff to collect it at a home visit, applicant exits mandatory quarantine, etc.).

If there is no finding of good cause, and it was an application submission, the application for Cash Assistance must be denied with reason code **N17** (Failure to Complete Eligibility Process) as IAR is a condition of eligibility. If it was a recertification submission, the continuing eligibility date (CED) must be entered to ensure that the SNAP benefits will continue and then the CA case must be closed with reason code **Y99** (Other) and a manual notice must be sent. To assist staff with creating the proper manual notice, a fillable version of the Notice of Intent to Change Benefits: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Timely & Adequate) (NYC) (**LDSS-4015 A/B-NYC**) has been created. The fillable version has the proper regulatory citation and text for the closing.

Note: A separate Medicaid and SNAP determination will be required as IAR is not a requirement for these programs.

To provide applicants with instructions on their next steps, the Post Telephone Submission Instructions (**FIA-1229**) form**,** has been created and must be included in the mailing to the applicant. This form informs applicants that they must return the **W-148A** with a n ink signature a ”wet signature”) within 30 days. The **FIA-1229** also informs the applicant that if any of the information on the POS application or recertification that was mailed to them is incorrect, or if anything needs to be added, that they can do so on that form, initial the change, and send it back.

At the end of the interview, staff must:

- enter a detailed case note indicating that the application/recertification was completed over the telephone per the COVID-19 waiver;
- include in the case note that they affirm that the applicant/participant agreed to all signature parts of the application/recertification and the OTDA script (**Attachment A**) has been read to the applicant/participant and received the applicant’s/participant’s verbal assent; and

- indicate in the AT-HOME system that the outcome was a completed telephone submission by selecting “Phone Interview Complete – No APP” and noting the date that the application/interview was completed.

Note: Staff are reminded that when communicating with an applicant/participant, even over the phone, that their communication preferences must be honored. Staff must obtain appropriate interpretation services for individuals who are Limited English Proficient (LEP) or deaf/hard-of-hearing. Please refer to **PD #18-10-OPE**, **PD #17-19-OPE**, and **DSS-PB-2019-003** for detailed instructions.

Applicant/Participant Still Requires a Home Visit For Submission and Interview

During the initial confirmation call, if the applicant/participant indicates that none of the other options are viable and a home visit is still needed, Center #90 staff must ask the following questions:

- Has anyone in the household experienced fever, cough or shortness of breath?
- In the 14 days prior to home visit, have you or anyone in the household traveled to a foreign country?
- Has anyone in the household recently had contact with a person who is suspected or confirmed to have infection with novel coronavirus (COVID-19)?

If the answer is “yes”, to any of these questions, the home visit should be postponed, and the individual should be advised to seek medical attention. These incidents must be reported to the Center Director or their designee immediately. Prior to the postponed appointment date, Center #90 staff must again offer the alternatives to the home visit.

Reference:
20 GIS TA/DC 049
20 GIS TA/DC 055
20 GIS TA/DC 066
20 GIS TA/DC 075

Attachments:

Attachment A	OTDA CA/MA/SNAP Script
Attachment B	OTDA SNAP Only Script
W-148A	Authorization To Repay Public Assistance Benefits From Retroactive SSI (Rev. 12/28/2017)
FIA-1229 (E)	Post Telephone Submission Instructions (07/14/2020)
LDSS-4015 A/B NYC	Notice of Intent to Change Benefits: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Timely & Adequate) (NYC) (**LDSS-4015 A/B-NYC**)

ATTACHMENT A

PA, SNAP or MA on a PA case Application

Telephonic Signature Script

This script is based on the expectation that the applicant will complete the application by telephone, that the worker will be reading and reviewing all the information required on the LDSS 2921 (or local equivalent) with the applicant and reading to the applicant all of the notices, assignments, authorizations, consents and penalty warnings in such application and reading and reviewing the Rights and Responsibilities as contained in the Rights and Responsibilities booklet LDSS 4148B.

