Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING

POLICY BULLETIN # 23-27-ELI

CHILD CARE ASSISTANCE FOR 12-MONTH ELIGIBILITY PERIOD

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Date: May 5, 2023	Subtopic(s): Child Care

Purpose

The purpose of this policy bulletin is to inform Benefits Access Centers and Child Care Review Team (CCRT) staff that pursuant to 21-OCFS-ADM-30, HRA must provide child care assistance for a twelve-month eligibility period. Under new child care regulations, individuals determined eligible for child care assistance must have such child care continue throughout the 12-month child care eligibility period. There are only limited exceptions that permit child care assistance to terminate before the completion of the 12-month eligibility period. This policy bulletin is informational for all other staff.

Background

Parents or caretakers in receipt of CA and who are working or engaged in an approved activity and have a child or children that meet the eligibility criteria, can receive child care assistance.

Eligible child means a child who resides with a parent/caretaker that meets the program and financial eligibility requirements for the particular type of child care assistance and who:

- is under 13 years of age; or
- is under 18 years of age and is either a child with special needs or is under court supervision; or,
- is under 19 years of age, is a full-time student in a secondary school, or in an equivalent level of vocational or technical training, and is a child with special needs, or is under court supervision.

Note: A child who ages out of care during the eligibility period may continue to receive child care assistance through the end of the 12-month eligibility period.

Refer to PD#16-08-EMP

Participants who are eligible for CA (including those receiving Childcare in Lieu of Cash Assistance [CILOCA]) and meet the programmatic eligibility requirements for child care assistance can receive child care assistance from the Human Resources Administration (HRA). New York City's Administration for Children's Services (ACS) Transitional Child Care (TCC) Unit administers child care assistance for participants whose CA case closed and who qualify for transitional child care assistance.

Refer to PD#15-04-OPE for further information on TCC.

HRA and ACS utilize a single child care management and payment system known as the Automated Child Care Information System (ACCIS). For families who qualify for child care assistance, ACCIS verifies the accuracy of all child care payments. When a participant is found ineligible for CA, or they voluntarily close their CA case and their income is no longer within CA standards but may be eligible for TCC, an ACCIS clearance allows for continuous child care assistance and payments.

Refer to PD#13-22-ELI

All child care providers must be registered in ACCIS to receive payment from ACS.

Child Care 12-Month Eligibility

Refer to: 21-OCFS-ADM-30

A recipient's continued eligibility for child care may be redetermined when case factors indicate that a redetermination could be beneficial to the family by reducing the family share or increasing subsidy, or a change has occurred which might bring the family over 85% State Median Income (SMI), or at redetermination.

Note: Due to a change in policy, CA participants found exempt from CA work requirements are now eligible for continued child care assistance.

Note: Families in receipt of CA are exempt from paying a family share. Families who are exempt from paying a family share will continue to be exempt from paying a family share through the remainder of their 12-month eligibility period. The current family share for families in receipt of CILOCA is $1 per month. The family share for CILOCA families cannot be increased during the remainder of their 12-month eligibility period.

Any family share can only be decreased or remain stable during the 12-month eligibility period. For HRA's CA participants, HRA has updated information about the household's income and work information on a daily basis, therefore, HRA is able to redetermine these households based on current information to extend the 12-month child care eligibility period.

However, except for a child with special needs or a child under court supervision, no child age 13 or over may receive child care assistance beyond the remainder of the current 12-month eligibility period.

Change in Policy: CA participants found Exempt from CA work requirements are now eligible for continued child care assistance

The 12-month eligibility period begins with the child care subsidy start date, and once approved, will be backdated as far as the date the application was received, including when the family is using an enrolled legally exempt provider. Once the child care assistance is approved, the 12-month eligibility period cannot be shortened unless the case meets one of the case-closing criteria discussed in the **CA Child Care Case Closure** section of this policy bulletin.

The Approval of Your Application for Child Care Benefits (**OCFS-LDSS-4779**) is used when a new application for child care benefits has been approved. It must be indicated in the child care benefits portion of the form if the child care benefits will be paid to the parent or provider. The effective dates of the child care benefits are also included on the notice. For CA applicants/participants, there is no family share so that section will remain blank. For CILOCA cases, it will be filled in.

Note: If there are any changes, such as a parent/caretaker becomes work exempt from CA work requirements, the family must still receive child care assistance as authorized for the remainder of the 12-month eligibility period.

The Notice of Intent to Change Child Care Benefits and Family Share Payments (**OCFS-LDSS-4781**) must be used when there is a decrease in family share or inclusion of an additional payment amount, change in child care provider, and/or increase in benefits.

If a case is approved and opened for child care, it cannot be closed due to a lack of funding prior to the end of the 12-month eligibility period. Insufficient funding is never an acceptable reason for case closing during the 12-month eligibility period. This applies to Category 1 cases, all of which must be opened under the guarantee, and Category 2 and 3 cases which are opened subject to available funds. In all cases, the case must remain open unless the case closing criteria listed in this policy bulletin are met.

When a CA case closes for failing to recertify, child care will still continue through the end of the 12-month eligibility period unless the child care case closing criteria are met. The parent/caregiver must not be asked to provide verification or documents regarding child care eligibility during the 12 month child care eligibility period unless case factors indicate that a redetermination could be beneficial to the family by reducing the family share or increasing subsidy, or a change has occurred which might bring the family over the eligibility threshold of 85% SMI.

The following changes to a CA case must not result in the closing of a child care case:

- Any cessation of work or attendance at a training or education program that does not exceed three consecutive months (including CA assigned activities).
- Any interruption in work for a seasonal worker who is not working between regular industry work seasons.
- Any student holiday or break for a parent participating in training or education.
- Any reduction in work, training, or education hours, as long as the parent/caretaker is still working or attending training or education.
- When a parent's or caretaker's average weekly hours fall below the required hours to be considered "engaged in work", but the parent or caretaker is still working, this is considered to be temporary cessation and the case must remain open and assistance must be continued unchanged.

Note: If the parent or caretaker fails to meet the definition of being "engaged in work" for three (3) consecutive months, then the child care case must be closed. This includes individuals who become and remain sanctioned for CA.

