Human Resources Administration
Department of Social Services

CD #20-21

M E M O R A N D U M

DATE: August 12, 2020

TO: Job Center Directors, Supplemental Nutrition Assistance Program (SNAP) Center Directors, HASA Center Directors

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

SUBJECT: **Replacement of Food Purchased with SNAP Benefits Lost Due to Power Outages Caused by Tropical Storm Isaias**

As a result of Tropical Storm Isais, many households may have lost power and thus the food that was purchased with their Supplemental Nutrition Assistance Program (SNAP) benefits.

Requests
Households, or their authorized representatives, reporting such a loss are required to submit the Request for Replacement of Food Purchased with Supplemental Nutrition Assistance Program (SNAP) Benefits (**LDSS-2291**). The form is being made available on HRA's website (www.nyc.gov/hra) and participants are being asked to submit the form using the mobile upload feature of the ACCESS HRA Mobile App.

By submitting the form in this way, both the Paperless Office System (POS) as well as Streamlined POS (SPOS) will create a Case Change activity, for Cash Assistance (CA) and SNAP respectively, which must be processed timely. Households may also mail, fax, or drop-off the request in-person. For SNAP only cases, mailed and faxed requests are being directed to the Mail Application Referral Unit (MARU). For CA/SNAP cases, requests are being directed to the open locations. For both CA/SNAP and SNAP only in-person requests, participants are being directed to one of the open locations.

Documentation
For households residing in the zip codes listed in **Attachment A,** no further documentation of the outage is required.

For households not residing in one of the zip codes in **Attachment A**, staff must request documentation by issuing either the Documentation Request Form (**W-113A**) for CA clients or the Notice of Documentation Required (**W-132S**) for SNAP only clients, with a 10-day due date to return the documents. Some common types of verification include, but is not limited to, statements from a utility provider, a community based organization, or a landlord.

Processing Requests

When processing the request, staff must issue the lower of the amount that is requested, or the benefit amount issued for the month being replaced. For example, if a participant requests $500 in replacement, but they only received $400 in SNAP benefits, only $400 may be issued. Staff must issue the replacement for the month of July using benefit issuance codes:

- CA/SNAP households Code **18** – Disaster related issuance
- NCA/SNAP households Code **19** – Disaster related issuance

Note: Staff must use July dates when issuing these replacement benefits.

When determining the maximum benefit amount that can be replaced, staff must consider any supplemental SNAP benefits the household may have received as part of the Emergency Allotment Supplements resulting from COVID-19. However, staff must not factor in Pandemic EBT (PEBT) benefits as these are not SNAP benefits and are not subject to replacement. PEBT benefits can be identified by the following benefit issuance codes:

- **T6** COVID-19 P-EBT for school-aged children (for CA/SNAP cases)
- **T7** COVID-19 P-EBT for school-aged children (for NCA SNAP cases)

For additional information, refer to Policy Bulletin #14-30-ELI.

Note: Additional guidance may be issued at a later date as further information from the State is received.

Attachments:

Attachment A	Zip Codes for which Documentation Is Not Required
LDSS-2291	Request for Replacement of Food Purchased with Supplemental Nutrition Assistance Program (SNAP) Benefits

cc: FIA Call Center
Code X

Attachment A

Households requesting replacement of food purchased with SNAP benefits living in any of these zip codes DO NOT need to provide verification of the outage that caused the need to replace food

BRONX

10451	10456	10461	10466	10471
10452	10457	10462	10467	10472
10453	10458	10463	10468	10473
10454	10459	10464	10469	10474
10455	10460	10465	10470	10475

MANHATTAN

10001	10010	10021	10027	10035	10069
10002	10011	10022	10028	10036	10075
10003	10012	10023	10029	10037	10115
10005	10014	10024	10030	10038	10128
10006	10016	10025	10031	10039	10162
10007	10019	10026	10032	10065	10279

BROOKLYN

11201	11210	11218	11225	11233
11203	11211	11219	11226	11234
11204	11212	11220	11228	11235
11206	11214	11221	11229	11236
11207	11215	11222	11230	11237
11208	11216	11223	11231	11238
11209	11217	11224	11232	11249

STATEN ISLAND

10301	10305	10309
10302	10306	10310
10303	10307	10312
10304	10308	10314

Attachment A

QUEENS

11001	11357	11369	11412	11423
11004	11358	11370	11413	11426
11101	11360	11372	11414	11427
11102	11361	11373	11415	11428
11103	11362	11374	11416	11429
11104	11363	11375	11417	11432
11105	11364	11377	11418	11433
11106	11365	11378	11419	11434
11354	11366	11379	11420	11435
11355	11367	11385	11421	11436
11356	11368	11411	11422	11693

LDSS-2291 (Rev.7/16)

REQUEST FOR REPLACEMENT OF FOOD PURCHASED WITH SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

If you are blind or seriously visually impaired and need this application/form in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available, contact your social services district or visit www.otda.ny.gov.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? ____ Yes ____ No

If Yes, check the type of format you would like: ___ Large Print ___ Data CD ___ Audio CD ___ Braille, if you assert that none of the other alternative formats will be equally effective for you.