SCRIPT (must be read in its entirety):
You have had your rights and responsibilities concerning notices, assignments, authorizations and consents explained to you, **including those set forth below**. You understand what was explained to you and you were given an opportunity to ask questions about anything, including the following:

1. You have authorized the collection and use of social security numbers for each household member applying for Public Assistance (PA), Supplemental Nutritional Assistance Program (SNAP) or Medicaid (MA) on a PA case.

2. You have been read and understand the Nondiscrimination notice.

3. You have consented to any investigation to verify or confirm the information you have given in connection with your request for PA, SNAP or MA on a PA case.

4. You have authorized the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance purposes to OTDA.

5. You have agreed to the sharing of information regarding PA or SNAP to service providers for purposes of verifying eligibility and payment related to program administration provided by a State or local contractor.

6. You have agreed to inform the agency promptly of any change in address, needs, income, resources and property, able-bodied adult without dependents (ABAWD) status, household composition, pregnancy status or living arrangements.

7. You have been read and understand the information concerning the penalties for not telling the truth when applying for PA, Medicaid or SNAP.

8. You have been read and understand the requirements about accurately reporting household expenses, and you agree to report household expenses.

9. You have been informed of your ability to authorize a representative to apply for SNAP and MA benefits on a PA case for you.

10. You have been informed about your possible eligibility for the standard utility allowance.

11. You have been advised and agree to the release of medical information for the purposes read to you.

ATTACHMENT A

12. You agree, if applicable, to the release of educational records, information for the early intervention program, and the child/teen health program.

13. You have been informed of the possible reimbursement of medical expenses in the Medicaid program, and the authorization of payments in the Medicare Program.

14. You have been informed and agree that you must file any claims for health or accident insurance benefits, and to pursue any personal injury claims or any other resources to which you may be entitled, and agree to assign any such resources to the social services district to whom this application is made. In addition, you will assist in making any assigned benefits available to the social services district to whom this application is made.

15. You authorize payments owed to you or members of your household for health or accident insurance benefits to be made directly to the appropriate social services district for medical and other health services furnished while you are eligible for Medicaid.

16. You have been read and understand that as a condition of receiving PA, you may be required to execute a deed or mortgage of real property that you own, and that tax refunds and portions of lottery winnings may be taken to repay your debt for PA.

17. You authorize the Social Security Administration (SSA) to use your first Supplemental Security Income (SSI) payment to reimburse the district for Public Assistance it paid from State and local funds to you while SSA decides if you are eligible for SSI.

18. You understand that you will not be bound until the State gives notice to SSA that you and the district representative have signed an authorization. If the State does not give notice within 30 calendar days of matching your SSI record with your State record, SSA will send your retroactive SSI payment to you under SSA rules.

19. You understand that only your first payment of SSI can be used. If your first payment is larger than the amount owed to the district, SSA will send the rest to you.

20. SSA can reimburse the district in two situations: (1) It will repay the district if SSA finds you eligible, or (2) if your SSI benefits are reinstated after termination or suspension.

21. SSA will only reimburse the district for PA it paid during the time you were waiting for an SSA determination of eligibility. This is called “interim assistance.” The period begins: 1) with the first month you become eligible for payment of SSI benefits, or 2) on the first day you are reinstated after your SSI was suspended or terminated. No later than 10 days after SSA reimburses the social services district, the district must send you a notice telling you the amount of interim assistance paid.

22. Under its rules, SSA may use the date you sign this authorization as the date you first become eligible for SSI. It will do this only if you apply for SSI within the next 60 days.

23. This authorization applies to any SSI application or appeal you now have pending before SSA. This authorization terminates if your SSI case is completely decided. It terminates when SSA first pays you. The State and you can also agree to terminate the authorization.

ATTACHMENT A

24. You will be given an opportunity for a fair hearing if you disagree with a decision the district made about reimbursement.

25. You have been advised that applying for or receiving PA or title IV-E foster care operates as an assignment of rights to the State and to the social services district, and you agree to the assignment of support rights.