Refer to:
21-OCFS-ADM-30

A child remains eligible for child care assistance through the end of the 12-month eligibility period even when the child:

- turns 13 years old, or
- turns 18 years old and is a child with special needs or is under court supervision; or
- turns 19 years old and is a child with special needs or is under court supervision who is a full-time student in a secondary school, or in an equivalent level of vocational or technical training.

CA Child Care Case Closure

The following are reasons why child care assistance will be discontinued before the end of the 12-month eligibility period:

- The family's income exceeds 85% of SMI.
- The family "has experienced a non-temporary cessation in work or attendance at a training or education program".
- Participant receiving child care has remained sanctioned for not being engaged in work for three (3) or more months. HRA will discontinue child care assistance if a parent or caretaker remains unengaged and not exempt for three (3) or more months.

- If there is a child care overpayment, participant failed to agree to a reasonable plan for repayment or recovery of an overpayment or failed to comply with an agreed upon plan for repayment or recovery of an overpayment.
- If the DSS Accountability Office determines that the participant has been convicted of or voluntarily admitted to fraudulently receiving child care assistance.
- If the DSS Accountability Office determines that the participant certified and attested to false information on the application for child care assistance and/or enrollment form or any attachment.

When a parent or caretaker's average weekly hours fall below the required hours to be considered "engaged in work", but the parent or caretaker is still working, that is considered to be a temporary cessation and the case must remain open and assistance must be continued unchanged.

If the parent or caretaker fails to meet the definition of "engaged in work" consistently for three consecutive months, the parent or caretaker is considered to be experiencing a non-temporary cessation of work as they do not meet the eligibility criteria, and the child care assistance must discontinue.

The Denial of Your Application for Child Care Benefits (**OCFS-LDSS-4780**) must be used when a new application for child care benefits has been denied. Staff must select one or more of the denial reasons listed on the form.

The Notice of Intent to Discontinue Child Care Benefits (**OCFS-LDSS-4782**) must be used when staff decide to end the child care benefit, either during the 12-month eligibility period or at redetermination.

Note that in limited circumstances, due to an ATC directive or court order, child care may continue until a resolution.

If the household is determined eligible for child care assistance, HRA will extend child care assistance for all closing CA cases for another 12 months, with proper notice as discussed in this policy bulletin. However, a child who has turned 13 during the 12-month eligibility period authorized under the CA case, but prior to the CA case closing must only receive child care assistance for the duration of that eligibility period. Child care assistance must not continue for a child who has turned 14 unless that child has a Special Needs authorization or is under court supervision.

12 Month Eligibility Workflow Summary

When the WMS case is closed, a Client Notices System (CNS) notice or manual child care Notice of Intent (NOI) is sent to the household.

If the household earns over 85% SMI, child care in ACCIS is suspended with the household notified 15 days beforehand. The Notice of Intent to Discontinue Child Care Benefits (**FIA-1100c**) notice is conditionally sent to the client. A provider termination letter is also sent to the provider(s).

Note: ACCIS cases with Reason for Care (RFC) code **11** (child only case), **15** (CILOCA), and **01** (Applicant cases) will not receive the **FIA-1100c**. WMS Closing Reason codes **E65, E69, P44, P45, P46, MX1-3, G41, PX1-3, M77, M55, N19, N21, N31, N41, N44, VE1-3, W11, W12, W40, WC1-3, WS1-8, WE1, WX1, WX4, N42, N43, WE2, WE3, WX2, WX3, WX5, WX6, M55** will not receive the **FIA-1100c**.

If the household does not earn over 85% SMI and the CA case was closed with a reason code potentially eligible for TCC, staff will check if the case is approved for TCC. **Note:** TCC eligible closing codes include **E31, E32, E33, G99, E36, E40, EM4, EM5, G87, G88, G89, G90, G92, G94, G96, G97, G98, G46, EM17, 401**.

If the case is approved for TCC, the Approval of Your Transitional Child Care Benefits (**OCFS-LDSS-4785**) notice is sent to the household.

If the case is not approved for TCC, TCC staff will extend child care for 12 months.

The following will occur:

- The end date of the current enrollment is changed to 12 months from the closed date.
- A new RFC is established.
- A new enrollment termination code is established.
- The Notice of Evaluation of Child Care Benefits-No Change (**OCFS-LDSS-4788**) will be sent out to the household.
- TCC users and specific ACS users are allowed to modify case/child/enrollments for this category.
- If the case becomes active for CA during the 12-month period, the 12-months child care extension is removed and the RFC is changed to **10**. The New York City Work Accountability and You (NYCWAY) system will be updated daily to correct the RFC.

If the household does not earn over 85% SMI, and the CA case was not closed with a reason code potentially eligible for TCC, child care will be extended for 12 months.

The following will occur:

- The end date of the current enrollment is changed to 12 months from the closed date.
- A new RFC is established.
- A new enrollment termination code is established.
- "The Notice of Evaluation of Child Care Benefits-No Change (**OCFS-LDSS-4788**) will be sent out to the household.
- TCC users and specific ACS users are allowed to modify case/child/enrollments for this category.
- If the case becomes active for CA during the 12-month period, the 12-month child care extension is removed, and the RFC is changed to **10**. The NYCWAY system will be updated daily to correct the RFC.

Reporting Requirements

There must not be unnecessary documentation requirements imposed on families. Families receiving child care assistance must report changes in financial circumstances that put the family's income over 85% SMI.

Families continue to be required to report any changes in living arrangements, employment, household composition, child care provider, or other circumstances that affect the family's need or eligibility for child care assistance.

Refer to: 21-OCFS-ADM-30

A parent or caretaker's failure to respond to or comply with requests for documentation in connection with an investigation, audit, or program review may result in the closing of the child care assistance case, in accordance with 18 NYCRR 415.2(d)(4).

Family Share

CILOCA households are only subject to the 12-month recertification

Households receiving CA will not have any "family share" contribution (or copay) for their child care assistance. Households in receipt of CILOCA have a $1 monthly family share.

HRA has updated financial information from CA households on a periodic basis: there are semi-annual CA recertification requirements (Periodic Mailer) and an annual full CA recertification process, including interview.

Households who fail to return the CA six month mailer, “Mail-In Recertification/Eligibility Questionnaire” (**M-327h**) will be subject to a CA case closing with either code **G36**/**G37,** but their child care assistance will continue.

