



OFFICE OF POLICY, PROCEDURES, AND TRAINING

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POLICY BULLETIN # 17-46-OPE

(This Policy Bulletin Replaces PB #16-21-OPE)

REVISIONS TO THE FAIR HEARING RESOLUTION NOTICE (FHA-1)

Date: April 26, 2017	Subtopic(s): Fair Hearing
<p>Refer to HRA-PB-16-04 for more information regarding HRA's plain language guidelines.</p>	<p>The purpose of this policy bulletin is to inform Fair Hearing Administration (FHA) staff that the "Fair Hearing Resolution Notice" (FHA-1) has been revised.</p> <p><u>Revisions to the FHA-1</u></p> <p>The FHA-1 has been revised to conform to HRA's plain language guidelines by making the form easier to read by applicants/participants. Other revisions to the FHA-1 are as follows:</p> <p>Section I: Fair Hearing Issue</p> <ul style="list-style-type: none"> The phrase, "The resolution actions explained in this resolution notice...", has been revised to: "The actions explained in this resolution notice..." <p>Section II: Action(s) Taken</p> <ul style="list-style-type: none"> A new checkbox was added to the Deleted/Removed section, with the following language: "Benefits taken to recover RTI #: ... were credited to RTI #: ... or another active recoupment." The checkbox indicating "We have recertified your..." was moved from the Budget section to the Re-instated/Added section. The words "eligibility for" were removed from the Child Care benefits phrase in the Re-instated/Added section.

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or
send an e-mail to *FIA Call Center Fax* or fax to: (917) 639-0298

- The format was changed in the Issued section from subsections with checkboxes to tables.
- A new section was added – “Miscellaneous”.
- The word “Other” was removed from the Other section.
- The web address for applicants/participants to access OTDA’s Fair Hearing Online Withdrawal Form was changed.
- The following phrase was added to the Fair Hearing statement:

You may withdraw your request for a fair hearing on issues concerning the SNAP program in any of the ways listed above except by telephone.

Purpose of the **FHA-1**

The purpose of the **FHA-1** is to inform applicants/participants of the resolution to a Fair Hearing request and specify the actions taken by the agency. The **FHA-1** is a fillable form and must be completed by opening it in HRA eDocs. The form must be scanned and indexed into the electronic case record and a copy mailed to the applicant’s/participant’s mailing address as recorded in the Welfare Management System (WMS). The **FHA-1** must be included in the evidence packet associated with that hearing.

A sample of the revised form is attached


Effective Immediately

Related Item:

[HRA-PB-16-04](#)

Attachments:

FHA-1 (E)	Fair Hearing Resolution Notice (3/22/17)
FHA-1 (S)	Fair Hearing Resolution Notice (Spanish) (3/22/17)

 Please use Print on Demand to obtain copies of forms.

Date: _____
 Case Number: _____
 Case Name: _____
 Center: _____

FAIR HEARING RESOLUTION NOTICE

*** Note: only the boxes or sections filled out below are about your case.**

Section I: Fair Hearing Issue

Your Fair Hearing Number _____

- You requested a Fair Hearing because we sent you a notice:
 Notice Number: _____ Date of Notice: _____
 Telling you: _____
 Because: _____
- Your Fair Hearing request was not related to a notice.
- The actions explained in this resolution notice are not related to a Fair Hearing.

SAMPLE

Section II: Action(s) Taken

Deleted/Removed

- We withdrew the notice CNS or RTI #: _____ dated _____
- Benefits taken to recover RTI #: _____ were credited to RTI #: _____ or another active recoupment.
- We deleted from your case record the:
 - Employment sanction for: _____ dated _____
 - Overpayment/recoupment RTI # _____ in the amount of: \$ _____
 - Child Support (OCSE) sanction
- We removed _____ from your
 - Cash Assistance (CA) household budget.
 - Supplemental Nutrition Assistance Program (SNAP) household budget.

Re-instated/Added

- We reopened your case.
- We have recertified your:
 - Cash Assistance case SNAP case
 Your new CED date is: _____

Section II: Action(s) Taken (Continued)

Re-instated/Added (continued)

- We reinstated your:
 - Medicaid eligibility retroactively to: _____
 - Child Care for the period of _____ to _____
 If your child care provider has not received payment for services provided, please contact the Administration for Children's Services Voucher Payment Unit at (212) 227-2257.
- We added _____
 to your Cash Assistance (CA) household budget.
 Supplemental Nutrition Assistance Program (SNAP) household budget.