26. You have been read and agree to the requirements for receiving HEAP benefits.

27. You have been provided with sexual assault information.

28. You have also certified that if applying for childcare assistance, your family resources do not exceed $1,000,000.

29. That you will receive either an LDSS-2921 application in counties outside of New York City or an Authorization To Repay Public Assistance Benefits From Retroactive SSI in New York City (W-148A) in the mail and you and all applying adults will sign and send it back to your social services district within 30 days of making this telephone application.

30. You will be given an opportunity for a fair hearing if you disagree with a decision about your eligibility, or, if you are found eligible, your household's benefit amount.

You acknowledge and understand that by verbally signing this application you are verbally agreeing that you:

1) have been read and understand the notices in this application;

2) understand and agree to the assignments, authorizations and consents in this application;

3) have been read and understand the penalty warnings in this application;

4) authorize the Social Security Administration (SSA) to reimburse the district for Public Assistance you received while SSA decided your application for SSI as described in the application that was read to you;

5) swear and/or affirm under the penalties of perjury that the information you have given in this application or will give to the social services district is complete and correct.

Please indicate your verbal agreement and signature by stating " I so sign". If applying for PA, the applicant, applicant's spouse and all applying adults must be on the phone and must verbally sign as set forth above.

ATTACHMENT B

SNAP-Only Application

Telephonic Signature Script

This script is based on the expectation that the applicant will complete the application by telephone, that the worker will be reading and reviewing all the information required on the LDSS-4826, SNAP Application/Recertification form, with the applicant, and reading to the applicant all of the notices, assignments, authorizations, consents and penalty warnings in the application and reviewing the Rights and Responsibilities as contained in the Rights and Responsibilities booklet, LDSS-4148B.

SCRIPT (must be read in its entirety):
You have had your rights and responsibilities concerning notices, assignments, authorizations and consents explained to you, **including those set forth below**. You understand what was explained to you and you were given an opportunity to ask questions about anything, including the following:

1. You have authorized the collection and use of your social security number for each household member applying for the Supplemental Nutritional Assistance Program (SNAP) and for all other programs for which the collection of social security numbers are required.

2. You have been read and understand the Nondiscrimination Statement.

3. You have consented to any investigation to verify or confirm the information you have given in connection with your request for SNAP.

4. You have authorized the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance purposes to OTDA.

5. You have agreed to the sharing of information regarding SNAP to service providers for purposes of verifying eligibility and payment related to program administration provided by a State or local contractor.

6. You have agreed to inform the agency promptly of any change in address, needs, income and property, able-bodied adult without dependents (ABAWD) status, pregnancy status or living arrangements.

7. You have been read and understand the information concerning the penalties for not telling the truth when applying for SNAP.

8. You have been read and understand the requirements about accurately reporting household expenses, and you agree to report household expenses.

9. You have been informed of your ability to authorize a representative to apply for SNAP benefits for you.

10. You have been informed about your possible eligibility for the standard utility allowance.

ATTACHMENT B

11. You have been informed of the possible reimbursement of out-of-pocket Medical expenses for members of your household who are age 60 or older, or disabled.

12. You have been advised of and agreed to the release of medical information for the purposes read to you.

13. You will be given an opportunity for a fair hearing if you disagree with a decision about your eligibility or, if you are found eligible, your household's benefit amount.

14. You have been read and agree to the requirements for receiving HEAP benefits.

You acknowledge and understand that by verbally signing this application you are verbally agreeing that you: 1) have been read and understand the notices in this application; 2) understand and agree to the assignments, authorizations and consents in this application; 3) have been read and understand the penalty warnings in this application; and, 4) swear and/or affirm under the penalties of perjury that the information you have given in this application or will give to the social services district is complete and correct. Please indicate your verbal agreement and signature by stating " I so sign".