Refer to:
21-OCFS-ADM-30

When a case type changes during the 12-month eligibility period, procedures must be in place to enable families to keep their child care services without interruption as long as families remain eligible for such services. It is at the agency’s discretion to authorize up to an additional 12 months of child care services to ensure that the family receives a full 12-month eligibility period. When this happens, the family share must not be increased.

Moreover, for CA households, any time there is a change in household circumstances, including income, the household **must** report the change to HRA within 10 days of the change for HRA to redetermine the household’s continued CA eligibility. This ensures that HRA has contemporary and accurate information about the household’s income and other factors that may relate to eligibility for child care assistance.

Note: For the purposes of CILOCA, CA eligibility rules must be followed regarding reporting requirements, as one of the eligibility criteria for CILOCA is being eligible for CA.

However, during the 12-month child care eligibility period, the household cannot have their child care assistance terminated for failing to provide verification or reporting changes related to the CA case. If the household fails to provide verification or documentation for CA eligibility, including failing to recertify or failing to return the **M**-**327h**, the child care will continue through the current 12-month authorization.

When an eligible family has not received the required 12 months of child care assistance, an authorization may be granted for the required 12 months of child care subsequent to the case change, pursuant to **21-OCFS-ADM-30** on page 9, to ensure continuity of care for the child in the best interest of the family.

Family share cannot be added during the 12-month eligibility period for HRA's CA households. This limitation applies to families that are determined exempt from paying a family share who experience a change in the circumstances that made them exempt, for example:

- families receiving CA when they transition to receiving TCC during the 12-month child care eligibility period,
- and families experiencing homelessness who are no longer homeless.

In such instances, families who were exempt from paying a family share for their child care assistance will continue to have no copay through the remainder of their 12-month eligibility period for child care.

This also applies to families whose child care assistance case type changes during the eligibility period, for example:

- for families in receipt of CILOCA who transition to receiving TCC during the 12-month eligibility period, the family share cannot be increased for the remainder of the 12-month eligibility period.

Additional 12-Month Child Care for New Child(ren) and Extending Child Care for Other Child(ren) Receiving Child Care in Household

Redetermination of Child Care when Adding New Child

Refer to:
22-OCFS-INF-05

For active CA and CILOCA households, when a new child(ren) is added to the household whether by birth, adoption, etc., a full child care redetermination is required for all children in the household receiving child care assistance such that a redetermination could be beneficial to the family by increasing subsidy. Child(ren) who are 13 years of age cannot have their child care assistance extended beyond the current 12-month eligibility period unless they have a Special Needs designation or are a child under court supervision.

Refer to:
21-OCFS-ADM-30

If the family's income does not exceed 300% SIS (State Income Standard), the new child(ren) will be granted 12 months of child care, and child care is extended for 12 months for the other child(ren) ages 12 and under in the household already receiving child care. If HRA determines a family's income is above 300% SIS and below 85% SMI, HRA must add the child to the case and authorize child care assistance for the remainder of the current 12-month eligibility period. If the family is above 85% SMI, HRA must close the case because the family is no longer eligible to receive child care assistance.

In CILOCA cases, CCRT will request documentation regarding the new child (birth certificate, SSN, presence in the household), the parent's current/resumed employment, and child care enrollment information for the new child, as well as confirmation that there have been no changes affecting continued CA and CILOCA eligibility since the last recertification. The next periodic recertification interview will then be scheduled one month prior to the end of the extended 12-month eligibility period.

After the CA or CILOCA case closes and the household is in receipt of child care during the continuing 12-month eligibility period, the household can add a new child or request a change in provider, but there would be no redetermination for another 12-month period. A household whose child care is not continuing as TCC should report changes (including changes related to continuing eligibility) to CCRT, which will take any necessary action.

Note: The requirement to redetermine eligibility if beneficial to the family still applies. If HRA determines a family's income is above 300% SIS and below 85% SMI, HRA must add the child to the case and authorize child care assistance for the remainder of the current 12-month eligibility period. If the family is above 85% SMI, HRA must close the case because the family is no longer eligible to receive child care assistance.

Redetermination of Eligibility

HRA must redetermine a recipient's continued eligibility for child care only when:

- case factors indicate that a change has occurred, which might bring the family over the eligibility threshold of 85% SMI; or
- a non-temporary break in work, education, or training activity of over 3 consecutive months has occurred; or
- at recertification (this applies especially to CILOCA cases).

HRA must:

- not reduce the 12-month eligibility period when redeterminations are made during the 12-month period, unless one of the case closure criteria is met.
- continue any decrease in family share or increase in subsidy through the remainder of the current 12-month eligibility period.
- complete a full redetermination on an open case when a child is born or otherwise joins the family's child care assistance unit, such that a redetermination could be beneficial to the family by increasing subsidy.

If HRA:

- determines that a family's income does not exceed 300% SIS, HRA must give the family a new 12-month eligibility period since the new child is programmatically eligible for a full 12-month eligibility period.
- determines a family's income is above 300% SIS and below 85% SMI, HRA must add the child to the case and authorize child care assistance for the remainder of the current 12-month eligibility period. If the family is above 85% SMI, HRA must close the case because the family is no longer eligible to receive child care assistance.

Closing of Cash Assistance Case

HRA has updated financial information from CA households on a periodic basis: there are semi-annual CA recertification requirements (Periodic Mailer) and an annual full CA recertification process, including interview.

Moreover, any time there is a change in household income, the household **must** notify HRA of the change for HRA to redetermine the household's continued CA eligibility. Therefore, HRA has contemporary and accurate information about the household's income on a daily basis.

Since ACCIS does not measure or track the 12-month eligibility period for HRA's CA participants, and HRA maintains updated information on the household's income and need for child care, to ensure that all households will receive a full 12-month eligibility period at the time of CA case closing, HRA will redetermine the eligibility for all children under the age of 13, and 13 year olds who are still in their 12-month eligibility period. This will ensure that all children will receive the full 12-month eligibility period.

Note: Child care for any child already 13 years of age will not continue beyond the current 12-month eligibility period. This is to ensure no child 14 years of age or older will receive child care other than a child with a special needs designation.

Electronic Application Submissions

Refer to:
18 NYCRR Part 415.3(a)

Applications for CA including child care services and for CILOCA may be submitted by mail or electronically in ACCESS HRA (AHRA).

