FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #05-12-OPE

REVISIONS TO MANUAL STATE NOTICES

Date:	Subtopic(s):
January 21, 2005	Forms
This procedure can now be accessed on the FIAweb.	The purpose of this policy bulletin is to inform Job Center and NPA Food Stamp staff of the revisions to the manual State applicant/participant notices. This policy bulletin is informational for all other staff. The following forms have been revised: • Action Taken on Your Food Stamp Case (NYC) (**LDSS-3152 NYC**) • Notice of Food Stamp Benefits Overpayment (Demand Letter) (Timely and Adequate) (NYC) (**LDSS-3156 NYC**) • Notice of Intent to Change Food Stamp Benefits (Timely and Adequate) (NYC) (**LDSS-3620 NYC**) • Notice of Intent to Change Food Stamp Benefits (Adequate Only) (NYC) (**LDSS-3621 NYC**) • Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage (NYC) – PART A (**LDSS-4013A NYC**) • Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage (NYC) – PART B (**LDSS-4013B NYC**) • Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services (NYC) – PART A (**LDSS-4014A NYC**) • Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services (NYC) – PART B (**LDSS-4014B NYC**)

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 2 at the prompt followed by 765 or
send an e-mail to *FIA Call Center*

Distribution: X

- Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A (Timely & Adequate) (NYC) (**LDSS-4015A NYC**)
- Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B (Timely & Adequate) (NYC) (**LDSS-4015B NYC**)
- Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A (Adequate Only) (NYC) (**LDSS-4016A NYC**)
- Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B (Adequate Only) (NYC) (**LDSS-4016B NYC**)
- Notification of Overpayment of Public Assistance to a Former Recipient and Demand for Repayment (NYC) (**LDSS-4682 NYC**)
- Intentional Program Violation (IPV) Disqualification Notice for the Food Stamp Benefits (FS) Program (NYC) (**LDSS-4799 NYC**)
- Intentional Program Violation Disqualification Notice for the Public Assistance Program (**LDSS-4827 NYC**)

The Conference and Fair Hearing information for applicants/participants on all manual State notices has been revised as follows:

- The Albany, NY telephone number of the Office of Administrative Hearings (OAH) of the New York State Office of Temporary and Disability Assistance (OTDA) for applicants/participants to call for a Fair Hearing has been replaced by a toll-free telephone number: **(800) 342-3334**.
- Applicants/participants can now request a Fair Hearing by completing an online request form at the Web site of the Office of Administrative Hearings:

  http://www.otda.state.ny.us/oah/forms.asp

- Information regarding the method of requesting a Fair Hearing Conference was added: "If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, by walk-in or online, please write to ask for a Fair Hearing before the deadline."
- The NYC "Access to Your File and Copies of Documents" section was updated to include NYC-specific telephone numbers and an address where applicants/participants can get copies of their files.

Additional revisions to the manual State notices are as follows:

Revisions to **LDSS-3152 NYC**

FRONT PAGE:

- In the Overpayment Information section at the bottom of the front page, an Other checkbox and two lines to fill in information were added.

Revisions to **LDSS-3621 NYC**

FRONT PAGE:

- A new number 7: an Other checkbox and two lines to fill in information were added.

Revisions to **LDSS-4013A NYC**

FRONT PAGE:

- "PART A" was added to the title.
- In the Public Assistance Accepted section, the last sentence was deleted:

  "The reason for recoupment is explained below."

Revisions to **LDSS-4013B NYC**

FRONT PAGE:

- After the Denied section an Other checkbox and two lines to fill in information were added.

Revisions to **LDSS-4014A NYC**

FRONT PAGE:

- The following sentence was added before the last sentence in the Public Assistance Recoupment section:

  The recoupment rate must be at least 5%.

REVERSE PAGE:

- "(Part B)" was changed to "Part A–NYC" after the revision date at the top of the page.

Revisions to **LDSS-4014B NYC**

FRONT PAGE:

- After the Denied section an Other checkbox and two lines to fill in information were added.

Revisions to **LDSS-4015A NYC**

FRONT PAGE:

- The first item in the Public Assistance section was changed to provide more information about why the participant's public assistance is being reduced: either because the participant failed without good cause to cooperate with the Office of Child Support Enforcement or for an "other" reason to be specified by the Worker.
- The NYC regulation number and a telephone number to call to lift the sanction are provided.

REVERSE PAGE:

- New information on how to lift a sanction for non-cooperation with a child support requirement was added to the top of the page.

Revisions to **LDSS-4015B NYC**

FRONT PAGE:

- After the Discontinue section an Other checkbox and two lines to fill in information were added.

Revisions to **LDSS-4016A NYC**

FRONT PAGE:

- The last sentence in the Public Assistance Recoupment section that read "The reason for this recoupment is explained below" was deleted.

Revisions to **LDSS-4016B NYC**

FRONT PAGE:

- After the Discontinue section an Other checkbox and two lines to fill in information were added.

Revisions to **LDSS-4682 NYC**

FRONT PAGE:

- In Section II, after the first paragraph, the statement, "Make sure you sign and date this agreement below, before you return it" was added.
- Also in Section II, the last sentence in number 1 was changed to read, "If you choose to pay in installments, please check the installment method you wish to use:"
- The asterisks were deleted from Section II, numbers 2, 3 and 4 and the footnote below them was also deleted.
- A section for the former participant's address and telephone number was added directly after the statement, "I agree to repay by this method."

Revisions to **LDSS-4799 NYC**

FRONT PAGE:

- In Section II, Period of Disqualification, a new, third checkbox and the following statement were added:

  For 120 months, because you were found guilty about making a false statement about who you are or where you live in order to get multiple FS.

- In section II, Period of Disqualification, a new, fourth sub checkbox and the following statement were added:

  first FS-IPV and it is based on a court finding of trafficking in FS worth $500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of FS, authorization cards or access devices.

Revisions to **LDSS-4827 NYC**

FRONT PAGE:

- In Section IV, the sentence in parentheses after the second checkbox was changed to read:

  (We do not count the disqualified person in the Public Assistance household, but we must count that person's income.)

- Also in Section IV, the title "Public Assistance Repayment Agreement" was changed to "Public Assistance Repayment."

- In section IV, two additional sub category checkboxes were added in the Public Assistance Repayment section. The two new statements read:

  The recoupment is for the recovery of the overpayment that resulted from the IPV.

  The recoupment is to repay a previous overpayment. The overpayment that resulted from this IPV will be recouped when the previous overpayment(s) has been recouped.

REVERSE PAGE:

- The title of the notice was added to the top of the page on the reverse side.
- Name, Address and Case Number fill-in boxes were added directly below the title.

Center Directors must ensure that all previous versions of the forms are recycled.

Samples of the revised forms have been attached.

Effective Immediately

Reference:

04-INF-26

Attachments:

Please use Print on Demand to obtain copies of forms.

LDSS-3152 NYC	Action Taken on Your Food Stamp Case (NYC) (Rev. 6/04)
LDSS-3156 NYC	Notice of Food Stamp Benefits Overpayment (Demand Letter) (Timely and Adequate) (NYC) (Rev. 6/04)
LDSS-3620 NYC	Notice of Intent to Change Food Stamp Benefits (Timely and Adequate) (NYC) (Rev. 6/04)
LDSS-3621 NYC	Notice of Intent to Change Food Stamp Benefits (Adequate Only) (NYC) (Rev. 6/04)
LDSS-4013A NYC	Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage (NYC) – PART A (Rev. 9/04)

LDSS-4013B NYC	Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage (NYC) – PART B (Rev. 9/04)
LDSS-4014A NYC	Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services (NYC) – PART A (Rev. 9/04)
LDSS-4014B NYC	Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services (NYC) – PART B (Rev. 9/04)
LDSS-4015A NYC	Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A (Timely & Adequate) (NYC) (Rev. 9/04)
LDSS-4015B NYC	Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B (Timely & Adequate) (NYC) (Rev. 9/04)
LDSS-4016A NYC	Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A (Adequate Only) (NYC) (Rev. 9/04)
LDSS-4016B NYC	Notice of Intent to Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B (Adequate Only) (NYC) (Rev. 9/04)
LDSS-4682 NYC	Notification of Overpayment of Public Assistance to a Former Recipient and Demand for Repayment (NYC) (Rev. 6/04)
LDSS-4799 NYC	Intentional Program Violation (IPV) Disqualification Notice for the Food Stamp Benefits (FS) Program (NYC) (Rev. 8/04)
LDSS-4827 NYC	Intentional Program Violation Disqualification Notice for the Public Assistance Program (Rev. 6/04)

IMPORTANT NOTICE

Important Notice: If you need help reading this notice, contact your worker.