Department of Social Services
Human Resources Administration
Department of Homeless Services
Family Independence Administration

Authorization To Repay Public Assistance Benefits From Retroactive SSI

I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of Supplemental Security Income (SSI) [i.e. my retroactive SSI payment] to reimburse the local Social Services District (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for SSI. SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SAMPLE

SSA can reimburse the SSD in two situations:

(1) It will repay the SSD if I apply for SSI and SSA finds me eligible.
(2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called “interim assistance”. The period begins (1) with the first month I become eligible for payment of SSI benefits, or (2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and, that if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

(Turn page)

This authorization applies to any SSI application or appeal I now have pending before SSA.

This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called "What You Should Know About Social Services Programs." I understand what it says about interim assistance.

I swear (or) affirm that the information I have given or will give to the SSD is true and correct.

SAMPLE

Name (please print)

Signature Date

Spouse or Authorized Representative Signature Date

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

Date: _____

Case Number: _____

Case Name: _____

Center: _____

POST TELEPHONE SUBMISSION INSTRUCTIONS

Thank you for submitting your application or recertification over the phone. But you aren't done yet!

Included with this letter are three very important documents that we discussed with you over the phone:

- Authorization To Repay Public Assistance Benefits (W-148A)
- Documentation Requirements and/or Assessment Follow-Up (W-113K)
- Paper copy of the interview completed over the phone (LDSS-2921/LDSS-3174)

SAMPLE

Each of these documents requires your review and may also require an action from you.

W-148A

You must read and sign this form in ink (a "wet" signature). This form must be returned within 30 days. If the signed form is not returned and you don't have a good cause reason why it is not, you may not be eligible for Cash Assistance benefits.

W-113K

This form tells you what documents we still need from you to see if you are eligible for benefits. You must return these documents within 10 days. If you do not send us the documents you may not be eligible for Cash Assistance or possibly Supplemental Nutrition Assistance Program (SNAP) benefits.

LDSS-2921/LDSS-3174

This is a paper copy of the application/recertification interview you had over the telephone. Please review it to see if there are any errors or if anything was left out. Please make any changes that are needed and put your initials next to the change.

(Turn Page)

You can send these forms back to us using any of the following methods:

	**E-Mail:**	**ctr90hvnrequests@hra.nyc.gov**
	**Fax:**	**917-639-0433**
	**Mail:**	HRA Homebound Center 90 109 East 16th Street New York, NY 10003
	**ACCESS HRA's Mobile App:**	Go to www.nyc.gov/hradocs on your mobile device. Or, you can get the mobile app for free in the Apple App Store or the Google Play Store.

SAMPLE

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

LDSS-4015 A NYC (Rev. 5/16)

NOTICE OF INTENT TO CHANGE BENEFITS: PART A

PA, MA, SNAP, Serv – Change

PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE) (NYC)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	Home Visit Needed/RAR 109 E. 16th St., 6th FL New York, NY 10003
CASE NAME (And C/O Name if Present) AND ADDRESS	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
090	HVN			

We are CHANGING your benefits as explained below and on PART B, next to the checked box(es) ☑ :

SEE PART B FOR SNAP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **REDUCE** your Public Assistance Benefit effective _____ from $ _____ to $ _____ because:

☐ _____ failed without good cause to cooperate with the Office of Child Support Enforcement (OCSE) on _____ by _____ [18NYCRR 352.3(d)]:

To lift this sanction, call (____)_____. **Read the detailed instructions on the back of this notice.**

☐ Other: _____.

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

☐ [name(s)] _____has been added to your case.

☐ We cannot add the following individuals to your case:

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

_____

SAMPLE

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

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

☒ **DISCONTINUE** your Public Assistance grant effective _____

The **REASON** for this action is Failure to sign Interim Assistance Reimbursement

_____ .

The above decision(s) is based on 18 NYCRR 353.2(b) .

MEDICAL ASSISTANCE

☐ **CONTINUE** the Medical Assistance coverage for [name(s)]_____unchanged.

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

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

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

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

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

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

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

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

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

Enclosure

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

To Lift a Sanction for Non-cooperation with a Child Support Requirement

A sanction for non-cooperation with a child support requirement is open-ended and will continue until _____contacts the Child Support Enforcement Unit and cooperates.