When HRA accepts an application upon request via fax, staff must print the cover page to document the date of receipt for auditing purposes. These requirements apply to both initial applications and redeterminations.

Electronic applications are to be considered equivalent to submitting a hard copy application by mail or in person, with the date of application being the date the application is received, or the next business day if received after normal operating hours

Effective May 15, 2023

References:

21-OCFS-ADM-30
22-OCFS-INF-05
22-OCFS-ADM-18

Related Items:

PD#16-08-EMP
PD#15-04-OPE
PB#22-14-OPE
PD#13-22-ELI

Attachments:

FIA-1100c	Notice of Intent to Discontinue Child Care Benefits (Rev. 06/16/16)
M-327h	Mail-In Recertification/Eligibility Questionnaire-CA 6 Month mailer (Rev. 07/31/18)
OCFS-LDSS-4779	Approval of Your Application for Child Care Benefits (Rev. 11/21)
OCFS-LDSS-4780	Denial of Your Application for Child Care Benefits (Rev. 07/22)
OCFS-LDSS-4781	Notice of Intent to Change Child Care Benefits and Family Share Payments (Rev.11/21)
OCFS-LDSS-4782	Notice of Intent to Discontinue Child Care Benefits (Rev.04/23)
OCFS-LDSS-4785	Approval of Your Transitional Child Care Benefits (Rev.11/21)
OCFS-LDSS-4788	Notice of Evaluation of Child Care Benefits-No Change (Rev.11/21)

Notice Date: _____
Case Number: _____
Case Name: _____
ACCIS Number: _____
Caseload: _____
FH&C Phone: _____

Notice of Intent to Discontinue Child Care Benefits

This Agency intends to discontinue payment of your child care benefits, effective _____.
Date

The reason for this action is the Agency has determined that you are programmatically ineligible for child care because you are no longer participating in an approved work-related activity.

The regulations allowing us to do this are: 18 NYCRR § 385.4, 415.2, and 415.8.

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

Conference and Fair Hearing Information

CONFERENCE

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

STATE FAIR HEARING

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

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

(2) WRITE: Send a copy (and keep a copy for yourself) of this entire notice, with the "Fair Hearing Request" section completed, to:

Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201

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

(4) IN PERSON: Bring a copy of this entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at:
14 Boerum Place, Brooklyn NY 11201

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

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

If you have a disability, and cannot travel, you may appear through a representative such as a friend, relative or lawyer**.** If your representative is not a lawyer, or an employee of a lawyer, your representative must bring the hearing officer a written letter, signed

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

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

AVAILABILITY OF POLICY MATERIALS: The Office of Children and Family Services (OCFS) policy issuances are posted on the OCFS website at **http://ocfs.ny.gov/main/policies/external.** These policies 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 HRA, specific HRA policy issuances are available to explain to you or your representative how the agency reached its determination. To request an HRA specific policy, call **(718) 722-5012**, or fax **(718) 722-5018**, or email **CRO@hra.nyc.gov**, or write to **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201**.

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

FAIR HEARING REQUEST (SELECT ONE)

☐ **Do not stop my child care benefits until a fair hearing decision has been issued.**

If you ask for a Fair Hearing within ten (10) days of the date of this notice, we will continue your child care benefits until a Fair Hearing decision is issued. If you ask for a conference only, and not a State Fair Hearing, your child care benefits will not continue.

If you lose the Fair Hearing, you will have to pay back any child care benefits that you received, but should not have received, while you were waiting for the Fair Hearing decision. If you ask for a Fair Hearing and you do not want your child care benefits to be restored while you wait for the decision to be issued, you must tell the State when you call for a Fair Hearing, OR check the box below and send back this notice.

☐ **I do not want my child care benefits restored while I wait for the Fair Hearing decision to be issued.**

Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within sixty (60) days from the date of this notice.

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

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

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

Address: _____

_____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

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.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

APPROVAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS

NOTICE DATE / /	EFFECTIVE ELIGIBILITY DATE / /	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR OR Agency Conference Fair Hearing Information **1-800-342-3334** Record Access Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO.

Your application dated ____/____/____ for child care benefits has been approved. You are eligible to receive child care benefits for child care provided on ____/____/____ through ____/____/____ while you are ____.

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION.
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION.

BENEFITS. Payment will be provided on behalf of the following:

Child(ren):	For this provider:	For the amount of:*	Full Time or Part Time:

Actual payments may vary as permitted by regulation.

Benefits will be paid: ☐ Directly to you ☐ Directly to your provider

Your child care provider must submit a bill and attendance sheet to your local department of social services.

FAMILY PAYMENTS. You are responsible for paying the following fees:

☐ Effective ____/____/____, a **Weekly Family Share** must be paid to ____
in the amount of $____ per week.

☐ Effective ____/____/____, an **Additional Payment** must be paid to ____
in the amount of $____ per week, to recoup an overpayment.

☐ Effective ____/____/____, a **Court-Ordered Payment** must be paid to ____
in the amount of $____ per week, for the child(ren) ____.

The following information is an explanation of how your weekly family share was determined.

Family's annual gross income $____
Minus 100% annual state income standard for a family size of ____ $____
Remaining income $____
Remaining income $____ X family share % ____% = $____
$____ / 52 weeks = $____ weekly family share

All family share amounts are rounded to the nearest $0.50. There is a minimum family share requirement of $1 per week. This fee is waived for those receiving Temporary Assistance, experiencing homelessness, or when such assistance is provided to a child where the child care services unit is comprised of the eligible child(ren) only. This fee is also waived for those receiving child care as a protective service, a preventive service, or for a foster child.

In order to continue to receive benefits these are your responsibilities:

Notify your caseworker immediately of any increase in family income that exceeds 85% of the state median income or any change related to who lives in your house, employment, child care arrangements or other changes that may affect your continued eligibility or the amount of your benefit. Promptly pay any family share required.

The LAW(S) AND/OR REGULATION(S) that allows us to do this is/are:

CLIENT/FAIR HEARINGS COPY

RIGHT TO ACCEPT OR DECLINE SERVICES: Approval of your benefits does not obligate you to accept the services. You may choose to decline the services by contacting your local department of social services.

If you disagree with your local department of social services' decision, you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) Calling: ( ) - (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Writing: Check the box below and mail to _____

   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. You can request a fair hearing without requesting a conference.

