Human Resources Administration
Department of Social Services

CD #21-07

M E M O R A N D U M

DATE: June 28, 2021

TO: Job Center Directors, SNAP Center Directors, Income Clearance Program Director, MMAP Director, Reginal Managers

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

SUBJECT: Cash Assistance Six-Month Mailer / SNAP Periodic Report - Negative Actions Returning

The purpose of this memorandum is to advise all staff that the flexibility to not take negative actions against households who fail to return either the Cash Assistance (CA) six month mailer, "Mail-in Recertification/Eligibility Questionnaire" (**M-327h**) or the Supplemental Nutrition Assistance Program (SNAP) Periodic Report (**LDSS-4310/LDSS-4310A**) is ending.

Starting with six-month mailers and Periodic Reports due in July, households who fail to submit will be subject to a case closing with either codes **G36/G37** for CA or **E50** for SNAP.

Timely

If a participant reports to an open location to return their completed **M-327h** or **LDSS-4310/LDSS-4310A** on or before the due date, they should be routed to the self-service scanners for them to scan the documents themselves. If unable, or unwilling, to use the self-service scanners, the participant may submit the document at the CSIC counter. Regardless of the participant's case type (CA or SNAP) and regardless of their home center designation, the document must be scanned and indexed by CSIC.

Pending Closing

If a participant reports to an open location with a pending closing for failing to submit and has a completed version with them, staff must ensure that all questions are answered and that the form is signed. Staff must scan and index the documents as this will ensure the pending closing is stopped in WMS.

Note: Staff must accept the form even if the participant's case belongs to another center and scan and index it using the document intake activity in POS.

If a CA participant does not have the **M-327h,** a paper version must be printed and provided to the participant for them to complete, in their preferred language, when available. Staff must then scan and index the **M-327h** in order to stop the closing.

Note: Staff should confirm the next day that the action was stopped and if not, initiate a Settle in Conference activity in the Paperless Office System (POS). If the case belongs to the particular center, Job Center staff will select "Settle in Conference" in the Action menu and SNAP Center staff will select "SNAP Settle in Conference" in the Action menu. If the case does not belong to the center, an email must be sent to the appropriate home center to process the Settle in Conference activity.

If a SNAP participant does not have the **LDSS-4310/LDSS-4310A**, they should first be offered a chance to complete the SNAP Periodic Report using Access HRA at the PC Bank. If the participant doesn't want to use the PC bank, a paper version must be printed and provided to the participant for them to complete, in their preferred language, when available. The paper version of the **LDSS-4310/LDSS-4310A** must be scanned and indexed in order to stop the closing.

Closed Less Than 30 Days

If a CA participant reports to the center after the case is closed **G36/G37**, but within 30 days of closing, staff must either accept a completed **M-327h** if provided or provide the participant with one to complete. The document must be scanned and indexed, and the case reopened. Any missed benefits must be issued back to the date of compliance (date participant submits the **M-327h**).

Note: If based on the information contained on the mailer the household is no longer eligible, the case must be placed in Single Issue status and then closed with a new notice and proper reason for closing.

If a SNAP participant reports to the center after a case is closed **E50**, but within 30 days of closing, staff must either accept a completed **LDSS-4310/LDSS-4310A** if provided or provide the participant with one to complete. The document must be scanned and indexed, and the case reopened. Any missed benefits must be issued back to the date of compliance (date participant submits **LDSS-4310/LDSS-4310A**).

Note: If based on the information contained on the mailer the household is no longer eligible, the case must be placed in Single Issue status and then closed with a new notice and proper reason for closing.

Effective Immediately

Related Items:
PB #18-20-OPE
PD #18-13-ELI
PD #09-30-OPE
CD #20-27

Attachments:

LDSS-4310	Periodic Report
LDSS-4310A	Follow-Up to the Periodic Report
M-327h	Mail-in Recertification/Eligibility Questionnaire

WHEN YOU RETURN THIS REPORT, MAKE SURE THAT THE **LOCAL DISTRICT ADDRESS ON THE BACK** OF THIS REPORT SHOWS IN THE RETURN ENVELOPE WINDOW.

LDSS-4310 (Rev. 3/18)

Periodic Report

You must fill out this Report and return it to the address listed on the back by _____ to continue getting benefits.

This "Periodic Report" helps us to gather information about any changes you may have had since the last time you were in contact with your eligibility worker. Please make sure to read and follow all the instructions before filling out this "Periodic Report". It is important for you to complete, sign and return this "Periodic Report" by the due date listed above. Failure to do so may result in your Child Care and/or SNAP Benefits being discontinued.