When _____ contacts the Child Support Enforcement Unit, he or she will be told what action(s) must be taken to end the sanction. The sanction will end when he or she takes the required actions(s). If _____ did not cooperate but now wants to report a good reason for not cooperating with child support he or she should call (____)_____.

Some examples of a good reason for not cooperating with child support are:

- fear of emotional or physical harm to you or the children in your family; or,
- the child was born due to rape or incest; or,
- the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three months.

To find out more information about how to end the sanction, call (____)_____.

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

Even if you are no longer eligible for Public Assistance or Medical Assistance, Social Services may provide information and education about family planning for up to 90 days from the effective date stated in this notice.

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

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

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

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

SAMPLE

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4015 B NYC (Rev. 5/16) **NOTICE OF INTENT TO CHANGE BENEFITS: PART B** PA, MA, SNAP, Serv Change

PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE) (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	Home Visit Needed/RAR 109 E. 16th St., 6th FL New York, NY 10003
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
090	HVN			

We are CHANGING your benefits, as explained below and on Part A , next to the checked box(es) ☑ :

SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE AND SERVICES INFORMATION.

If you do not use your SNAP account for a period of 365 consecutive days, any SNAP benefit remaining in the account that is at least 365 days old will be expunged (removed) from the account. Expunged SNAP benefits cannot be reissued.

SNAP

1. ☐ **INCREASE** your SNAP benefits from $ _____ to $ _____ effective _____ .

☐ [name(s)] _____ has been added to your case.

☐ Your SNAP certification period has been extended. Your benefits will now end in _____

2. ☐ **CONTINUE** your SNAP benefits at $ _____ effective _____ for [name(s)] _____.

☐ Your SNAP certification period has been extended. Your benefits will now end in _____.

3. ☐ **REDUCE** your SNAP benefits from $ _____ to $ _____ effective _____.

☐ Your SNAP certification period has been extended. Your benefits will now end in _____.

4. ☐ **DISCONTINUE** your SNAP benefits as of _____

5. ☑ **OTHER:** Your SNAP benefits will continue under a different case number.
You will get another letter with your new SNAP case information.

SAMPLE

6. ☐ **OVERPAYMENT INFORMATION (Check All That Apply)**

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

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

In the future if your case is closed, you will receive a separate notice providing repayment options and guidelines to ensure paying back the remaining balance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance.

7. ☐ We cannot add the following individuals to your case:
Name:_____ Reason(s)_____
Name:_____ Reason(s)_____

8. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

9. ☐ **OTHER INFORMATION:**

The reason for this action is:_____

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

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

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

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

NAME:	ADDRESS:	CASE NUMBER:

CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

If you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2:

1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer.

The Office of Temporary and Disability Assistance (OTDA) policy issuances and manuals are posted on the OTDA website at otda.ny.gov/legal. These issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. In addition, upon request to your local social services district, specific OTDA policy issuances and manuals will also be available to assist you or your representative.

1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

   If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See "Keeping Your Benefits The Same" below.)

2. **STATE FAIR HEARING –** You have the following number of days from the date of this notice to ask for a fair hearing:

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

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

KEEPING YOUR BENEFITS THE SAME: We will not change your Public Assistance, SNAP, Medical Assistance and Social Services benefits, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any Public Assistance and SNAP benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

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

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

☐ Public Assistance ☐ Medical Assistance ☐ SNAP ☐ Social Services

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by **mail,** by **phone,** by **fax,** by **walk-in** or **online.**

Mail: Send a copy of **Part A and Part B** to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy of each notice for yourself.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

SAMPLE

Phone: **800-342-3334** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

Fax: Fax a copy of the front and reverse of this notice to: **(518) 473-6735** or

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn.

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

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your file that we will provide the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your file that you think you may need to prepare for your Fair Hearing. To ask for documents or to find out how to look at your file, call **(718) 722-5012**, fax **(718) 722-5018** or write to **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201.**

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.