If you require another accommodation, please contact your social services district.

NEW YORK STATE — OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

CASE NAME				COUNTY
CASE NUMBER	SSN			DATE OF BIRTH
ADDRESS *(including house and Apt number)*	CITY	STATE	ZIP	PHONE NUMBER

I _____, am the head of household or an adult household member for the above named case and wish to report the following to the agency representative:

My household experienced a loss in the amount of $ _____ of food purchased with Supplemental Nutrition Assistance Program (SNAP) benefits, destroyed as a result of:

☐A power outage
☐A fire
☐A flood
☐Other disaster Describe: _____

_____

Worker Comments: _____

_____

_____

Client Comments: _____

_____

CERTIFICATION

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE STATEMENTS BELOW

I am aware that offering a false instrument for filing as described in Article 175 of the Penal Law is a crime that may have a maximum penalty of four (4) year's imprisonment. If I do so, I will be subject to prosecution under the Civil and Criminal Laws of the United States and New York State and under the regulations of the New York State Office of Temporary and Disability Assistance.

I understand I have a right to a fair hearing to contest the denial or delay of a replacement issuance for my household. Replacements would not be issued pending the fair hearing decision.

I understand that if I do not sign and return this statement to the agency within ten (10) days of the date the loss was reported, the agency will not replace the SNAP benefits.

Signature	Date

*Please return this completed form to your local County Social Service Department (SSD) or for NYC residents visit the HRA website for a list of the local center closest to you.

LDSS-2291 (Rev.7/16)

PETICIÓN DE REEMPLAZO DE ALIMENTOS ADQUIRIDOS CON EL SUBSIDIO DEL PROGRAMA DE ASISTENCIA NUTRICIONAL SUPLEMENTARIA (SNAP)

Si usted es una persona ciega o tiene un impedimento visual grave y necesita esta solicitud / formulario en un formato alterno, lo puede solicitar de su distrito de servicios sociales. Si desea información adicional sobre los tipos de formatos disponibles, comuníquese con su distrito de servicios sociales o ingrese a www.otda.ny.gov.

Si usted es una persona ciega o tiene un impedimento visual grave, ¿Le gustaría recibir notificaciones en un formato alterno? ____ Sí ____ No

Si contestó «Sí», marque el tipo de formato que desea: ___ Letra Grande ___ CD de Datos ___ CD Audio ___ Braille, si usted determina que ninguno de los otros formatos alternos le serán de igual utilidad a usted.

Si usted necesita otra modificación, favor de comunicarse con su distrito de servicios sociales.

NEW YORK STATE — OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

CASO A NOMBRE DE:				CONDADO
Nº DE CASO	Nº DE SEGURO SOCIAL			FECHA DE NACIMIENTO
DIRECCIÓN (incluya el Nº de la casa o del apto.)	CIUDAD	ESTADO	CÓDIGO POSTAL	Nº DE TELÉFONO

Yo _____, siendo el jefe del hogar o integrante adulto del hogar correspondiente al caso mencionado arriba, deseo informar lo siguiente al representante de la agencia:

Mi hogar sostuvo una pérdida por el monto de $ _____ de alimentos comprados con subsidios del Programa de Asistencia Nutricional Suplementaria (SNAP) y los cuales se dañaron debido a:

☐ Una interrupción del servicio eléctrico
☐ Un incendio
☐ Una inundación
☐ Otro desastre Describa: _____

_____

Comentarios del trabajador social: _____

_____

_____

Comentarios del cliente: _____

_____

CERTIFICACIÓN

NO FIRME HASTA QUE HAYA LEÍDO Y ENTENDIDO LOS ENUNCIADOS A CONTINUACIÓN

Yo entiendo que el ofrecer un instrumento falso para su registro, tal como lo describe el Artículo 175 de la Ley Penal, es un delito el cual conlleva una pena máxima de cuatro (4) años de prisión. Si lo hago, estaré sujeto a procedimientos judiciales bajo la Leyes Civiles y Penales Estadounidenses y del Estado de Nueva York y según las pautas de la oficina estatal New York State Office of Temporary and Disability Assistance.

Entiendo que tengo el derecho a una audiencia imparcial con el fin de oponerme a la denegación o la demora del remplazo destinado a mi grupo familiar. No se emitirán remplazos mientras se espera por la decisión de la audiencia imparcial.

Entiendo que si no firmo y devuelvo esta declaración a la agencia dentro de diez (10) días contados a partir de la fecha que se informa la pérdida, la agencia no remplazará los subsidios SNAP.

Firma	Fecha

*Sírvase regresar este formulario completamente rellenado al departamento local de servicios sociales de su condado (SSD); o los residentes de la Ciudad de Nueva York, sírvanse ingresar a la página web de HRA para ver la lista de los centros locales más cercanos a su domicilio.