Aviso importante: Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a) de casos.

إخطار هام: إذا احتجت إلى مساعدة في قراءة هذا الإخطار، خاطب مسؤول ملفك.

重要通知：如需幫助閱讀此通知，請與您的個案負責人接洽。

Avis important: Si vous avez besoin d'assistance pour lire cet avis, veuillez contacter votre travailleur.

Avi enpotan: Si w bezwen èd pou li avi sa a, antre an kontak ak travayè w la.

중요한 통지서: 이 통지서를 읽는데 도움이 필요하시면, 담당 직원에게 연락하십시오.

Важная информация. Если при чтении этого извещения у Вас возникнут трудности, обратитесь к сотруднику, ведущему Ваше дело.

Thông báo quan trọng. Nếu cần được giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

וויכטיגע מעלדונג איז: אויב איר דארפט הילף צו לייענען די מעלדונג, פארבינדט זיך מיט אייער ארבעטער.

Enclosure

LDSS-3152 NYC (Rev 6/04) FS App/Recert/OP Recoup/Ad Only

ACTION TAKEN ON YOUR FOOD STAMP CASE (NYC)

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 Record Access Legal Assistance information

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

The action(s) taken on your application/recertification request for Food Stamp Benefits dated _____ is explained below, next to the checked box(es) ☑ .

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

☐ **APPROVED** for Food Stamp Benefits from _____ to _____ .

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:

   1a. ☐ The date you applied to the end of the month. You may access your benefit on _____ .

   1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____ .

2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____ .This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $ _____ is for the entire month. You may access your combined benefit on _____ .

3. ☐ Beginning _____ you will get $ _____ monthly in Food Stamp Benefits. You may access these benefits on the _____ of each month.

4. ☐ Beginning _____ you will get $ _____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide:

   _____

   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.

6. ☐ Other Information: _____

☐ **DENIED** for Food Stamp Benefits because:

_____

_____

_____

7. ☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed above by _____ , you will not have to reapply. After that date, you will have to reapply.

☐ **OVERPAYMENT INFORMATION** (check all that apply)

- ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
- ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
- ☐ The benefit in Section 3 above reflects a ____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**
- ☐ The benefit in Section 4 above reflects a ____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**
- ☐ Other: _____

_____

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

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

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

Enclosure

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

NAME	ADDRESS	CASE NUMBER

☑ If you were denied Food Stamp Benefits, please tell this agency if you are later approved for Supplemental Security Income (SSI) or Family Assistance (FA), since this may mean you can get Food Stamp Benefits.

☑ If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits.

☑ If you are getting Food Stamp Benefits, you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

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

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

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

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

2. **STATE FAIR HEARING** – You have **90** days from the date of this notice to ask for a fair hearing.

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by:

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

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

_____

_____

_____

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

Walk-In: Bring a copy of this notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, New York or 30 West 34th Street, NYC.

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

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

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your 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**, or 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. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

IMPORTANT NOTICE

Important Notice: If you need help reading this notice, contact your worker.

Aviso importante: Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a) de casos.

إخطار هام: إذا احتجت إلى مساعدة في قراءة هذا الإخطار، خاطب مسؤول ملفك.

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Avi enpòtan. Si w bezwen èd pou li avi sa, kontakte n kontak ak travayè w la.

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Thông báo quan trọng. Nếu cần được giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

וויכטיגע מעלדונג איז: אויב איר דארפט הילף צו לייענען די מעלדונג, פארבינדט זיך מיט אייער ארבעטער.

Enclosure

LDSS-3156 NYC (Rev 6/04) FS AE/IHE-Active/Closing/Closed Case-New/Previous OP/Timely

NOTICE OF FOOD STAMP BENEFITS OVERPAYMENT (DEMAND LETTER) (Timely and Adequate) (NYC)

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 _____
		Record Access _____
		Legal Assistance information _____

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

OVERPAYMENT INFORMATION

1. ☐ **New Overpayment Amount $** _____ **Date of Discovery** _____

We discovered that from _____ to _____ you or your household got more in Food Stamp Benefits than you should have (overpayment). This is because:

1a. ☐ We incorrectly gave you or your household more benefits than you should have gotten (Agency Error); see Reason below;

1b. ☐ You or your household failed to provide correct or complete information which resulted in us giving you more benefits than you should have gotten (Inadvertent Household Error) due to the Reason below. We may investigate further to decide if the error you or a member of your household made was an intentional violation of the Food Stamp Benefits rules. If we decide that it was, you or that household member will not be able to receive Food Stamp Benefits for a period of time. The amount you owe us may also increase. With an intentional violation, we can go back six years instead of one to calculate the amount of Food Stamp Benefits you owe. We will send you another notice if we find there was an intentional violation.

Reason: _____

This decision is based on 18 NYCRR 387.19. We may calculate the amount of this type of overpayment back to a period of twelve (12) [illegible] from the date of discovery. Enclosed is a form that shows how your overpayment was calculated.

2. **Amount you still owe for last Overpayment(s) $** _____

[illegible] your household were notified [illegible] of a Food Stamp Benefits overpayment(s). The amount on line 2 is what you still owe. You have a right to a fair hearing on this amount. It corrects [illegible] all payments that have already been made. You are not allowed a fair hearing on the fact that you have an overpayment, since you were already notified of the overpayment and were told [illegible] fair hearing at that time.

3. ☐ **[illegible] you owe for all New and Past Overpayment(s)** _____ Line [illegible]

REPAYMENT INFORMATION

– All adult members in the household at the time the overpayment occurred are required, according to 18 NYCRR 387.19, to repay this agency by:

1. ☐ Reduction of Your Food Stamp Benefits (Recoupment)

1a. ☐ New Recoupment – We will reduce your Food Stamp Benefits (recoupment) to pay back your overpayment. See separate notice about this recoupment and how it will affect your Food Stamp Benefits.

1b. ☐ Existing Recoupment – Because you have an existing recoupment, no further reduction of your Food Stamp Benefits will be made at this time. When this current recoupment has been completed, we will take at least ten percent (10%) of your Food Stamp Benefits until this new overpayment has been collected.

1c. ☐ Continue Recoupment – We will continue your current recoupment until your current overpayment is paid off.

In addition to your recoupment, you may voluntarily pay back more, including using benefits from your EBT account.

2. ☐ Repayment Agreement - The enclosed Repayment Agreement gives you ways to repay. You must sign and return the enclosed Repayment Agreement.

3. ☐ Request for Compromise – You requested a compromise (reduction) to your claim. We have:

☐ Approved your request. Your balance has been reduced by $_____. Your new balance is $_____.

☐ Denied your request. See the back of this notice for your rights to appeal this decision.

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges. This decision is based on 31 CFR 285.

If you have a Food Stamp Benefits Inadvertent Household Error (IHE) and/or an Agency Error (AE) overpayment that has not been paid back, and your case is now closed or being closed, you may be able to get a reduction (compromise) of what you owe. If you cannot repay the full balance of what you owe, talk to your local department of social services. Intentional Program Violations are not considered for reduction.

If you do not access your Food Stamp Benefits within 270 days, they will be expunged (taken back). If you have a Food Stamp Benefits overpayment, your expunged benefits will be put towards your overpayment. If you apply for Food Stamp Benefits again, and have not repaid the amount you owe, your Food Stamp Benefits will be reduced if you begin to get Food Stamp Benefits again. You will be notified, at that time, of the amount of reduced benefits you will get.

BE SURE TO READ THE BACK OF THIS NOTICE TO SEE WHAT RIGHTS YOU HAVE TO APPEAL THIS DECISION.

Enclosure

DISTRIBUTION: White-Client/Fair Hearing Copy Yellow-Client Copy Pink-Agency Copy

LDSS-3156 NYC (Rev 8/04) Reverse FS AE/HE-Activ/Closing/Closed Case-New/Previous OP/Timely

NAME:	ADDRESS:	CASE NUMBER:

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

☑ If you are getting Food Stamp Benefits, you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

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

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

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

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

2. **STATE FAIR HEARING** – You have **90** days from the date of this notice to ask for a fair hearing.

   If this notice is telling you that you got too much in Food Stamp Benefits and that you must pay them back and you do not agree, you MUST call for a fair hearing within 90 days of the date of this notice. If you do not call for a fair hearing within 90 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

   KEEPING YOUR BENEFITS THE SAME: We will not change your Food Stamp Benefits if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any benefits you got, but should not have gotten, while you were waiting for the decision. If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a fair hearing or, if you send back this notice, check the box below:

   ☐ I do not want to keep my Food Stamp Benefits the same until the fair hearing decision is issued.

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by:

Mail: Send a copy of the entire notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12... Please keep a copy for yourself.