   You may request a fair hearing by:

   (1) Calling: 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Online: To send your fair hearing request online, go to https://otda.ny.gov/hearings/, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box, complete the information below and mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) Faxing: Check the box, complete the information below and fax both sides of this form to (518) 473-6735.

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

   Name: _____ District: _____

   Address: _____ Case Number: _____

   _____ Phone Number: ( ) -

If you request a fair hearing, the state will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

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

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 or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file, which you may need to prepare for your fair hearing. 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 conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS

NOTICE DATE / /		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
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 **1-800-342-3334**
		Record Access
		Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO. ( ) -

Your application dated ____/____/____ for child care benefits has been **denied**, and the reason(s) your application has been denied is/are explained below.

Comments: _____

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION.
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION.

You are ineligible to receive benefits because:

☐ Your family's gross income exceeds 300% of the state income standard or 85% of the state median income, which is the maximum income allowed by New York State regulation to be eligible for child care assistance. Your family's monthly gross income of $ _____ exceeds the maximum monthly income of $ _____ for a family size of _____.

(Please see the attached addendum for additional information.)

☐ You have not provided us with the following documents: _____

☐ You are not programmatically eligible for child care assistance because: _____

☐ Due to insufficient funding the district is not opening cases at this time. _____

☐ Other: _____

The LAW(S) AND/OR REGULATION(S) that allows us to do this is/are: _____

CLIENT/FAIR HEARINGS COPY

If you disagree with your local department of social services' decision, you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) Calling: ( ) - (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Writing: Check the box below and mail to _____
   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. You can request a fair hearing without requesting a conference.

   You may request a fair hearing by:

   (1) Calling: **1-800-342-3334** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Online: To send your fair hearing request online, go to https://otda.ny.gov/hearings/, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box, complete the information below, and mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) Faxing: Check the box, complete the information below and fax both sides of this form to (518) 473-6735.

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

   Name: _____ District: _____
   Address: _____ Case Number: _____
   _____ Phone Number: ( ) -

If you request a fair hearing, the state will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

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

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 or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file, which you may need to prepare for your fair hearing. 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 conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

ADDENDUM TO DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS/FINANCIAL ELIGIBILITY CALCULATION

Effective Date: / /

Case Name:

Case Number:

We have determined that you are not eligible for child care benefits. Your family's monthly gross income is $ _____ .

☐ This exceeds 300% of the state income standard or 85% of the state median income, the maximum monthly gross income for initial eligibility, of $ _____ for a family size of _____ .

Please check the information below. If there is a mistake, contact your caseworker listed on page one of this notice. If there is a mistake, it could mean that the decision made about your benefits is not correct.

There is a child with special needs residing in your household. ☐ Yes ☐ No **If you have a child with special needs who needs child care, you may have received this notice in error. Contact your caseworker on page one of this notice to determine if you were denied child care benefits in error.**

Your family's monthly gross income was determined from the following sources:			
☐	Wages or salary (18 NYCRR § 404.5(b)(5)(i)) before taxes in the amount of:	$	per month.
☐	Social Security (18 NYCRR §404.5(b)(5)(iv)) in the amount of:	$	per month.
☐	Child Support (18 NYCRR §404.5(b)(5)(xi)) in the amount of:	$	per month.
	***Other income not listed above as defined in New York State regulation**		
☐	***18 NYCRR §404.5(b)(5) in the amount of:***	$	per month.
	Your family's total monthly gross income:	$	per month.

Below are the monthly income standards used by the district to determine your eligibility for child care benefits. To determine eligibility for child care benefits, your family's monthly gross income for your family size was compared to 300% of the monthly state income standard and 85% of the state median income. For a family to be eligible for child care benefits, a family's income cannot exceed the monthly state income standard and monthly state median income amount listed below for its family size.

Family Size	300% Monthly State Income Standard	85% Monthly State Median Income
1		
2		
3		
4		
5		
6		
7		
8		

For families with more than 8 persons, add $ _____ for each additional person.

Your family's monthly gross income is $ _____ for a family size of _____ . This exceeds the maximum of $ _____ .

**Other income not listed above and defined in New York State regulation 18 NYCRR 404.5(b)(5) is defined as, but not limited to the following: net income for non-farm self-employment, i.e., gross receipts minus expenses from one's own business, professional enterprise or partnership; or net income from farm self-employment, i.e., gross receipts minus operation expenses from the operation of a farm by a person on their own account, as owner, renter or sharecropper; or dividends, interest (on savings or bonds) income from estates or trusts, net rental income or royalties; public assistance (PA) or welfare payments (include PA payments such as PA, SSI and home relief); pensions and annuities (include pensions or retirement benefits paid to a retired person or their survivors); or unemployment compensation, workers' compensation; alimony; or veterans' pensions.*

In addition to the citations listed on this notice, refer to the district's Child and Family Services Plan at https://ocfs.ny.gov/main/childcare/plans/plans.asp for additional information.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NOTICE OF INTENT TO CHANGE CHILD CARE BENEFITS AND FAMILY SHARE PAYMENTS

NOTICE DATE / /	EFFECTIVE BENEFIT CHANGE DATE / /	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
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 **1-800-342-3334** Record Access Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO.

This agency intends to change your child care benefit. Your current benefit will end, and a new benefit will begin. Your current benefit will include services provided through _____.

The new benefit will begin with child care services provided on ____/____/____ through ____/____/____.

The changes are:

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION.
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION.

BENEFITS:

Child(ren):	For this provider:	For the amount of:*	Full Time or Part Time:

Actual payments may vary as permitted by regulation.

FAMILY PAYMENTS. You are responsible for paying the following fees:

☐ Effective ____/____/____, a **Weekly Family Share** must be paid to _____
in the amount of $_____ per week.

☐ Effective ____/____/____, an **Additional Payment** must be paid to _____
in the amount of $_____ per week, to recoup an overpayment.

☐ Effective ____/____/____, a **Court-Ordered Payment** must be paid to _____
in the amount of $_____ per week for the child(ren) _____.

The following information is an explanation of how your weekly family share was determined.

