



The City of New York

**HUMAN RESOURCES ADMINISTRATION
DEPARTMENT OF INCOME MAINTENANCE**



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FOLD

FOLD

PROHIBITED

AGREEMENT TO REPAY

Please sign only ONE of the Agreements and mail in the enclosed return envelope

1. CASH REPAYMENT AGREEMENT

You may repay the entire amount of the claim in cash all at once, or you may use cash to repay part of the claim now and then repay the rest in monthly installments. You may also choose to repay the entire amount of the claim in monthly installments. We will notify you if you fail to make payments. After this notice, we may reduce your household's Food Stamp allotment if you fail to make over due payments or discuss a new payment schedule with us.

Please check the cash repayment method you wish to use and sign your agreement:

- I agree to repay the amount of your claim as follows:
- All at once
- Part now, the rest in monthly installments. Monthly payments only - minimum monthly amount: \$ _____

Signature: _____ Date: _____

We will contact you to discuss your chosen method of repayment, and give you a written statement showing how much you will be repaying (and how long your payments will continue if you choose to repay through monthly payments). If you have Food Stamp coupons that you do not need, you may use them instead of, or along with, cash to make a partial payment or to make monthly payments.

OR

2. ALLOTMENT REDUCTION AGREEMENT

Should you choose this repayment method, the amounts of Food Stamps we will keep from your household's monthly allotment will depend on what caused the overissuance. We will contact you to explain the method used to determine how much we will keep and tell you how much you will get while you are repaying with this method. This repayment schedule may change without notice if you allotment amount changes.

I agree to repay by this method.

Signature: _____ Date: _____

YOU MAY HAVE A CONFERENCE TO DISCUSS THIS NOTICE

If you do not understand this notice or are in disagreement with the action we intend to take, you may request a conference. To do so call 1(718) 403-5931 as soon as possible. You will have a chance to discuss your case with a worker who will explain our action and correct any mistake we have made. This is a fast, easy and effective way to be certain that your case is being handled properly.

By requesting a conference you are not giving up your rights to a fair hearing provided that you request a fair hearing within the time limits described below.

YOU HAVE A RIGHT TO A FAIR HEARING IF YOU DON'T AGREE WITH OUR ACTIONS

If you believe we should not take the above actions on your Food Stamp case, or disagree with the amount of the claim you should request a State fair hearing.

- (1) By telephoning 1(212) 488-6550. or
- (2) By sending a copy of this notice to Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany N.Y. 12201.

You have 90 days to request a hearing on your Food Stamps.

If you request a fair hearing, a notice will be sent to you telling you the time and place of the hearing. You can be represented by an attorney or other representative. You or your representative can present written and oral evidence to show why we should not take these actions on your case, and can question any persons who appear at the hearing and present evidence against you. You can have witnesses to speak in your favor. You should bring to the hearing any documents such as paystubs, rent receipts, medical bills, hearing bills, childcare expenses, etc., that may be helpful in supporting your case. You have the right to see the entire contents of your file before the hearing.

If you think you need legal assistance for your conference or fair hearing, you may be able to obtain it free if you cannot afford a lawyer by contacting a local legal aid or legal services office.



Date: _____

Case Name: _____

Case Number: _____

Caseload: _____

Center: _____

Telephone number for conference and record access:

FH&C

For questions or help, call your worker at the telephone number below.

Notice of Voluntary Rent Restriction

Dear Participant:

This is to advise you that, in accordance with your agreement with your landlord, the Human Resources Administration will restrict your rent payments effective _____

As long as you remain on voluntary rent restriction, a separate public assistance check will be issued each semi-monthly period for rent.

Your rent check will be issued:

- as a two party check in both your name and the landlord's. This check will be mailed to your home address . You cannot cash the two party rent check. Only your landlord can deposit the two party check after you have both signed it.
- as a direct payment to your landlord. This check will be mailed directly to your landlord.

Your rent restriction is entirely voluntary. If you wish at any time to have the restriction ended, or if you have any questions about voluntary rent restriction, please contact your worker.

Worker/Date

Telephone Number

Supervisor/Date

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

We will review this decision with you if you call us at the above telephone number and ask for a LOCAL CONFERENCE. You also have the right to ask for a STATE FAIR HEARING. You must request a STATE FAIR HEARING within 60 days of the date on the top of this notice. You must meet this deadline to request a STATE FAIR HEARING even if you ask for a LOCAL CONFERENCE first. The STATE FAIR HEARING is held by the New York State Office of Temporary and Disability Assistance. If you request a STATE FAIR HEARING before the effective date of this notice, you will continue to receive your benefits unchanged until the STATE FAIR HEARING decision is issued. A request for a LOCAL CONFERENCE alone will not result in a continuation of benefits.