☐ If you want a fair hearing and do not agree with the agency's action, you may explain why you disagree, but you do not have to include an explanation.

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

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

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, New York or 330 West 34th Street, NYC.

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

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your 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**, or 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. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

IMPORTANT NOTICE

Important Notice: If you need help reading this notice, contact your worker.

Aviso importante: Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a) de casos.

إخطار هام: إذا احتجت إلى مساعدة في قراءة هذا الإخطار، خاطب مسؤول ملفك.

重要通知：如需幫助閱讀此通知，請與您的個案負責人接洽。

Avis important: Si vous avez besoin d'assistance pour lire cet avis, veuillez contacter votre travailleur.

Avi enpòtan. Si w bezwen èd pou li avi sa, antre en kontak ak travayè w la.

중요한 통지서: 이 통지서를 읽는데 도움이 필요하시면, 담당 직원에게 연락하십시오.

Важная информация. Если при чтении этого извещения у Вас возникнут трудности, обратитесь к сотруднику, ведущему Ваше дело.

Thông báo quan trọng. Nếu cần được giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

וויכטיגע מעלדונג איז: אויב איר דארפט הילף צו לייענען די מעלדונג, פארבינדט זיך מיט אייער ארבעטער.

Enclosure

LDSS-3620 NYC (Rev. 6/04) FS Red/Closing/DP/Timely

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE) (NYC)

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 _____
		Record Access _____
		Legal Assistance information _____

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

We are CHANGING your Food Stamp Benefits, as explained below, next to the checked boxes ☑.

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

1. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____ effective _____.

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

2. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____.

3. ☐ **OVERPAYMENT INFORMATION**

   ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (enclosed) for your case is closing the Repayment Agreement (if) for more information on this overpayment. **This decision is based on 18 NYCRR 387.1**

   ☐ You currently owe a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will pay this overpayment.

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

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

The reason for this action is: _____

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

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

☑ If you are getting Food Stamp Benefits, you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

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

Enclosure

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

LDSS-3620 NYC (Rev. 6/04) REVERSE FS Red/Closing/OP/A/C-Timely

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

2. **STATE FAIR HEARING** – You have **90** days from the date of this notice to ask for a fair hearing.

   KEEPING YOUR BENEFITS THE SAME: We will not change your Food Stamp Benefits, if you ask for a fair hearing before the effective date of this notice. However, if you lose the fair hearing, you will have to pay back any Food Stamp Benefits you got, but should not have gotten, while you were waiting for the decision.

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

   ☐ I do not want to keep my Food Stamp Benefits the same until the fair hearing decision is issued.

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

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

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

_____

_____

_____

Phone: [illegible]642-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

Fax: Fax a copy of the front and back of this notice to: (5[illegible]) 47[illegible]6735

Walk-in: Bring a copy of the entire notice to the New York State Office of Temporary and Disability Assistance, 14 Boerum Place, Brooklyn or 330 [illegible] Street, NYC.

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

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

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

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

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

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

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

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

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

IMPORTANT NOTICE

Important Notice: If you need help reading this notice, contact your worker.

Aviso importante: Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a) de casos.

إخطار هام: إذا احتجت إلى مساعدة في قراءة هذا الإخطار، خاطب مسؤول ملفك.

重要通知：如需幫助閱讀此通知，請與您的個案負責人接洽。

Avis important: Si vous avez besoin d'assistance pour lire cet avis, veuillez contacter votre travailleur.

Avi enpòtan. Si w bezwen èd pou li avi sa, kontakte n kontak ak travayè w la.

중요한 통지서: 이 통지서를 읽는데 도움이 필요하시면, 담당 직원에게 연락하십시오.

Важная информация. Если при чтении этого извещения у Вас возникнут трудности, обратитесь к сотруднику, ведущему Ваше дело.

Thông báo quan trọng. Nếu cần được giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

וויכטיגע מעלדונג איז: אויב איר דארפט הילף צו לייענען די מעלדונג, פארבינדט זיך מיט אייער ארבעטער.

Enclosure

LOSS-3621 NYC (Rev. 6/04) FS Red/Clos/Cont-A/C-Adequate

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (Adequate Only)(NYC)

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: _____
		Record Access: _____
		Legal Assistance information: _____

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

We are CHANGING your Food Stamp Benefits, as explained below, next to the checked boxes ☑ .

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED

1. ☐ **INCREASE** your Food Stamp Benefits from $_____ to $_____ effective _____ .

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____ .

2. ☐ **CONTINUE** your Food Stamp Benefits at $_____ effective _____ .

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____ .

3. ☐ **REDUCE** your Food Stamp Benefits from $_____ to $_____ effective _____ .

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____ .

   ☐ **DISCONTINUE** your Food Stamp Benefits as of _____

5. ☐ **OVERPAYMENT INFORMATION**

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

   ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

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

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

7. ☐ **OTHER** _____

The reason for this action is: _____

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER

☑ If you are getting Food Stamp Benefits, you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

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

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

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

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

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

2. **STATE FAIR HEARING** – You have 90 days from the date of this notice to ask for a fair hearing:

   KEEPING YOUR BENEFITS THE SAME: We will restore your Food Stamp Benefits to the same level they were before this notice, if you ask for a fair hearing within ten (10) days of the postmark of the mailing of this notice. If you lose the fair hearing, you will have to pay back any Food Stamp Benefits you got, but should not have gotten, while you were waiting for the decision.

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

   ☐ I do not want to keep my Food Stamp Benefits the same until the fair hearing decision is issued.

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

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

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

SAMPLE

Phone: [illegible]6334 (PLEASE HAVE [illegible]S NOTICE [illegible]H YOU WHEN YOU CALL.)

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

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn or 330 West 34th Street, NYC.

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your 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**, or 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. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

LDSS-4013A NYC (Rev. 9/04)

ACTION TAKEN ON YOUR APPLICATION: PART A

PA, MA, FS App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC)

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 _____
	Record Access _____
	Legal Assistance information _____

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

The action(s) taken on your application dated _____ is explained below and on Part B, next to the checked box(es) ☑ :

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **ACCEPTED** for the period from _____ to _____. You will get $_____, which will cover the period from _____ to _____. After this you will get $ _____.

☐ The above grant is based on a reduced budget because:

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

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

☐ _____ failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]:

☐ screening ☐ assessment ☐ rehabilitation

☐ or, has not provided consent or revoked consent to disclose treatment information to the agency.

☐ RECOUPMENT at the rate of _____ per ____%) is being taken against your Public Assistance. The reason for this recoupment is: _____.

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

☐ **DENIED** for [name(s)] _____ because _____

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

MEDICAL ASSISTANCE

☐ **ACCEPTED** for Medical Assistance effective _____ for [name(s)] _____

☐ **ACCEPTED** for Medical Assistance with a SPENDDOWN, effective _____ for [name(s)] _____

Your total monthly income is $ _____. Your total monthly deductions are $ _____. The difference between these figures is your monthly net income for Medical Assistance. This is $ _____. The allowable income standard for a family household your size is $ _____. The difference between your net income and this standard ($_____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program.

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

In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department.

☐ **PENDED**

☐ We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than _____ at _____ so we can tell you the information we need.

☐ Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.

☐ Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance.

☐ OTHER _____

This above decision(s) is based on _____

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

Enclosure

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

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

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

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

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

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

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

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

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

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

☑ Regulations require you immediately notify this Department of any changes in net income, resources, living arrangements or address.

☑ If you are getting Public Assistance, Food Stamp Benefits, Medical Assistance you may be able to get a discount on your telephone service. For information on the LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013B NYC (Rev 5/04) **ACTION TAKEN ON YOUR APPLICATION: PART B** PA, MA, FS, App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC)

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: _____
		Record Access: _____
		Legal Assistance information: _____

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

The action(s) taken on your application dated _____ is explained below and on Part A, next to the checked box(es) ☑.

SEE PART A FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE INFORMATION.

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

☐ **APPROVED** for Food Stamp Benefits from _____ to _____.

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:
   - 1a. ☐ The date you applied to the end of the month. You may access your benefit on _____.
   - 1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____.
2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____. This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $ _____ is for the entire month. You may access your combined benefit on _____.
3. ☐ Beginning _____ you will get $ _____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.
4. ☐ Beginning _____ you will get $ _____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.
5. ☐ We could not get Food Stamp Benefits right away. We calculated your benefit without receipt of [illegible] and here is the proof you still need to provide: _____

   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.
6. ☐ Other Information: _____

☐ **DENIED** for Food Stamp Benefits for [name(s)] because: _____

☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed above by _____, you will not have to reapply. After that date, you will have to reapply.