Family's annual gross income $_____
Minus 100% annual state income standard for a family size of ____ $_____
Remaining income $_____
Remaining income $_____ X family share % _____% = $_____
$_____ / 52 weeks = $_____ weekly family share

All family share amounts are rounded to the nearest $0.50. There is a minimum family share requirement of $1 per week. This fee is waived for those receiving Temporary Assistance, experiencing homelessness, or when such assistance is provided to a child where the child care services unit is comprised of the eligible child(ren) only. This fee is also waived for those receiving child care as a protective service, preventive service, or for a foster child.

The reason for this action is: _____

The LAW(S) AND/OR REGULATION(S) that allows us to do this is/are:

CLIENT/FAIR HEARINGS COPY

If you disagree with your local department of social services' decision, you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. If you want a fair hearing and your child care benefit to remain unchanged (aid continuing) until the fair hearing decision is issued you must request a fair hearing before the EFFECTIVE BENEFIT CHANGE DATE on the front page of this notice. A request for a conference alone will not result in your benefits being continued. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) Calling: ( ) - (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Writing: Check the box below and mail to _____

   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. If you do not want your child care benefit to change until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE BENEFIT CHANGE DATE listed on the front page of this notice. You do not have to request a conference before requesting a fair hearing.

   You may request to keep your child care benefit unchanged until a fair hearing decision has been issued. If you request your benefit not to be changed until a fair hearing decision has been issued, and you lose the fair hearing, you will have been overpaid. The local department of social services will seek to recover the overpayment from you by reducing future child care benefits, by collecting a lump sum payment or installment payments, or through legal action.

   You may request a fair hearing by:

   (1) Calling: 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Online: To send your fair hearing request online, go to https://otda.ny.gov/hearings/, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box and complete the information below. Mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) Faxing: Check the box and complete the information below. Fax both sides of this form to (518) 473-6735.

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

   Select one.

   ☐ **Do NOT change** my child care benefit until a fair hearing decision has been issued.

   ☐ **Change** my child care benefit on the effective date listed on this notice, pending the fair hearing decision.

   Name: _____ District: / /

   Address: _____ Case Number: _____

   _____ Phone Number: ( ) -

If you request a fair hearing, the state will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case

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

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 or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. 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 conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

ADDENDUM TO NOTICE OF INTENT TO CHANGE CHILD CARE BENEFITS AND FAMILY SHARE PAYMENTS-FINANCIAL ELIGIBILITY CALCULATION

Effective Date: / /

Case Name: _____

Case Number: _____

The amount that you pay for your family share has changed from / / to / / .

Below are the sources of income used to calculate your family's income and the calculation used to determine your family share.

Please check the information below. If there is a mistake, contact your caseworker listed on page one of this notice.

Your family's monthly gross income was determined from the following sources:		
☐ Wages or salary (18 NYCRR § 404.5(b)(5)(i)) before taxes in the amount of:	$	per month.
☐ Social Security (18 NYCRR §404.5(b)(5)(iv)) in the amount of:	$	per month.
☐ Child Support (18 NYCRR §404.5(b)(5)(xi)) in the amount of:	$	per month.
☐ ***Other income not listed above as defined in New York State regulation 18 NYCRR §404.5(b)(5) in the amount of:***	$	per month.
Your family's total monthly gross income:	$	per month.

The following information is an explanation of how your weekly family share was determined.

Family's total monthly gross income $ _____ X 12 months = $ _____ Annual Income

Family's annual gross income $ _____

Minus 100% state income standard for a family size of _____ $ _____

Remaining income $ _____

Remaining income $ _____ X family share % _____ % = $ _____

$ _____ / 52 weeks = $ _____ weekly family share

Family Size	100% Annual State Income Standard
1	
2	
3	
4	
5	
6	
7	
8	

For families with more than 8 persons, add **$** _____ for each additional person.

**Other income not listed above and defined in New York State regulation 18 NYCRR 404.5(b)(5) is defined as, but not limited to the following: net income for non-farm self-employment, i.e., gross receipts minus expenses from one's own business, professional enterprise or partnership; or net income from farm self-employment, i.e., gross receipts minus operation expenses from the operation of a farm by a person on his own account, as owner, renter or sharecropper; or dividends, interest (on savings or bonds) income from estates or trusts, net rental income or royalties; public assistance (PA) or welfare payments (include PA payments such as PA, SSI and home relief; or pensions) and annuities (include pensions or retirement benefits paid to a retired person or his survivors); or unemployment compensation, workers' compensation; alimony; or veterans' pensions.*

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NOTICE OF INTENT TO DISCONTINUE CHILD CARE BENEFITS

NOTICE DATE: / /	EFFECTIVE CLOSING DATE: / /	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE:
CASE NUMBER:	CIN NUMBER:	
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 **1-800-342-3334**
		Record Access
		Legal Assistance Information

OFFICE NO.:	UNIT NO.:	WORKER NO.:	UNIT OR WORKER NAME:	WORKER TELEPHONE NO.: ( ) -

This notice is to inform you that your child care benefit case will be closed on (date) __/__/____. You are not eligible for child care benefits for services provided after _____.

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION.
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION.

The reason for this action is:

☐ Your family's gross income exceeds 300% of the state income standard or 85% of the state median income, which is the maximum income allowed by New York State regulation to be eligible for child care assistance at initial application and at every eligibility redetermination.

Your family's monthly gross income of $ _____ exceeds the maximum monthly income of $ _____ for a family size of ___.

(Please see the attached addendum for additional information.)

☐ Your family's gross income exceeds 85% of the state median income, which is the maximum income allowed by New York State regulation to be eligible for child care assistance during the eligibility period. Your family's monthly gross income of $ _____ exceeds the maximum monthly income of $ _____ for a family size of _____.

(***Please see the attached addendum for additional information.)***

☐ You are not programmatically eligible for child care services because: _____

☐ You did not provide us with the information we requested to determine your continued eligibility for child care assistance. Without this information, we were unable to determine your eligibility for such assistance. _____

☐ Other: _____

The LAW(S) AND/OR REGULATION(S) that allow(s) us to do this is/are: _____

CLIENT/FAIR HEARINGS COPY

If you disagree with your local department of social services' decision, you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE because the outcome of the conference may impact your decision to request a fair hearing. If you want a fair hearing and your child care benefit to remain unchanged (aid continuing) until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE CLOSING DATE on the front page of this notice. A request for a conference alone will not result in your benefits being continued. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) Calling: ( ) - _____ (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Writing: Check the box below and mail to _____
   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. If you do not want your child care benefit to change until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE CLOSING DATE listed on the front page of this notice. You do not have to request a conference before requesting a fair hearing.