BE SURE TO READ THE REVERSE ON HOW TO APPEAL THIS DECISION

Conference and Fair Hearing Information

CONFERENCE (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call the Fair Hearing and Conference (FH&C) Unit at the number found on the front, or write to your Center to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we change our decision, we will take corrective action and give you a new notice. (See Keeping Your Benefits the Same, below).

STATE FAIR HEARING

Deadline for Request: If you want the State to review our decision, you must ask for a fair hearing within 60 days from the date of the notice for public assistance, medical assistance and social services issues, and 90 days for food stamp issues.

Keeping Your Benefits the Same: We will keep your benefits the same as they were before this notice if you ask for a fair hearing before the effective date of the notice. If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you write or call for a fair hearing.

Right to a Fair Hearing: If you believe the action(s) we are taking is (are) wrong, you may request a State fair hearing by telephone, in writing, by fax, or in-person.

- (1) TELEPHONE:** (212) 417-6550 (Please have this notice with you when you call).
- (2) WRITE:** Send a copy of the notice, with this side completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, NY 12201. Please keep a copy for yourself.
- (3) FAX:** Send a copy of the notice, with this side completed, to Fax Number: **(518) 473-6735**.
- (4) WALK-IN:** Bring a copy of the notice, with this side completed, to a New York State Office of Temporary and Disability Assistance office listed below:
14 Boerum Place, Brooklyn
109 East 16th Street, Manhattan, 3rd floor
330 West 34th Street, Manhattan, 3rd floor

I want a fair hearing. The Agency's action is wrong because: _____

Signature of Participant: _____ Date: _____

Print Name: _____ Case Number: _____

Address: _____ Telephone 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 fair hearing, the applicant/participant or their representative has the opportunity to present written and oral evidence, establish facts and circumstances and to question or refute the evidence presented by the local agency. 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.

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".

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 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 or write to us, we will send you free copies of other 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 the Fair Hearing and Conference (FH&C) Unit at the telephone number found on the front, or write to your Center at the address listed at the top of this notice. If you want copies of documents from your case file, you should ask for them ahead of time.

If your situation is extremely serious, the State will attempt to process your request for a fair hearing as quickly as possible. If you call to request a fair hearing, please be prepared to explain your situation to the person who answers the phone. If you write for a fair hearing, please explain your situation and enclose a copy of this notice.



The City of New York
Human Resources Administration
Family Independence Administration

Form W-145M(S) (face)
 6/1/00

Fecha: _____

Nombre de Caso: _____

Número de Caso: _____

Manto de Casos: _____

Centro de IS/Job: _____

Número de teléfono para conferencia y acceso a registros: _____

Aviso de Restricción Voluntaria de Renta

_____ FH&C
 Para preguntas o ayuda, llame a su trabajador al número de teléfono que aparece debajo.

Estimado Participante:

La presente es para informarle que, en cumplimiento con el acuerdo con su casero, el Departamento restringirá sus pagos de renta a partir del _____.

Siempre y cuando se mantenga bajo restricción de renta voluntaria, un cheque separado de asistencia pública será emitido para su renta cada período de quince días.

Su cheque para la renta será emitido:

como un cheque para dos personas en su nombre y el de su casero. Este cheque le será enviado a la dirección de su casa. Usted no puede cambiar el cheque para dos personas. Solo su casero puede depositar este cheque luego que ambos lo firmen.

como un pago directo a su casero. Este cheque será enviado directamente a su casero.

Su restricción de renta es enteramente voluntaria. Si usted desea terminar la restricción en cualquier momento, o si tiene alguna pregunta relacionada con la restricción voluntaria de renta, por favor contacte a su trabajador.

Trabajador/Fecha

Número de Teléfono

Supervisor/Fecha

Usted Tiene El Derecho De Apelar Esta Decisión

Nosotros revisaremos esta decisión junto con usted si nos llama al número de teléfono que aparece arriba y solicita una CONFERENCIA LOCAL. Usted también tiene el derecho a solicitar una AUDIENCIA IMPARCIAL ESTATAL. Usted debe solicitar una AUDIENCIA IMPARCIAL ESTATAL antes de los 60 días de la fecha que aparece en la parte superior de este aviso. Usted debe cumplir con esta limite de tiempo para solicitar una AUDIENCIA IMPARCIAL ESTATAL aún si solicita una CONFERENCIA LOCAL primero. La AUDIENCIA IMPARCIAL ESTATAL es realizada por el New York State Office of Temporary and Disability Assistance. Si usted solicita una AUDIENCIA IMPARCIAL ESTATAL antes de la fecha efectiva que aparece en este Aviso, usted continuará recibiendo sus beneficios sin cambios hasta que se tome la decisión de la AUDIENCIA IMPARCIAL ESTATAL. Una petición para una CONFERENCIA LOCAL por sí sola, no resultará en una continuación de sus beneficios.