☐ **OTHER**: _____

☐ **OVERPAYMENT INFORMATION** (check all that apply)

- ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. This decision is base on 18 NYCRR 387.19.
- ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
- ☐ The benefit in Section 3 above reflects a ____ % reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.
- ☐ The benefit in Section 4 above reflects a ____ % reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

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

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

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

Enclosure

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

LDSS-4013B NYC (Rev. 9/04) (Part B) Reverse PART B - NYC PA, MA, FS App – No A/C – Adequate

NAME	ADDRESS	CASE NUMBER

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

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

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

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

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

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

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

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

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

_____

_____

_____

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

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

Walk-in: Bring a copy of the front and reverse of this notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn or 330 West 34th Street, N.Y.C.

Online: Complete an online form at **https://www.otda.state.ny.us/oah/forms.asp**.

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

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

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

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

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

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

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

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

If you want copies of documents from your case file, you should ask them ahead of time. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

LDSS-4014A NYC (Rev. 9/04) **ACTION TAKEN ON YOUR RECERTIFICATION: PART A** PA, MA, FS, Serv-Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

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 _____
		Record Access _____
		Legal Assistance information _____

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

The action(s) taken on your recertification dated _____ is explained below and on Part B, next to the checked box(es) ☑.

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **RECERTIFIED** for the period from _____ to _____.

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

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

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

☐ **A RECOUPMENT** at the rate of _____ percent (%) is being taken against your Public Assistance.
If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know [illegible] of proof you need to sh[illegible]at the reco[illegible]ent a[illegible]ause undue hardshi[illegible]at the recoupm[illegible] will cause undue hardsh[illegible] recoupm[illegible]e will [illegible] changed t[illegible] rate [illegible]ween 5 and 10%. The recoupment rate must be at least 5%. [illegible]s d[illegible]sion is ba[illegible]d [illegible] 18 NYC[illegible]2.31(

☐ DISCO[illegible]E your P[illegible]lic Assi[illegible]nce be[illegible]t e[illegible]ctive _____.

Th[illegible]EASON for [illegible] act[illegible]s _____.

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

MEDICAL ASSISTANCE

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

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

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

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

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

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

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

The above decision(s) is based on _____.

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

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

Enclosure

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

NAME	ADDRESS	CASE NUMBER

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

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

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

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

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

☑ If you are getting Public Assistance, Food Stamp Benefits, or Medical Assistance, you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4014B NYC (Rev. 9/04) **ACTION TAKEN ON YOUR RECERTIFICATION: PART B** PA, MA, FS, Serv Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

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

Record Access

Legal Assistance information

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

The action(s) taken on your recertification dated _____ is explained below and on Part A, next to the checked box(es) ☑:

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

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED

☐ **APPROVED** for continued Food Stamp Benefits from _____ to _____.

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:

   1a. ☐ The date you applied to the end of the month. You may access your benefit on _____

   1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____.

2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____. This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $_____ is for the entire month. You may access your combined benefit on _____.

3. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.

   3a. ☐ You will continue to get the benefit above until _____. This is because you are eligible for Transitional Food Stamp Benefits. You are not required to report changes until the end of the transition period. If you have changes during your transition period that increase your benefits, you must contact your worker to find out if an early recertification application is needed to receive the increase. Certain situations that result in benefit increases will end your transition period, otherwise, your transitional period and benefit will continue as described above.

4. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide:

   _____

   _____

   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.

6. ☐ Other information: _____

☐ **DENIED** for Food Stamp Benefits because: _____

_____

☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed on the above lines by _____, you will not have to reapply. After that date, you will have to reapply for benefits.

☐ **OTHER:** _____

_____

☐ **OVERPAYMENT INFORMATION**

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

☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

☐ The benefit in Section 3 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

☐ The benefit in Section 4 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

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

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

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

Enclosure

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

LDSS-4014B NYC (Rev. 9/04) (Part B) Reverse PART B - NYC PA, MA, FS, Serv Recert - Timely – A/C No FS

NAME	ADDRESS	CASE NUMBER:

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

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

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

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

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

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

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

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

KEEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance, Medical Assistance and Social Services Benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing, your Food Stamp Benefits **cannot be continued in the same amount as** before your recertification, but will be in the new amount shown in this notice. If you lose the fair hearing, you will have to pay back any Public Assistance benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

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

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

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

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

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

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

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

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

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn or 330 West 34th Street, NYC.

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

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

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

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

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

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

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

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

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

If you want copies of documents from your case file, you should ask them ahead of time. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

LDSS-4015A NYC (Rev. 9/04) **NOTICE OF INTENT TO CHANGE BENEFITS: PART A** PA, MA, FS, Serv – Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE) (NYC)

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 Record Access Legal Assistance information

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

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

SEE PART B FOR FOOD STAMP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **REDUCE** your Public Assistance Benefit effective _____ from $ _____ to $ _____ becau[illegible] _____ fa[illegible] without [illegible] cause t[illegible] perat[illegible] with the Office of Child Support Enforcement (OCSE) on _____ by _____ [18 NYCRR 352.3(d)]:

To lift thi[illegible] anct[illegible]) Rea[illegible] the c[illegible] hild instructions on the back of t[illegible] notice.

Other: _____

☐ **INCREASE** your Public Assistance Benefit effective _____ from $ _____ to $ _____.

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

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

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

The **REASON** for this action is _____

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

MEDICAL ASSISTANCE

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

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

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

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

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

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

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

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

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

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

Enclosure

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

LDSS-4015A NYC (Rev. 9/04) (Part A) Reverse PART A - NYC PA, MA, FS, Serv Change - A/C - Timely

NAME	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

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

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

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

☑ If you are getting Public Assistance, Food Stamp Benefits, or Medical Assistance you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4015B (Rev.9/04) **NOTICE OF INTENT TO CHANGE BENEFITS: PART B** PA, MA, FS, Serv Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE)

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 _____
		Record Access _____
		Legal Assistance information _____

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

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

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

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

FOOD STAMPS

1. ☐ **INCREASE** your Food Stamp Benefits from $ _____ to $ _____ effective _____.

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

2. ☐ **CONTINUE** your Food Stamp Benefits at $ _____ effective _____.

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

3. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____ effective _____.

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____

5. ☐ **OTHER** _____

6. ☐ **OVERPAYMENT INFORMATION**

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

   ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

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

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

8. ☐ **OTHER INFORMATION:** _____

The reason for this action is: _____

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

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

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

Enclosure

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

LDSS-4015B (Rev.9/04) (Part B) Reverse PART B PA, MA, FS, Serv Change - A/C - Timely

NAME	ADDRESS	CASE NUMBER

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

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

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

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

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

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

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

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

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

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

I do not want to keep my benefits the same until the fair hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ Food Stamp Benefits ☐ Social Services

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

Mail: Send a copy of Part A and Part B to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assist[illegible], P.O. Box 1930, Alb[illegible] New York [illegible]. Please ke[illegible] copy [illegible] for yourself.

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

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

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

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

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the **front** of this notice or write to us at the address on the **front** of this notice.

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

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

LDSS-4016A NYC (Rev.8/04) **NOTICE OF INTENT TO CHANGE BENEFITS: PART A** PA, MA, FS, Serv Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY) (NYC)

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 _____ Record Access _____ Legal Assistance information _____

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

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

SEE PART B FOR FOOD STAMP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

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

☐ **INCREASE** your Public Assistance Benefit effective _____ from $ _____ to $ _____.

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

☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance. If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate b[illegible] 10%. The recoupment [illegible] least 5%. This decision is based on [illegible] CRR 352.

☐ **DISCONTINUE** your Public Assistance grant effective _____.

The REASON for this action is _____

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

MEDICAL ASSISTANCE

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

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

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

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

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

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

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

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

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

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

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

☑ If you are getting Public Assistance, Food Stamp Benefits, or Medical Assistance you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4016B NYC (Rev. 9/04) **NOTICE OF INTENT TO CHANGE BENEFITS: PART B** PA, MA, FS, Serv Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY) (NYC)

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: _____
		Record Access: _____
		Legal Assistance information: _____

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

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

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

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

FOOD STAMPS

1. ☐ **INCREASE** your Food Stamp Benefits from $ _____ to $ _____ effective _____.
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

2. ☐ **CONTINUE** your Food Stamp Benefits at $ _____ effective _____.
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

3. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____ effective _____.
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____.