   You may request to keep your child care benefit until a fair hearing decision has been issued. If you request your benefit to be continued until a fair hearing decision has been issued, and you lose the fair hearing, you will have been overpaid. The local department of social services will seek to recover the overpayment from you by reducing future child care benefits, by collecting a lump sum payment or installment payments, or through legal action.

   You may request a fair hearing by:

   (1) Calling: **1-800-342-3334**. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Online: To send your fair hearing request online, go to https://otda.ny.gov/hearings/, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box and complete the information below, and mail it to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, NY 12201-1930. Please keep a copy for yourself.

   (4) Faxing: Check the box and complete the information below. Fax both sides of this form to (518) 473-6735.

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

   Select one.

   ☐ **Do NOT stop** my child care benefit until a fair hearing decision has been issued.

   ☐ **Stop** my child care benefit on the effective date listed on this notice, pending the fair hearing decision.

   Name: _____ District: _____

   Address: _____ Case Number: _____

   _____ Phone Number: ( ) - _____

If you request a fair hearing, the state will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing, you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by searching online, using key words such as your county of residence and "Legal Aid Society" or "advocate group," by checking your Yellow Pages under "Lawyers," or by calling the number indicated on the first page of this notice.

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 or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file, which you may need to prepare for your fair hearing. 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 conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

ADDENDUM TO NOTICE OF INTENT
TO DISCONTINUE CHILD CARE BENEFITS/FINANCIAL ELIGIBILITY CALCULATION

Effective Date: / /

Case Name: _____ Case Number: _____

We have determined that you are no longer eligible for child care benefits. Your family's monthly gross income is $ _____ .

This exceeds 300% of the state income standard or 85% of the state median income, the maximum monthly gross income for redetermination, of $ _____ for a family size of _____ .

This exceeds 85% of the state median income, the maximum income during the eligibility period of $_____ for a family size of _____ .

Please check the information below. If there is a mistake, contact your caseworker listed on page one of this notice. If there is a mistake, it could mean that the decision made about your benefits is not correct.

There is a child with special needs residing in your household. ☐ Yes ☐ No **If you have a child with special needs who needs child care, you may have received this notice in error. Contact your caseworker listed on page one of this notice to determine if your case was closed in error.**

Your family's monthly gross income was determined from the following sources:			
☐	Wages or salary (18 NYCRR § 404.5(b)(5)(i)) before taxes in the amount of:	$	per month.
☐	Social Security (18 NYCRR §404.5(b)(5)(iv)) in the amount of:	$	per month.
☐	Child Support (18 NYCRR §404.5(b)(5)(xi)) in the amount of:	$	per month.
☐	***Other income not listed above as defined in New York State regulation 18 NYCRR §404.5(b)(5) in the amount of:***	$	per month.
	Your family's total monthly gross income:	$	per month.

Below are the state median income levels and state income standard levels used by the district to determine your eligibility for child care benefits. To determine eligibility for child care benefits, your family's monthly gross income for your family size was compared to 85% of the state median income and 300% of the state income standard. During the eligibility period, your family's gross income may not exceed 85% of the state median income.

Family Size	300% State Income Standard (SIS)	85% State Median Income (SMI)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

**Other income not listed above and defined in New York State regulation 18 NYCRR 404.5(b)(5) is defined as, but not limited to the following: net income for non-farm self-employment, i.e., gross receipts minus expenses from one's own business, professional enterprise or partnership; or net income from farm self-employment, i.e., gross receipts minus operation expenses from the operation of a farm by a person on their own account, as owner, renter or sharecropper; or dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties*; *public assistance (PA) or welfare payments (include PA payments such as PA, SSI and home relief); pensions and annuities (include pensions or retirement benefits paid to a retired person or their survivors); or unemployment compensation, workers' compensation; alimony; or veterans' pensions.*

Your family's monthly gross income is $ _____ **for a family size of** _____ .

This exceeds the maximum income of $ _____ .

In addition to the citations listed on this notice, refer to the district's Child and Family Services Plan at https://ocfs.ny.gov/main/childcare/plans/plans.asp for additional information.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

APPROVAL OF YOUR TRANSITIONAL CHILD CARE BENEFITS

NOTICE DATE / /	EFFECTIVE DATE / /	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
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 **1-800-342-3334** Record Access Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO.

Your transitional child care benefits have been approved. You are eligible to receive child care benefits for child care services provided on __/__/____ through __/__/____ while you are working.

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION.
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION.

BENEFITS. Payment will be provided on behalf of the following:

Child(ren):	For this provider:	For the amount of:*	Full Time or Part Time:

Actual payments may vary as permitted by regulation.

Benefits will be paid: ☐ Directly to you ☐ Directly to your provider
Your provider must submit a bill and attendance sheet to your local department of social services.

FAMILY PAYMENTS. You are responsible for paying the following fees:

☐ Effective __/__/____, a **Weekly Family Share** must be paid to _____
in the amount of $ _____ per week.

☐ Effective __/__/____, an **Additional Payment** must be paid to _____
in the amount of $ _____ per week, to recoup an overpayment.

☐ Effective __/__/____, a **Court-Ordered Payment** must be paid to _____
in the amount of $ _____ per week, for the child(ren) _____.

The following information is an explanation of how your weekly family share was determined.

Family's annual gross income $ _____
Minus 100% annual state income standard for a family size of _____ $ _____
Remaining income $ _____
Remaining income $ _____ X family share % _____ = $ _____
$ _____ / 52 weeks = $ _____ weekly family share

All family share amounts are rounded to the nearest $0.50. There is a minimum family share requirement of $1 per week. This fee is waived for those receiving Temporary Assistance, experiencing homelessness, or when such assistance is provided to a child where the child care services unit is comprised of the eligible child(ren) only. This fee is also waived for those receiving child care as a protective service, a preventive service, or for a foster child.

In order to continue to receive benefits these are your responsibilities:

- Notify your caseworker immediately of any increase in family income that exceeds 85% of the state median income or any change related to who lives in your house, employment, child care arrangements or other that may affect your continued eligibility or the amount of your benefit.
- Promptly pay any family share required.