CASE NAME		CASE NUMBER
OFFICE	UNIT	WORKER
If you have any questions on how to fill out this Report, call :(___) _____	We must get your completed Report by _____. If we don't get the completed Report by this date, your Child Care and/or SNAP Benefits will stop. Failure to return this report will not affect your Medicaid coverage.	

General Instructions

1. You must **answer all questions** on this Report. Answer all questions on this Report for everyone who is getting, **or** anyone who is legally responsible for someone getting Child Care and/or SNAP Benefits.
2. You must complete and sign this Report and return it to the address on the back of this report by _____, or your Child Care or SNAP Benefits may be reduced or closed.

Reminder: If you are also receiving Temporary Assistance and Medicaid, you must report any changes to your worker within 10 days. For SNAP, you must report within ten days after the end of the month if your total monthly gross income exceeds the 130% limit you have been given. If anyone in your SNAP household is an Able-Bodied Adult Without Dependents (ABAWD), he/she MUST tell the district if their hours go below 80 hours each month within 10 days after the end of that month. The ABAWD can request a qualifying work activity from the district to help him/her meet the federal ABAWD requirement. If anyone in your SNAP household is an ABAWD, he/she should also report if your household has moved to an area with a federally approved ABAWD waiver or if the ABAWD believes he/she should be exempt from the ABAWD requirement. Otherwise, you do not need to report changes at any time other than on this Periodic Report or at Recertification, whichever occurs first. You must contact your worker immediately if any changes occur that affect your Child Care.

FOR NYC – NEW! You can now submit your Periodic Report quickly and easily ONLINE (instead of mailing it).
Go to www.nyc.gov/accesshra

LDSS-4310 (Rev. 3/18)

SECTION 1: Please list ALL income for EACH household member. If you are only receiving SNAP benefits, you only have to list earnings here for each household member who works.

(Examples of income include earnings from a job, Unemployment Insurance, Social Security Benefits, Supplemental Security Income [SSI])

Who	Name of Employer or Other Source of Income	How Often? (Daily, Weekly, Bi-Weekly, Monthly)	Total # of Hours Worked Per Week

Send in proof of all income that any household member got during the entire month of _____.

SECTION 2: Have there been any other changes (read boxes below) since your last Report, or do you expect any changes?

☐ No or ☐ Yes If Yes, **you must check (√) at least one of the boxes below.**

- ☐ An able-bodied adult in your household did not work/participate in a work activity for at least 80 hours in each month. (Write who and the months not meeting the requirement below.)
- ☐ Your household moved (Write the new address below.)
- ☐ Someone moved into or out of your household (Write who moved and when and new amount of rent.)
- ☐ Your rent went up or down (Write new rent amount.)
- ☐ You now pay separately from your rent for: ☐ Heating ☐ Air Conditioning ☐ Other utilities (electricity, cooking gas, water, sewer, trash)
- ☐ Someone started or left work (Write who, when, and where they started or left work.)
- ☐ Someone had a change in the amount of their unearned income.
- ☐ Your child care costs (cost you pay not child care subsidy) are new or changed or child care provider changed (Write new amount and who provides the child care.)
- ☐ Death or Birth of someone in the household (Write who and when.)
- ☐ Change in legally obligated child support paid by a member of your household (Write who in your household pays the support.)
- ☐ Change in medical conditions that limit someone in the household's ability to work or the type of work they can perform. (Write who and when the medical condition occurred.)
- ☐ Other changes that may affect benefits (Write who, what, and when change occurred and give proof, if possible.)

Write the details of your change(s) here, and if you have proof send it in: _____

_____

CERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my Temporary Assistance Benefits, SNAP Benefits, Child Care Benefits or closing my case. If my gross income exceeds the 130% level, I must report it within 10 days after the end of the month in which it was received. I am aware that Federal and State Law provide for fine and/or imprisonment of any person who fraudulently attempts to receive, or fraudulently receives Temporary Assistance, Medicaid, Child Care or SNAP Benefits to which the person is not entitled. Information reported on this form may affect my eligibility for Medicaid.

I understand that I must contact my worker to report any changes that occur for my Temporary Assistance and Medicaid case within 10 days.

I understand that I must contact my worker immediately if any changes occur that affects my child care. I also understand that if I use a child care provider who is not licensed or registered, my provider must meet certain requirements in order to be paid.