5. ☐ **OTHER** _____

6. ☐ **OVERPAYMENT INFORMATION**
   - ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits that you should have. See the Demand Letter and also, if your case is closing, the Repayment Agreement for more information on this overpayment. This decision is based on 18 NYCRR 387.19.
   - ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
   - ☐ The benefit above reflects a _____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

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

8. ☐ Other Information: _____

The reason for this action is: _____

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

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

KEEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance, Medical Assistance and Social Services Benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing, your Food Stamp Benefits **cannot be continued in the same amount as** before your recertification, but will be in the new amount shown in this notice. If you lose the fair hearing, you will have to pay back any Public Assistance benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

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

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

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

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

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

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

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

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

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn or 330 West 34th Street, NYC.

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

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

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

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

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

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

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

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

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

If you want copies of documents from your case file, you should ask them ahead of time. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

LDSS-4682 NYC (Rev.6/04) Closed Case

NOTIFICATION OF OVERPAYMENT OF PUBLIC ASSISTANCE TO A FORMER RECIPIENT AND DEMAND FOR REPAYMENT (NYC)

NOTICE DATE		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
FORMER 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
		Record Access
		Legal Assistance information

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

SECTION I – PUBLIC ASSISTANCE

This is to tell you about an overpayment that occurred when your Public Assistance case was active. The time period during which the overpayment occurred was from _____ to _____.

The amount of the overpayment is: _____.

The reason(s) for the overpayment is: _____

_____

_____

_____

_____

THE LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 352.31(d)(5). (DELETED LINE THAT WAS HERE)

SECTION II – METHOD OF REPAYMENT

You may repay the entire amount of the overpayment all at once, or in installments. Please return this agreement as soon as you know about the repayment method you may choose by _____.

Make sure you sign and date this agreement below before you return it.

1. ☐ EBT Cash Account – Please take:

   ☐ Everything in my EBT Cash Account, up to the amount of my overpayment(s).

   ☐ $ _____ from my EBT Cash Account, up to the amount of my overpayment(s).

   I understand that if there is not enough in my EBT Cash Account to pay all my overpayment(s),

   I must also check another box below for other ways to repay.

If you choose to pay in installments, please check the installment method you wish to use:

2. ☐ All at once 3. ☐ Part now, the rest in monthly payments 4. ☐ Monthly payments

I agree to repay by this method.

Your Address (if different than above): _____

Your Phone Number or Where We Can Reach You (_____) _____.

Signature_____ Date _____

- We will contact you to discuss the repayment method you have chosen and give you a written statement showing how much you will be repaying (and how long your payments will continue should you choose to repay through monthly payments).

If you do not appeal this decision or if you fail to respond to this notice to repay or you do not repay this debt either all at once, or by monthly payments, the social services district may refer the debt for collection in a number of ways including, but not limited to, automated collection from your tax refund.

IF YOU NEED HELP IN COMPLETING THIS AGREEMENT, PLEASE CALL US AT THE TELEPHONE NUMBER ABOVE.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION.

Accounting Use Only – Cash Repayment 02

Date Entered on Admin. Screen ___/___/___ Transaction Amount $ ___.___.___

Entered by: _____ Date ___/___/___

LDSS-4682 NYC (Rev. 6/04) REVERSE

NAME:	ADDRESS:	FORMER CASE NUMBER:

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

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

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

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

   If you ask for a conference, you are still entitled to a fair hearing. **Even if you ask for a conference, you still have only 60 days from the date of this notice to request a fair hearing. HOWEVER, IF YOU WANT TO PREVENT COLLECTION OF THIS DEBT UNTIL YOU HAVE HAD A FAIR HEARING, YOU MUST REQUEST A FAIR HEARING WITHIN TEN DAYS FROM THE DATE OF THIS NOTICE. Read below for fair hearing information.**

2. **STATE FAIR HEARING** – You have 60 days from the date of this notice to ask for a fair hearing:

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

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

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

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

_____

_____

_____

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

Fax: Fax a copy of the front and reverse of this notice to (718) 473-6735.

Walk-in: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, or 330 West 34th Street, N.Y.C.

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

If you cannot reach the State by phone, by fax, or online, please write to ask for a fair hearing before the deadline.

TO PREVENT POSSIBLE COLLECTION ACTIVITIES UNTIL AFTER A FAIR HEARING HAS BEEN HELD: You must call for a fair hearing within ten days of the date of this notice. You may request a fair hearing up to 60 days from the date of this notice but if you make your request later than ten days after the date of this notice, you may not be able to delay collection until the fair hearing decision is issued.

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your 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**, or 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. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

LDSS-4799 NYC (Rev. 8/04)

INTENTIONAL PROGRAM VIOLATION (IPV)
DISQUALIFICATION NOTICE FOR THE FOOD STAMP BENEFITS (FS) PROGRAM (NYC)

NOTICE DATE		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/HIO 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 _____ Record Access _____ Legal Assistance information _____

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

This is to inform you and members of your family or household that you, _____, are disqualified from receiving FS, as explained below:

I. **Reason For Disqualification** - The reason for the disqualification is that you:

- ☐ Were determined to have committed a FS-IPV by an administrative disqualification hearing held on _____, which resulted in a decision dated _____.
- ☐ Waived rights to an administrative disqualification hearing by signing a waiver on _____.
- ☐ Were found guilty of a crime or offense by a court of law on _____ for committing a FS-IPV.
- ☐ Signed a disqualification consent agreement on _____.

The regulation that allows us to disqualify you is 18 NYCRR 359.9.

II. **Period of Disqualification** - You, the recipient named in this notice, are disqualified from receiving FS for the period(s) checked:

- ☐ For 12 months, because this is your first FS-IPV, and it is not a drug or firearms or explosives-related offense.
- ☐ For 24 months, because this is your:
  - ☐ second FS-IPV that is not a drug or firearms or explosives-related offense
  - ☐ first FS-IPV and it is based on a court finding of trafficking in controlled substances in exchange for FS.
- ☐ [illegible] months, because you were found guilty about [illegible] who you are or [illegible] in order to get multiple FS.
- ☐ **Permanently**, because this is your:
  - ☐ [illegible]rd FS-IPV that is not a drug or firearms or explosives-related offense
  - ☐ [illegible]-IPV and it is based on a court finding of trafficking in controlled substances in exchange for FS
  - ☐ [illegible] FS-IPV and it is based on a court finding of trading firearms, ammunition, or explosives in exchange for FS.
  - ☐ first FS-IPV and it is based on a court finding of trafficking in FS worth $[illegible] or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of FS, authorization cards or access devices.
- ☐ For _____ months because this is the penalty ordered by the court. This is your _____ FS-IPV.
- ☐ This is your _____ FS-IPV. Normally, this means you cannot get FS for _____ months, but because we did not notify you in time:
  - ☐ you will be disqualified for _____ months, beginning _____.
  - ☐ you will not be disqualified.
- ☐ Other: _____

III. **Dates of Disqualification** - Your disqualification period will begin _____ and will end _____.

IV. **Revised FS Amount**

- ☐ Your household's monthly amount of FS will be reduced from $ _____ to $ _____ for your disqualification period. In figuring the amount of FS your household will get, we do not count the disqualified person in the household, but we must count the disqualified person's income. You will **not** automatically be added back into the FS case when your disqualification period ends. To prevent a delay in getting FS again, you must contact us at the number above no later than 30 days before your disqualification period ends.
- ☐ Your FS will be discontinued, effective _____. Your FS case will **not** automatically be reopened when your disqualification period ends. To prevent a delay in getting FS again, you must reapply for FS no later than 30 days before your disqualification period ends.

V. **Amount of Overpayment and Overpayment Period** - Your household got $_____ more in FS than it should have during _____ to _____.

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges. This decision is based on 31 CFR 285.

If you do not access your FS within 270 days, they will be expunged (taken back). If you have a FS overpayment, your expunged FS will be put towards your overpayment. If you apply for FS again, and have not repaid the amount you owe, your FS will be reduced if you begin to get FS again. You will be notified, at that time, of the amount of reduced FS you will get.

LDSS-4799 NYC (Rev.8/04) REVERSE

INTENTIONAL PROGRAM VIOLATION (IPV)
DISQUALIFICATION NOTICE FOR THE FOOD STAMP BENEFITS (FS) PROGRAM (NYC)

NAME	ADDRESS	CASE NUMBER

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

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

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

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

2. **STATE FAIR HEARING**

   You or any members of your family or household may request a fair hearing ONLY to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined, (2) the amount of the FS allotment to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration.

   You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

   You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

   You have **90** days from the date of this notice to ask for a fair hearing.

   If this notice is telling you that you got too much in Food Stamp Benefits and that you must pay them back and you do not agree, you **must** call for a fair hearing within 90 days of the date of this notice. If you do not call for a fair hearing within 90 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

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

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

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

Phone: **800-34[illegible]334** ([illegible]E THIS NOTICE WITH YOU WHEN YOU CALL.)