The LAW(S) AND/OR REGLATIONS(S) that allows us to do this is/are:

RIGHT TO ACCEPT OR DECLINE SERVICES: Approval of your benefits does not obligate you to accept the services. You may choose to decline the services by contacting your local department of social services.

If you disagree with your local department of social services' decision, **you may request a conference and/or a fair hearing.**

1. **CONFERENCE**: You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. If you want a fair hearing and your child care benefit to remain unchanged (aid continuing) until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE DATE on the front page of this notice. A request for a conference alone will not result in your benefits being continued. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) Calling: ( ) - (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL).

   (2) Writing: Check the box below and mail to _____

   (3) Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING**: You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. If you do not want your child care benefit to change until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE DATE listed on the front page of this notice. You do not have to request a conference before requesting a fair hearing.

   You may request to keep your child care benefit unchanged until a fair hearing decision has been issued. If you request your benefit not to be changed until a fair hearing decision has been issued, and you lose the fair hearing, you will have been overpaid. The local department of social services will seek to recover the overpayment from you by reducing future child care benefits, by collecting a lump sum payment or installment payments, or through legal action.

   You may request a fair hearing by:

   (1) Calling: **1-800-342-3334** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Online: To send your fair hearing request online, go to https://otda.ny.gov/hearings/, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box and complete the information below. Mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) Faxing: Check the box and complete the information below. Fax both sides of this form to **(518) 473-6735**.

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

   Select one.

   ☐ **Do NOT change** my child care benefit until a fair hearing decision has been issued.

   ☐ **Change** my child care benefit on the effective date listed on this notice, pending the fair hearing decision.

Name: _____ District: _____

Address: _____ Case number: _____

_____ Phone: ( ) -

If you request a fair hearing, the state will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

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

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 or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. 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 conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NOTICE OF EVALUATION OF CHILD CARE BENEFITS - NO CHANGE

NOTICE DATE: / /	EFFECTIVE DATE: / /	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
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 **1-800-342-3334**
		Record Access
		Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO. ( ) -

☐ Your **TEMPORARY ASSISTANCE** or **Child Care in Lieu of Temporary Assistance** case is closing on (date) ____/____/____. The agency evaluated your circumstances and determined that you are still eligible for child care services. Unless you request to close your case, your child care benefits will not change. You will continue to receive the same benefits through (date) ____/____/____.

☐ Your **PROTECTIVE SERVICES** case is closing on (date) ____/____/____. The agency evaluated your circumstances and determined that you are still eligible for child care services. Unless you request to close your case, your child care benefits will not change. You will continue to receive the same benefits through (date) ____/____/____.

☐ You notified the agency of a **CHANGE IN YOUR CIRCUMSTANCES** on (date) ____/____/____. The agency evaluated this information and determined that your benefits will not change at this time. You will continue to receive the same benefits through (date) ____/____/____.

☐ The local department of social services has implemented the following changes that will reduce eligibility. However, you will continue to receive the same benefits through (date) ____/____/____.

☐ The local department of social services is increasing the family share percentage from % to % However, your family share will remain the same and you will continue to receive the same benefits through (date) ____/____/____.

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION. READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION.

BENEFITS. Payment will be provided on behalf of the following:

Child(ren):	For this provider:	For the amount of:*	Full Time or Part Time

Actual payments may vary as permitted by regulation.

FAMILY PAYMENTS. You are responsible for paying the following fees:

☐ Effective ____/____/____, a **Weekly Family Share** must be paid to _____
in the amount of $_____ per week.

☐ Effective ____/____/____, an **Additional Payment** must be paid to _____
in the amount of $_____ per week, to recoup an overpayment.

☐ Effective ____/____/____, a **Court-Ordered Payment** must be paid to _____
in the amount of $_____ per week, for the child(ren) _____.

CLIENT/FAIR HEARINGS COPY

The following information is an explanation of how your weekly family share was determined.

Family's annual gross income $ _____

Minus 100% annual state income standard for a family size of ____ $ _____

Remaining income $ _____

Remaining income $ _____ X family share % _____ = $ _____

$ _____ / 52 weeks = $ _____ weekly family share

All family share amounts are rounded to the nearest $0.50. There is a minimum family share requirement of $1 per week. This fee is waived for those receiving Temporary Assistance, experiencing homelessness, or when such assistance is provided to a child where the child care services unit is comprised of the eligible child(ren) only. This fee is also waived for those receiving child care as a protective service, a preventive service, or for a foster child

The LAW(S) AND/OR REGULATION(S) that allows us to do this is/are:

CLIENT/FAIR HEARINGS COPY

RIGHT TO ACCEPT OR DECLINE SERVICES: Approval of your benefits does not obligate you to accept the services. You may choose to decline the services by contacting your local department of social services.

If you disagree with your local department of social services decision you may request a conference and/or a fair hearing.

1. **CONFERENCE**: You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. If you want a fair hearing and your child care benefit to remain unchanged (aid continuing) until the fair hearing decision is issued you must request a fair hearing before the EFFECTIVE DATE on the front page of this notice. A request for a conference alone will not result in your benefits being continued. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) Calling: ( ) - PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Writing: Check the box below and mail to _____

   (3) Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING**: You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. If you do not want your child care benefit to change until the fair hearing decision is issued, you must request a fair hearing before the EFFECTIVE DATE listed on the front page of this notice. You do not have to request a conference before requesting a fair hearing.

   You may request to keep your child care benefit unchanged until a fair hearing decision has been issued. If you request your benefit not to be changed until a fair hearing decision has been issued, and you lose the fair hearing, you will have been overpaid. The local department of social services will seek to recover the overpayment from you by reducing future child care benefits, by collecting a lump sum payment or installment payments, or through legal action.

   You may request a fair hearing by:

   (1) Calling: **1-800-342-3334** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Online: To send your fair hearing request online, go to https://otda.ny.gov/hearings/, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box and complete the information below. Mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. Please keep a copy for yourself.

   (4) Faxing: Check the box and complete the information below. Fax both sides of this form to **(518) 473-6735**.

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

   Select one.

   ☐ Do **NOT** change my child care benefit until a fair hearing decision has been issued.

   ☐ Change my child care benefit on the effective date listed on this notice, pending the fair hearing decision.

Name: _____ District: _____

Address: _____ Case number: _____

_____ Phone: ( ) -

If you request a fair hearing, the state will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

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

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 or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. 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 conference or fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.