For my SNAP case, I must report changes on the Periodic Report and at Recertification, whichever occurs first. I may also report changes at any other time. If anyone in my SNAP household is an ABAWD, I must also report if their work hours go below 80 hours a month within 10 days after the end of that month.

IMPORTANT- YOU MUST SIGN AND RETURN THIS FORM. IF YOU CHECKED "YES" TO ANY CHANGES IN SECTION 2, MAKE SURE YOU CHECKED (√) **THE BOX(ES) AND GAVE MORE DETAIL. IF THIS REPORT IS NOT COMPLETE, WE WILL SEND YOU A DISCONTINUANCE** NOTICE.

Your Signature:	Date	Telephone Number (daytime)

Fill Out & Return In The Envelope Provided

When you return this Report, make sure you can see this address in the return envelope window ➔

LDSS-4310A (Rev. 3/18)

FOLLOW-UP TO THE PERIODIC REPORT

CASE NAME	CASE NUMBER	OFFICE/ UNIT NUMBER

WORKER NUMBER	WORKER NAME (CASELOAD)

If you have any questions on how to fill out this Report, call:	We must get your completed Report by _____. If we don't get the completed Report by this date, your Child Care and/or Supplemental Nutrition Assistance Program (SNAP) Benefits will stop. Failure to return this report will not affect your Medicaid coverage.

General Instructions

1. You must **answer all questions** on this Report. Answer all questions on this Report for everyone who is getting, **or** anyone who is legally responsible for someone getting Child Care, and/or SNAP Benefits.
2. Do **not** sign this Report any sooner than _____. If you do, this report is not considered complete.
3. You must complete this Report and return it to the address on the front of the enclosed notice by _____, or your Child Care or SNAP Benefits may be reduced or closed.

Reminder: If you are also receiving Temporary Assistance and Medicaid, you must report any changes to your worker within 10 days. For SNAP, you must report within ten days after the end of the month if your total monthly gross income exceeds the 130% limit you have been given. If anyone in your SNAP household is an Able-Bodied Adult Without Dependents (ABAWD), he/she MUST tell the district if their hours go below 80 hours each month within 10 days after the end of that month. The ABAWD can request a qualifying work activity from the district to help him/her meet the federal ABAWD requirement. If anyone in your SNAP household is an ABAWD, he/she should also report if your household has moved to an area with a federally approved ABAWD waiver or if the ABAWD believes he/she should be exempt from the ABAWD requirement. Otherwise, you do not need to report changes at any time other than on this Periodic Report or at Recertification, whichever occurs first. You must contact your worker immediately if any changes occur that affect your Child Care.

SECTION 1: Please list ALL income for EACH household member. If you are only receiving SNAP benefits, you only have to list earnings here for each household member who works.

(Examples of income include earnings from a job, Unemployment Insurance, Social Security Benefits, Supplemental Security Income [SSI])

Who	Name of Employer or Other Source of Income	How Often? (Daily, Weekly, Bi-Weekly Monthly,)	Total # of Hours Worked Per Week "Report Month"

Send in proof of all income that any household member got during the entire month of _____. (Report Month)

FOR NYC – NEW! You can now submit your Periodic Report quickly and easily ONLINE (instead of mailing it).
Go to: www.nyc.gov/accesshra

LDSS-4310A (Rev. 3/18)

SECTION 2: Have there been any other changes (read boxes below) since your last Report, or do you expect any changes?

☐ No or ☐ Yes **If Yes, you must check (√) at least one of the boxes below.**

- ☐ An able-bodied adult in your household did not work/participate in a work activity for at least 80 hours in each month. (Write who and the months not meeting the requirement below.)
- ☐ Your household moved (Write the new address below.)
- ☐ Someone moved into or out of your household (Write who moved and when and new amount of rent.)
- ☐ Your rent went up or down (Write new rent amount.)
- ☐ You now pay separately from your rent for:
  - ☐ Heating ☐ Air Conditioning ☐ Other Utilities (electricity, cooking gas, water, sewer, trash)
- ☐ Someone started or left work (Write who, when, and where they started or left work.)
- ☐ Someone had a change in the amount of their unearned income.
- ☐ Your child care costs (cost you pay not child care subsidy) are new or changed or child care provider changed (Write new amount and who provides the child care.)
- ☐ Death or Birth of someone in the household (Write who and when.)
- ☐ Change in legally obligated child support paid by a member of your household (Write who in your household pays the support.)
- ☐ Change in medical conditions that limit someone in the household's ability to work or the type of work they can perform. (Write who and when the medical condition occurred.)
- ☐ Other changes that may affect benefits (Write who, what, and when change occurred and give proof, if possible.)