Fax: [illegible]ax a copy of the front and back of this notice to **(518) [illegible]-672[illegible]**

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn or 330 West 34th Street, NYC.

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

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your 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**, or 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. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

LDSS- 4827 NYC (Rev 6/94)

INTENTIONAL PROGRAM VIOLATION
DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

NOTICE DATE		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID 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 _____
		Record Access _____
		Legal Assistance information _____

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

This is to inform you and members of your family, household or other assistance unit that you, _____, are disqualified from receiving the benefits for the time stated in Section II.

I. Reason For Disqualification

The reason for the disqualification is that you:

- ☐ were determined to have committed an Intentional Program Violation. This was determined by an administrative disqualification hearing held on _____, which resulted in a decision dated _____.
- ☐ waived rights to an administrative disqualification hearing by signing a Waiver on _____.
- ☐ were found guilty of a crime or offense by a court of law on _____ for committing an Intentional Program Violation.
- ☐ signed a disqualification consent agreement on _____ and this agreement:
  - ☐ did not need to be confirmed by a court.
  - ☐ was confirmed by a court on _____.

The regulation which allows us to disqualify you is 18 NYCRR 359.9.

II. Disqualification Period(s)

You, the recipient named in this notice, are disqualified from receiving Public Assistance for the period(s) checked:

- ☐ for 6 months because this is the first time that you committed a Public Assistance-IPV and you wrongfully received an amount less than $1,000.
- ☐ for 12 months because this is the second time that you committed a Public Assistance-IPV, or you wrongfully received between $1,000 and $3,900.
- ☐ for 18 months because this is the third time that you committed a Public Assistance-IPV, or you wrongfully received over $3,900.
- ☐ for 5 years because you have committed [illegible] more previous Public Assistance-IPV.
- ☐ for _____ months because this is the penalty ordered by the _____ time you committed a Public Assistance IPV.

NOTE: Your eligibility for other assistance programs such as Medical Assistance, Child Care Assistance, Emergency Assistance or other Social Services Assistance or Services, may be affected if you must be eligible for Public Assistance in order to receive [illegible].

III. When does the disqualification begin and end?

- ☐ Your disqualification will begin _____ and will end _____.

Your case will not automatically be reopened when the disqualification period ends. To prevent a delay in getting Public Assistance again, you must contact your Social Services District no later than 30 days before the disqualification period ends if you want to reapply for Public Assistance.

- ☐ You are not receiving benefits under Public Assistance. You will be subject to the above disqualification penalties if you apply for and are found eligible for assistance or benefits for these programs in the future.

IV. Revised Benefit Levels and Recoupment/Repayment Information

How much Public Assistance will the remaining members of your Public Assistance unit get?

- ☐ Your Public Assistance will be discontinued as noted in Section II.
- ☐ Your household's Public Assistance will be reduced from $ _____ to $_____. The reduction will begin as noted in Section II. (We do not count the disqualified person in the Public Assistance household, but we must count that person's income.)

Public Assistance Repayment

The amount of the Public Assistance overpayment made to your household is $ _____.

- ☐ The amount of the Public Assistance owed by your household is $ _____. (This is different from $ _____ because you have already repaid $ _____).
- ☐ A recoupment at the rate of _____ percent (%) is being taken against the grant of the remaining household members. If you believe that this reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase general incidentals, or to pay for extraordinary medical needs that are not covered by Medical Assistance. Your worker will let you know what kind of evidence you will need to support your hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction of between 5 and 10 percent (%).
  - ☐ The recoupment is for the recovery of the overpayment that resulted from the IPV.
  - ☐ The recoupment is to repay a previous overpayment. The overpayment that resulted from this IPV will be recouped when the previous overpayment(s) has been recouped.

  The regulation which allows us to do this is 18 NYCRR 352.31(d).
- ☐ You are not currently receiving assistance, but you will be responsible to repay the overpayment.

The regulation which allow us to do this is 18 NYCRR 359.9(f).

V. Affect On Your Food Stamp Benefits

- ☐ You do not receive Food Stamp Benefits.
- ☐ Your Food Stamp Benefits will continue unchanged.
- ☐ You will receive a separate notice about your Food Stamp Benefits.

LDSS-4827 NYC (Rev 6/04) REVERSE

INTENTIONAL PROGRAM VIOLATION
DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

2. **STATE FAIR HEARING** – You or any members of your family or household may request a fair hearing ONLY to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined, (2) the amount of the Public Assistance benefits to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration.

   You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

   You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

   You have **60** days from the date of this notice to ask for a fair hearing.

   If this notice is telling you that you got to much in Public Assistance benefits and that you must pay them back and you do not agree, you must, call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt is wrong.

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

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

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

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

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

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn or 330 West 34th Street, NYC.

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

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your files, which we will give to the Hearing Officer at the Fair Hearing. Also, if you call, write or fax to us, we will send you free copies of other specific documents from your 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**, or 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. Usually, they will be sent to you within three (3) working days of when you ask for them. If you make your request less than five (5) working days before your hearing, your case file documents may be given to you at your hearing.

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

Have You Thought about Child Support?

Raising a child alone in New York City can be difficult, especially if the other parent isn't helping out financially. Some parents don't want to receive court-ordered child support payments because the other parent is already giving money and gifts for their child. Others would rath start over and leave the past behind.

All of these reasons may work for now. But in the long run, yo child(ren) will not receive the full benefits to which they are entitled. New York State, children can receive child support until they reach a 21 even if the other parent is not involved in their life. You do not hav to bear the financial burden alone. Both parents should share the responsibilities of supporting their child(ren). The other parent should share the responsibilities of supporting your common child(ren). The Office of Child Support Enforcement (OCSE) can help you get a child support order and receive payments on a regular basis so that you can better provide for both you and your family.

Remember, the government has set time limits on how long you can receive cash assistance. Therefore receiving child support wi be very important to you when you are no longer receiving cas assistance.

The Office of Child Support Enforcement (OCSE)

If you are applying for or receiving public assistance, you are required to attend an interview at the Office of Child Support Enforcement (OCSE). OCSE is part of the Human Resources Administration (HRA Their job is to make sure that the noncustodial parent (parent not living with his/her child[ren]) provides financial support for their child(ren). In order to do that, OCSE locates the noncustodial parent (if you do not know where he/she lives), helps you to establish paternity (if needed) and gets child support orders through Family Court. Once the child sup port order is in place, OCSE collects child support payments on yo behalf (usually through payroll deductions) and distributes support pay ments.

If you are not applying for or receiving public assistance, and want to apply for child support services, visit the OCSE Family Court Suppor Services Office in the Family Court in your borough.

The Child Support Interview

Once you file an application for public assistance, you will be given an appointment notice for your child support interview and a form called the Absent Parent Questionnaire. You must fill out the questionnaire a bring it to your interview. You will meet with a caseworker in an OC Borough Office where you will be asked about the noncustodial pare Providing the information and documentation requested by OCSE is a important part of the public assistance application process. After your interview, OCSE will review your case for referral to Family Court. If you are notified to appear in Family Court for a child support hearing, you must cooperate by keeping the appointment and answering questions about the noncustodial parent.

What to Bring to the Interview

When you are referred for your interview at the OCSE borough office, y will be en an Appointment Notice and the Absent Parent estionnair

ng both o ese forms with you to the interview. In addition, as muc formation about the noncustodial parent as you can.

The most important things to bring are:

- The non todial parent's name and a document showing his/her Social S rity number

ates of the child(ren)

- Marriage certificate, divorce decree or separation papers
- Voluntary Acknowledgment of Paternity or Order of Filiations from Family Court
- Noncustodial parent's address, phone number and the name and his/her employer

If possible, bring the noncustodial parent with you to your child support proof of his/her Social Security number, address and employment.

If you don ow the whereabouts or Social Security number of the todial parent, the following information about him or would be helpful:

- income and assets such as pay stubs, tax returns, bank accounts and other investment and property holdings

and place of birth

- ne of the noncustodial parent's mother and father (including her's maiden name)

Cooperat with the Child Support Program

Coo with the child support program is a condition of eligibility for pu assis e. If you do not cooperate with OCSE, your public assis- benefits ay be reduced by 25% and you may lose your medical efits. The sanctions will remain in effect until you comply with SE's req ments. If you feel that you have good cause for not coopera h OCSE because the noncustodial parent may retaliate with physical or emotional harm to you or your children, let the child support worker know.

You will be referred to a domestic violence liaison. After you meet with the domestic violence liaison, OCSE will be notified about how to proceed with your case. You may be granted a partial or full waiver that excuses you from proceeding with some or all of the child support requirements.