ASEGÚRESE DE LEER EL REVERSO EN CÓMO APELAR ESTA DECISIÓN

Información sobre Conferencia y Audiencia Imparcial

CONFERENCIA (Reunión Informal con nosotros): Si usted considera que nuestra decisión fue errónea o si no entiende nuestra decisión, por favor llame al Fair Hearing and Conciliation (FH&C) Unit, al número de teléfono que aparece al frente, o escriba a su Income Support/Job Center para acordar una cita. A veces esta es la manera más rápida para resolver cualquier problema que usted pueda tener. Nosotros le recomendamos que haga esto aún cuando ha solicitado una audiencia imparcial. Si durante la conferencia nosotros descubrimos que tomamos una decisión errónea o si, debido a la información que usted provea, determinamos cambiar nuestra decisión, tomaremos acción correctiva y le proporcionaremos una nueva notificación.
(Vea debajo: Manteniendo Sus Beneficios Iguales.)

AUDIENCIA IMPARCIAL ESTATAL

Límite de Tiempo para Peticiones: Si usted desea que el estado revise nuestra decisión, usted debe solicitar una audiencia imparcial antes de los 60 días de la fecha del aviso de Asistencia Pública, y antes de los 90 días para asuntos de Cupones de Alimento.

Manteniendo Sus Beneficios Iguales: Nosotros mantendremos sus beneficios iguales a como estaban antes de este aviso, si solicita una audiencia imparcial antes de la fecha actual de este aviso. Si usted no desea que sus beneficios permanezcan iguales hasta que se emita una decisión, usted debe comunicárselo al estado cuando escriba o llame para solicitar una audiencia imparcial.

Derecho a una Conferencia Imparcial: Si usted cree que la(s) acción(es) que estamos tomando es(son) errónea(s), usted puede solicitar una Audiencia Imparcial Estatal por teléfono, por escrito, por fax, o en persona.

- (1) **LLAME:** (212) 417-6550 (por favor tenga este aviso a mano cuando llame).
- (2) **ESCRIBA:** Envíe una copia de este aviso con este lado completado, a: Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1980, Albany, New York 12201. Por favor mantenga una copia para usted.
- (3) **FAX:** Envíe una copia de este aviso, con este lado completado, al número de FAX: (518) 473-6735.
- (4) **LLEVE:** Lleve una copia de este aviso, con este lado completado, a una de las oficinas de New York State Office of Temporary and Disability Assistance que aparece listada debajo:
14 Boerum Place, Brooklyn
109 East 16th Street, Manhattan, 3rd floor
330 West 34th Street, Manhattan, 3rd floor

Deseo una audiencia imparcial. La acción de la agencia es errónea porque: _____

Firma del Recipiente: _____ Fecha: _____

Nombre Impreso: _____ Número de Caso: _____

Dirección: _____ Número de Teléfono: _____

Si usted solicita una audiencia imparcial, el estado le enviará una notificación informándole la hora y el lugar de la audiencia. Usted tiene el derecho de ser representado(a) por un abogado, un familiar, un amigo u otra persona, o puede representarse a sí mismo. Durante la Audiencia Imparcial, el solicitante/participante o su representante tiene la oportunidad de presentar evidencias escritas u orales, establecer hechos y circunstancias y cuestionar o argumentar la evidencia presentada por la agencia local. Su abogado u otro representante tendrá la oportunidad de presentar evidencia escrita y oral para demostrar la razón por la cual la acción no debe ser llevada a cabo, así como también tendrá la oportunidad de interrogar a cualquier persona que se presente a la audiencia.

ASISTENCIA LEGAL: Si usted necesita asistencia legal gratis, usted puede obtener tal ayuda contactando la sociedad de ayuda legal de su localidad (Legal Aid Society) u otro grupo legal de abogacía. Usted puede localizar la sociedad de ayuda legal o grupo de abogacía más cercano, buscando en sus páginas amarillas bajo "lawyers" (abogados).

ACCESO A SU REGISTRO Y COPIAS DE DOCUMENTOS: Para ayudarlo a prepararse para la audiencia, usted tiene derecho a revisar el registro de su caso. Si usted nos llama o escribe le enviaremos copias gratis de los documentos de sus registros, los cuales entregaremos al oficial de audiencia en la audiencia imparcial. También, si usted nos llama o escribe, le enviaremos copias gratis de otros documentos de su registro que considere que puede utilizar para su audiencia imparcial. Para solicitar documentos o para saber cómo revisar su registro, llame al Fair Hearing and Conciliation (FH&C) Unit al número de teléfono que aparece al frente, o escriba a su Income Support/Job Center a la dirección que aparece en la parte superior de este aviso. Si usted desea copias de documentos del registro de su caso, usted debe solicitarlas con anticipación.

Si su situación es extremadamente seria, el estado intentará procesar su petición para una audiencia imparcial lo más pronto posible. Si usted llama para solicitar una audiencia imparcial, por favor este preparado para explicar su situación a la persona que conteste el teléfono. Si usted solicita una audiencia imparcial por escrito, por favor explique su situación y adjunte una copia de este aviso.