Write the details of your change(s) here, and if you have proof send it in:

_____

_____

CERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my Temporary Assistance Benefits, SNAP Benefits, Child Care Benefits or closing my case. If my gross income exceeds the 130% level, I must report it within 10 days after the end of the month in which it was received. I am aware that Federal and State Law provide for fine and/or imprisonment of any person who fraudulently attempts to receive, or fraudulently receives Temporary Assistance, Medicaid, Child Care or SNAP Benefits to which the person is not entitled. Information reported on this form may affect my eligibility for Medicaid.

I understand that I must contact my worker to report any changes that occur for my Temporary Assistance and Medicaid case within 10 days.

I understand that I must contact my worker immediately if any changes occur that affects my child care. I also understand that if I use a child care provider who is not licensed or registered, my provider must meet certain requirements in order to be paid.

For my SNAP case, I must report changes on the Periodic Report and at Recertification, whichever occurs first. I may also report changes at any other time. If anyone in my SNAP household is an ABAWD, I must also report if their work hours go below 80 hours a month within 10 days after the end of that month.

IMPORTANT- YOU MUST SIGN AND DATE THIS FORM NO SOONER THAN _____. IF YOU CHECKED "YES" TO ANY CHANGES IN SECTION 2, MAKE SURE YOU CHECKED (√) **THE BOX(ES) AND GAVE MORE DETAIL.** IF THIS REPORT IS NOT COMPLETED, WE WILL SEND YOU A DISCONTINUANCE NOTICE.

Your Signature:	Date:	Telephone Number (daytime)

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Caseload: _____

Mail-in Recertification/Eligibility Questionnaire

To determine your continued eligibility for Cash Assistance (CA) and Supplemental Nutrition Assistance Program (SNAP), you must answer every question, sign, date, and return this form in the enclosed postage-paid envelope to the **Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10213-0195** by: _____.
(Return Date)

For CA, this form is considered a mail-in recertification form. For SNAP, this is an Eligibility Questionnaire.

- You must enclose copies of letters or documents that verify the changes you report. In addition, if you or your family member has a job (earned income), you must submit the last four paystubs *or other proof of gross income earned and the number of hours worked during the last 30 days* even if the wages have not changed.
- Failure to return the form or returning it without the required verification may result in the closing of your case or reduction of benefits.

1. Do you still need: Cash Assistance? ☐ Yes ☐ No
   SNAP? ☐ Yes ☐ No Medical Assistance? ☐ Yes ☐ No
   If you check ☑ No, your benefit will be stopped.

2. Did anyone **move into** or **out of** your household since the last time you reported the number of persons in your household (including births)? ☐ Yes ☐ No
   - If Yes, provide the information requested below.
   - If they want to apply for assistance an application must be completed.
   - If you are reporting a newborn enclose a copy of a birth certificate for verification.

Social Security Number	Name	Relationship to You	Moved In	Moved Out	Date

(Turn Page)

Case Number: _____

3. Other than Cash Assistance, did you, or anyone in your household, have a change in income? Has anyone begun receiving any new or increased income or lost income from any of the following sources since the last time you reported your income?

   If you check ☑ Yes, indicate the amount you receive and whether this amount is new, more, or less. If you or a family member has a job (earned income) you must fill in part B, Employment, and submit photocopies of the last 4 paystubs *or other proof of gross income earned and number of hours worked during the last 30 days* even if the wages have not changed.

Source of Income		Amount	New	More	Less
A. Contributions	☐ Yes ☐ No	$_____			
B. Employment (whether new or not and whether more or less than previously reported) Please indicate the number of hours you work per week_____.	☐ Yes ☐ No	$_____			
C. Unemployment Insurance Benefits (UIB)	☐ Yes ☐ No	$_____			
D. Supplemental Security Income (SSI)	☐ Yes ☐ No	$_____			
E. Social Security Income other than SSI	☐ Yes ☐ No	$_____			
F. Child Support (including court-ordered payments)	☐ Yes ☐ No	$_____			
G. Veterans or other military benefits	☐ Yes ☐ No	$_____			
H. Other Income	☐ Yes ☐ No	$_____			