To Lift a Sanction for Noncooperation with a Child Support Requirement

A sanction for noncooperation with a child support requirement is open-ended and will continue until the sanctioned individual contacts the Office of Child Support Enforcement and cooperates. When the sanctioned individual contacts the Office of Child Support Enforcement, he/she will be told what action(s) must be taken to end the sanction. The sanction will end when he or she takes the required action(s). If the sanctioned individual did not cooperate but now wants to report a good reason for not cooperating with child support, he/she should call the OCSE Borough Office of the borough where he/she resided when the sanction was imposed.

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

- Fear of emotional or physical harm to you or the child(ren) in the family; or
- The child was born due to rape or incest; or
- The child is freed for adoption; or
- You are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three (3) months.

If a sanctioned individual wants to cooperate, but doesn't know how, she or he should call the OCSE Borough Office of the borough where she or he resided when the sanction was imposed.

Establishing Paternity

Paternity means legal fatherhood. If you were never legally married to the other parent, paternity must be established, even if you live together. If both parents agree, paternity can be established at the hospital when the baby is born. After you leave the hospital, the NYC Department of Health and Mental Hygiene (DOHMH) or the Office of Child Support Enforcement can help you establish paternity by completing and signing a form. Paternity must be established before you can get a child support order.

Getting a child support order is not the only reason to legally establish paternity. If the father becomes disabled or dies, you need to be able to prove paternity before your child(ren) can be eligible to receive other benefits like insurance, pension or disability.

Going to Family Court

Child support orders are established in Family Court. Family Court does not share information with Criminal Court. It's the best place to go to settle issues relating to your child(ren). You may be asked to answer some questions. If paternity has not been established, it will be done in cou A DNA test may be ordered to prove fatherhood. The Suppo Magistrate will listen to all of the information and decide how much chi support the noncustodial parent will have to pay.

How Much Child Support You Will Receive for Your Child(ren)?

The amount of the child support order is based on guidelines set by New York State. It depends on the other parent's income and how many child(ren) you have together. The Court may also consider any children from another family the noncustodial parent must support. While you are on public assistance, you will get to keep the first $50 of the curre child support collected each month for the support of your child(ren). The rest of the money is used to offset the Human Resources Administration for your cash benefits. If your child support order is mor than your cash benefits, you may be able to close your public assi tance case and still be entitled to food stamps, child care and Medica benefits.

What Happens When You Go Off Public Assistance

When you are no longer receiving public assistance, all of the mone collected from the noncustodial parent for current support will go direc ly to you. OCSE will continue to make sure that payments are made regularly and on time. There are no fees for these services. If you don't have a child support order because there wasn't enough information about the noncustodial parent, OCSE will continue to try and locate him or her. If you have new information that will help locate the noncustod al parent and/or collect child support for your child(ren), contact th OCSE Family Court Support Services Unit in the Family Court located in your borough. If you are not sure where to go, call the Office of Child Support Enforcement's Customer Services Office at (212) 226-7125.

Location of Child Support Borough Offices

If you are applying for or receiving public assistance, you will be referred to one of the child support offices. If you have more information about the noncustodial parent after your appointment, call the office where your child support interview was held.

Bronx Borough Office
(Serving the Bronx)
260 East 161st Street
Bronx, NY 10451
(718) 664-1845

Brooklyn Borough Office
(Serving Brooklyn and the Rockaways)
625 Fulton Street
Brooklyn, NY 11201
(718) 330-2210/11/12

M hattan B ugh Office
(ving
n Island)
115 Chrystie Street
New York, NY 10002
(212) 334-765

Queens Borough Office
(Serving Queens, except the Rockaways)
32-20 Northern Boulevard
Long Island City, NY 11101
(718) 784-6979

ance with Your Child Support Order

Once you have a child support order from Family Court, you may have stions about your case or information that will help to collect child s rt for your child(ren).

Fo eneral child support program information and case-related issues, co t:

New York City Office of Child Support Enforcement Customer Services Division (212) 226-7125 or TDD: (212) 226-7652
aired)

eneral automated information 24 hours/7 days per week

To speak to d support representative Monday–Friday,
:00 PM

New York City Office of Child Support Enforcement (OCSE)
Custom ces Division
Broadway, 4th floor
ew k, NY 10038
Mond -Friday, 9:00 AM–3:00 PM

automated payment information, contact:
New York Client Information Line: (800) 846-0773

You

- he PIN ber assigned for your child support account
- Your Soc ecurity number

PUBLIC ASSISTANCE AND CHILD SUPPORT

What Parents Need to Know

City of New York
Human Resources Administration
Family Independence Administration

Form W-273KK LLF
Rev. 1/24/05

¿Ha Pensado Usted Acerca de la Manutención de Niños?

Criar a un(a) niño(a) solo(a) en la Ciudad de Nueva York puede ser difícil, especialmente si el otro padre o la madre no le está ayudando económicamente. Algunos padres no quieren recibir pagos para la manutención de niños por orden judicial porque el otro padre o la madre ya le está proporcionando dinero y regalos para su niño(a). Otros prefieren comenzar de nuevo y dejar el pasado atrás.

Todas estas razones son válidas por ahora, pero a la larga, su(s) niño(a)(s) no recibirán los beneficios completos a los cuales tienen derecho. En el Estado de Nueva York, los niños pueden recibir manutención de niño hasta que alcancen la edad de 21 años, aun si el padre o la madre no participa en la vida del niño(a). ¡Usted no tiene que cargar con la responsabilidad económica solo(a)! Ambos padres deben compartir las responsabilidades de mantener a sus hijos. La Oficina de Aplicación de Manutención de Niños (Office of Child Support Enforcement – OCSE) le puede ayudar a obtener una Orden de Manutención de Niños y a recibir pagos corrientes para que puedan mantenerse mejor usted y su familia.

Recuerde que el gobierno establece límites fijos en cuanto al período en que usted puede recibir asistencia de dinero en efectivo. Por tanto, el recibir manutención para niños será muy importante pa usted cuando ya no esté recibiendo asistencia de dinero en efectivo

La Oficina de Aplicación de Manutención de Niños (OCSE

Si usted está solicitando asistencia pública, o participa en la misma, es necesario que se presente a una entrevista en la Oficina de Aplicación de Manutención de Niños (OCSE). La OCSE es parte de la Administración de Recursos Humanos (HRA), y se encarga de asegurar que el padre o la madre sin custodia (que no vive con su(s) niño(s)), proporcione ayuda económica a sus niños. Para los efectos consiguientes, la OCSE ubica al padre sin la custodia (si usted desconoce dónde vive él/ella), le ayuda a establecer paternidad en caso necesario, y obtiene Órdenes de Manutención mediante el Tribunal Familiar (Family Court). Una vez dictada la orden de manutención de niños, la OCSE cobra y distribuye los pagos de manutención en nombre suyo (casi siempre mediante deducciones de nómina).

Si no está solicitando o recibiendo asistencia pública, y quiere solicitar servicios de manutención de niños, visite la Oficina de Servicios de Ayuda a Familias del Tribunal de OCSE en el Tribunal de Familias de su condado.

La Entrevista de Manutención de Niños

Una vez que presente la solicitud de asistencia pública, se le proporcionará una notificación de cita para su entrevista de manutención de niños y el formulario Cuestionario Acerca del Padre o de la Madre Ausente (Absent Parent Questionnaire). Usted tiene que llenar el cuestionario y traerlo a su entrevista. En su entrevista con la oficina OCSE del Condado, usted se reunirá con un trabajador de caso que le preguntará acerca del padre o de la madre sin custodia. El proporcionar información y documentación solicitada por la OCSE es una parte importante del trámite de solicitud de asistencia pública. Después de su entrevista, la OCSE repasará su caso para remitirlo al Tribunal Familiar. Si se le cita para que comparezca en el Tribunal Familiar para una vista de manutención de niños, debe cooperar cumpliendo la citación y contestando las preguntas respecto al padre o a la madre sin custodia.

Lo Que Debe Traer a la Entrevista

Cuando usted sea enviado a su entrevista a la Oficina de la OCSE del condado, se le entregará una Notificación de Cita y el Cuestionario Acerca del Padre o de la Madre Ausente (Absent Parent Questionnaire).

Traiga ambos formularios consigo a la entrevista. Además, traiga toda información que pueda acerca del padre o de la madre sin custodia.