4. Have there been any changes in the following since you last reported to us?
   A. Rent costs: ☐ Yes ☐ No
      If Yes, Increase ☐ Decrease ☐ New amount $_____
      (Enclose proof of change).
   B. Do you now pay separately from your rent for:
      ☐ Heat or Air Conditioning ☐ Yes ☐ No
      ☐ Other Utilities (electricity, cooking gas, water, sewer, trash, etc.) ☐ Yes ☐ No
   C. Is someone pregnant, disabled or 60 years of age or older? ☐ Yes ☐ No
      If Yes, provide name (enclose medical proof): _____

(Turn Page)

Case Number: _____

4. Have there been any changes in the following since you last reported to us? *(continued)*

   D. Resources (e.g., motor vehicle, bank account, etc.): ☐ Yes ☐ No
   If Yes, explain (enclose photocopy of car title, bank statement, etc.):
   _____

   E. Child support you pay to someone outside your household: ☐ Yes ☐ No
   If Yes, Increase ☐ Decrease ☐ New amount $_____
   (Enclose proof of court order).

   F. Medical expenses paid by household member who is disabled or who is 60 years old or older: ☐ Yes ☐ No
   If Yes, explain change: _____

   G. Other changes: ☐ Yes ☐ No
   If Yes, explain: _____

   H. Have any medical conditions that limit their ability to work or the type of work they can perform? ☐ Yes ☐ No
   If Yes, Name: _____

Able Bodied Adult Without Dependents (ABAWDs) - If anyone in your SNAP household is an Able-Bodied Adult Without Dependents ("ABAWD"), you must report when that individual's monthly participation in employment, or other work activities, falls below 80 hours.

Supplemental Nutrition Assistance Program (SNAP)

In order to determine if you can still get SNAP benefits, you must complete this Eligibility Questionnaire and return it by the date on **page 1** of this form. If you do not complete and return the Eligibility Questionnaire by the due date, your SNAP benefits will be reduced or stopped. We will send you another notice if this happens. This decision is based on Regulation 18 NYCRR 387.17.

List of changes you must report for SNAP at this time:

- Changes in any **source of income** for anyone in your household.
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month.

(Turn Page)

Case Number: _____

List of changes you must report for SNAP at this time:

- Changes in your household's total **unearned income from a public source** such as Social Security Benefits or Unemployment Insurance Benefits when it goes up or down by more than $100 a month.
- Changes in your household's total **unearned income from a private source** such as child support payments or private disability insurance when it goes up or down by more than $100 a month.
- Changes in the amount of court-ordered **child support you pay** to a child outside of your SNAP household.
- Changes in **who lives with you**.
- **If you move,** your new address and your new rent or mortgage costs, heat/air conditioning costs, and utility costs.
- **A new or different car,** or other vehicle.
- Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2,250 for a household without an elderly or permanently disabled household member or $3,500 for a household with an elderly or permanently disabled household member.
- If anyone in your SNAP household is an Able-Bodied Adult Without Dependents (ABAWD), they MUST tell the district if their participation in employment or other work activities falls below 80 hours each month within 10 days after the end of that month. The ABAWD can request a qualifying work activity from the district to help them meet the federal ABAWD requirement. If anyone in your SNAP household is an ABAWD, they should also report if your household has moved to an area with a federally approved ABAWD waiver or if the ABAWD believes they should be exempt from the ABAWD requirement.

MEDICAL ASSISTANCE – You must immediately report any changes in your address, income, resources or household size to this agency. You will be notified if your Medical Assistance coverage changes.

You must enclose copies of letters or documents that verify the changes you report. In addition, if you or your family member has a job (earned income), you must submit the last four paystubs *or other proof of gross income earned and the number of hours worked during the last 30 days* even if the wages have not changed.

If anyone in your SNAP household is an Able Bodied Adult Without Dependents (ABAWD), you must tell us if that individual's participation in employment or other work activities falls below 80 hours a month within 10 days after the end of that month.

(Turn Page)

Case Number: _____

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 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 Supplemental Security Income (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.

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.

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.

(Turn Page)

Case Number: _____

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 on this form is true and correct.

Name (please print): _____

Signature: _____ Date: _____

Spouse or Authorized Representative Signature: _____

Date: _____

WARNING: Federal and State law provides for penalties of fine, imprisonment or both if you do not tell the truth or if you conceal or fail to disclose facts regarding your continuing eligibility for assistance. Regulations require that you immediately notify this Agency of any changes in needs, income, resources, living arrangements or address.

Worker Signature: _____ Date: _____

NOTE: The last part of this form is an application to register to vote. If you would like help filling out the voter registration application form, ask your Worker. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency. Return this form to the Agency whether it has been completed or not.