Los documentos más importantes que debe traer son:

- El nombre del padre o de la madre sin custodia y un documento que muestre el número de Seguro Social de él/ella
- Certificado(s) de nacimiento de el/los Niño(s)
- Partida de matrimonio, decreto de divorcio o papeles de separación
- Reconocimiento de Paternidad Voluntaria o un Auto de Paternidad por parte del Tribunal Familiar
- El número de teléfono del padre o de la madre sin custodia, y el nombre y dirección del empleador de él/ella
- Traiga consigo a la entrevista al padre o a la madre sin custodia con prueba del número de Seguro Social, dirección y empleo de él/ella

Si usted desconoce el paradero o número del Seguro Social del padre o la madre sin custodia, la siguiente información acerca de él/ella resultaría útil:

- Ingreso y bienes tales como talones de paga, declaraciones de impuestos, cuentas de banco y otras inversiones y propiedades
- Fecha y lugar de nacimiento
- Nombre de los padres (incluido el nombre de soltera de la madre) del padre o de la madre sin custodia

Cooperación con el Programa de Manutención de Niños

Usted debe cooperar con el programa de manutención de niños como condición de elegibilidad respecto a asistencia pública. Si usted no coopera con la OCSE, sus beneficios de asistencia pública pueden ser reducidos por 25%, y puede perder sus beneficios médicos. Estas sanciones permanecerán en efecto hasta que usted cumpla con los requisitos de OCSE. Si usted considera que tiene un motivo justificado por no cooperar con OCSE, debido a que el padre o la madre sin custodia puede tomar represalias haciéndole daño físico o emocional a usted o a sus hijos, infórmeselo al trabajador de manutención de niños. Se le enviará a un Enlace de Violencia Doméstica. Después de reunirse con el Enlace de Violencia Doméstica, la OCSE será notificada de cómo proceder con su caso. Puede ser que se le conceda un dispensa parcial o total que le exonere de cumplir con algunos, o todos de los requisitos de manutención de niños.

Levantamiento de una Sanción por No Cooperar con un Requisito de Manutención de Niños

Las sanciones por no cooperar con un requisito de manutención de niños son sujetas a cambios y continuarán hasta que la persona sancionada se comunique con la Office of Child Support Enforcement y coopere. Cuando la persona sancionada se comunique con dicha oficina, se le informará de la(s) medida(s) a ser tomada(s) para poner fin a la sanción en cuestión. De hecho, la sanción terminará cuando se tomen la(s) medida(s) indicada(s). En caso de que la persona sancionada no haya cooperado pero ahora desee presentar razón válida por su falta de cooperación con la manutención de niños, debe llamar a la OCSE Borough Office del condado donde residía cuando se impuso la sanción.

Vea a continuación algunos ejemplos de razones válidas por no haber cooperado con la manutención de niños:

- Temor de ser usted o los niños de la familia víctimas de agresión emocional o física; o
- El nacimiento del niño es consecuencia de violación o incesto; o
- El niño está disponible para ser adoptado; o
- Usted recibe actualmente asistencia por parte de una agencia para determinar si el niño debe presentarse para ser adoptado y el tema no se ha discutido por más de tres (3) meses.

Si una persona sancionada desea cooperar y no sabe de qué manera, él o ella debe llamar a la Oficina OCSE del Condado donde él o ella residía cuando se le impuso la sanción.

Establecer la Paternidad

La paternidad conlleva consecuencias legales. Si nunca estuvo legalmente casada con el padre, la paternidad tiene que ser establecida, aun si ambos viven juntos. Si ambos padres están de acuerdo, la paternidad puede ser establecida en el hospital cuando nazca el bebé. Después de dada de alta del hospital, el Departamento de Salud e Higiene Mental (Department of Health and Mental Hygiene – DOHMH) o la Oficina de Aplicación de Manutención de Niños le pueden ayudar a establecer paternidad al usted llenar y firmar un formulario. La paternidad tiene que ser establecida antes de que pueda obtener una orden para la manutención de niños.

Establecer la paternidad no sólo sirve para obtener una orden de manutención de niños, sino también para que su(s) niños tenga(n) derecho a beneficios de seguros, pensiones o incapacidad, en el caso que el padre resulte incapacitado o fallezca.

Acudir al Tribunal Familiar

Las órdenes de manutención de niños se establecen en el Tribunal Familiar, que no comparte información con el Tribunal Criminal. Es el mejor lugar para resolver asuntos relacionados con sus niños. Puede que tenga que contestar algunas preguntas. Si la paternidad no ha sido arestablecida se adjudicará en el tribunal. Puede que se exija una prueba de ADN para probar la paternidad. El Juez de Manutención escuchará todo el caso y decidirá cuánta manutención el padre o la madre sin custodia tendrá que pagar respecto al niño.

¿Qué Cantidad de Manutención de Niños Recibirá para Su(s) Hijo(a)(s)?

La cantidad de la orden de manutención de niños se basa en normas fijadas por el Estado de Nueva York. Esto depende del ingreso del otro padre o de la madre y cuántos niños tienen en común. El Tribunal también **puede** considerar cualesquieras niños de otra familia que el padre o madre sin custodia tenga que mantener. Mientras esté recibiendo asistencia pública, usted podrá quedarse con los primeros $50 cobrados cada mes para la manutención de su(s) niño(s). El dinero restante se usará para compensar a la Administración de Recursos Humanos por sus beneficios en dinero en efectivo. Si su orden para la manutención de niños excede de la cantidad de sus beneficios de dinero en efectivo, usted puede cerrar su caso de asistencia pública y aún tener derecho a cupones para alimentos, cuidado infantil y beneficios de Medicaid.

Lo Que Sucede Cuando Deja de Recibir Asistencia Pública

Cuando usted ya no esté recibiendo asistencia pública, todo el dinero recaudado del padre o de la madre sin custodia para la manutención de niños será entregado a usted. La OCSE continuará asegurándose de que los pagos se realicen con regularidad y prontitud. No se cobra por estos servicios. Si usted no tiene una orden de Manutención de Niños porque no había suficiente información acerca de el padre o de la madre sin custodia, la OCSE continuará tratando de ubicarlo(a). Si usted tiene nueva información que ayudará a localizar al padre o a la madre sin custodia y/o a cobrar manutención de niños para su(s) hijo(s), comuníquese con la Unidad de Servicios de Manutención de Niños del Tribunal Familiar de la OCSE (Family Court Support Services Unit) en el Tribunal Familiar ubicado en su condado. Si no está seguro de a dónde tiene que ir, llame a la Oficina de Servicios al Cliente en la Oficina de Aplicación de Manutención de Niños al (212) 226-7125.

Locales de Oficinas para la Manutención de Niños de los Condados

Si usted esta solicitando o recibiendo asistencia pública, se le enviará a una de las Oficinas de Manutención de Niños listadas más abajo. Si después de su cita, usted tiene más información acerca de el padre o de la madre sin custodia, llame a la oficina a donde acudió a su entrevista de manutención de niños.

Bronx Borough Office
(Sirviendo al Bronx)
260 East 161st Street
Bronx, NY 10451
(718) 664-1845

Brooklyn Borough Office
(Sirviendo a Brooklyn y los Rockaways)
625 Fulton Street
Brooklyn, NY 11201
(718) 330-2210/11/12

Manhattan Borough Office
(Sirviendo a Manhattan/ Staten Island
Chrystie Street
0002
(212) 334-7654

Queens Borough Office
(Sirviendo a Queens, excepto los Rockaways)
32-20 Northern Boulevard
Long Island City, NY 11101
(718) 784-6979

Cómo Obtener Ayuda Respecto a Su Orden de Manutención de Niños

Si usted tenga una orden de manutención por parte del Tribunal Familiar, puede que tenga preguntas acerca de su caso o información que sirva para cobrar la manutención para su(s) niño(s).

Para información sobre el programa de Manutención de Niños y asuntos relacionados con su caso, comuníquese con:

New York City Office of Child Support Enforcement Customer Service Line (212) 226-7125 or TDD: (212) 226-7652 (para impedidos de audición)

Información general automatizada las 24 horas/7 días a la semana

Hable con un representante de manutención de niños de Lunes a Viernes, 8:30 AM–5:00 PM

O visite a la

New York City Office of Child Support Enforcement (OCSE)
División de Servicios al Cliente
151 West Broadway, 4to Piso
New York, NY 10038
Lunes a Viernes, 9:00 AM–3:00 PM

Para información de estado automatizada, comuníquese con:
La Línea Informativa para el Cliente del Estado de Nueva York (New York State Client Information Line): (800) 846-0773

Use el número:
El número del PIN asignado a su cuenta de manutención de niños

Su número de Seguro Social

ASISTENCIA PÚBLICA Y LA MANUTENCIÓN DE NIÑOS

Lo que los Padres Necessitan Saber

City of New York
Human Resources Administration
Family Independence Administration

Form W-273KK (S) LLF
Rev. 1/24/05