Issued

- We issued:
 - the cash benefits you lost because of our case action.
 Specifically we issued cash benefits on your EBT card in the amount(s) of:

Amount	Benefit Period	
	Start Date	End Date
\$		
\$		
\$		
\$		

- rent directly to your landlord in the amount(s) of:

Amount	Benefit Period	
	Start Date	End Date
\$		
\$		
\$		
\$		

- a shelter supplement (e.g. FEPS) directly to your landlord in the amount(s) of:

Amount	Benefit Period	
	Start Date	End Date
\$		
\$		
\$		
\$		

Section II: Action(s) Taken (Continued)

Issued (continued)

- the SNAP benefits you lost because of our case action.
 Specifically we issued SNAP benefits on your EBT card in the amount(s) of:

Amount	Benefit Period	
	Start Date	End Date
\$		
\$		
\$		
\$		

- carfare to you in the amount(s) of:

Amount	Benefit Period	
	Start Date	End Date
\$		
\$		
\$		
\$		

SAMPLE

Budget

- Since you were granted "aid to continue," you did not lose any benefits as a result of the notice we sent you. However:
- Your case/line is now active for recurring benefits.
 - Your case/line remains closed or sanctioned because of an unrelated closing or sanction.
- We are not issuing any Cash Assistance benefits at this time because your case/line is closed due to an unrelated issue.
- We are not issuing any SNAP benefits at this time because your certification period has expired.
- Your budget change will **NOT** go into effect and your benefits remain unchanged. A copy of your current budget is enclosed. If we plan to make any new change in your budget, we will send you a new notice in the mail explaining the change.
- Your budget is being changed. You will receive a new notice in the mail explaining the change and what you should do if you do not agree with the change.

Effective _____, your new grant will be \$_____ semi-monthly.

Miscellaneous

- We will review/re-evaluate your medical claim. You will receive a new appointment to review this claim.

Other



If you don't agree that we have resolved all the issues for this Fair Hearing, you should still go to the Fair Hearing.

If you agree that the action(s) taken resolve all the issues for this Fair Hearing, you can withdraw your Fair Hearing request by calling (877) 209-1134 or completing OTDA's Fair Hearing Online Withdrawal Form available at <http://otda.ny.gov/hearings/cancel>, or in-person at 14 Boerum Place, Brooklyn, NY 11201. You may withdraw your request for a fair hearing on issues concerning the SNAP program in any of the ways listed above except by telephone.

SAMPLE

Agency Representative

Telephone No.

Date

Fecha: _____
 Número del Caso: _____
 Nombre del Caso: _____
 Centro: _____

AVISO DE RESOLUCIÓN DE AUDIENCIA IMPARCIAL

*** Nota: Corresponden a su caso sólo las casillas o secciones llenadas más abajo.**

Sección I: Cuestión de la Audiencia Imparcial
<p style="text-align: center;">Su Número de Audiencia Imparcial _____</p> <p><input type="checkbox"/> Usted solicitó una Audiencia Imparcial por nosotros haberle enviado un aviso: Número del Aviso: _____ Fecha del Aviso: _____ Información: _____ Motivo: _____</p> <p><input type="checkbox"/> Su solicitud de Audiencia Imparcial no corresponde a un aviso. <input type="checkbox"/> Las medidas detalladas en este aviso de resolución no corresponden a una Audiencia Imparcial.</p>
Sección II: Medida(s) Tomada(s)
Borrado/Eliminado
<p><input type="checkbox"/> Hemos retirado el aviso de Núm. de CNS o RTI: _____ con fecha del _____</p> <p><input type="checkbox"/> Los beneficios utilizados para recuperar el Núm. de RTI: _____ se abonaron al Núm. de RTI: _____</p> <p><input type="checkbox"/> Hemos borrado de su expediente de caso:</p> <p style="margin-left: 20px;"><input type="checkbox"/> la sanción de empleo para _____ con fecha del _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> el/la sobrepago/recuperación del Núm. de RTI: _____ en la cantidad de: \$ _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> la sanción de Manutención de Niños (OCSE)</p> <p><input type="checkbox"/> Hemos borrado a _____ de su <input type="checkbox"/> presupuesto del hogar de Asistencia en Efectivo (CA). <input type="checkbox"/> presupuesto del hogar del Programa de Asistencia de Nutrición Suplementaria (SNAP).</p>
Restablecido/Añadido
<p><input type="checkbox"/> Hemos vuelto a abrir su caso.</p> <p><input type="checkbox"/> Hemos recertificado su:</p> <p style="margin-left: 20px;"><input type="checkbox"/> caso de Asistencia en Efectivo <input type="checkbox"/> caso de SNAP</p> <p style="margin-left: 20px;">Su nueva fecha de CED es: _____</p>

Sección II: Medida(s) Tomada(s) (continuación)

Restablecido/Añadido (continuación)

Hemos restaurado su:

elegibilidad para Medicaid retroactiva al: _____

Cuidado Infantil por el período de _____ a _____

Si su proveedor de cuidado infantil no ha recibido pago por servicios prestados, favor de comunicarse con la Unidad de Comprobantes de Pago de la Administración de Servicios al Niño al (212) 227-2257.

Hemos añadido a _____

a su presupuesto del hogar de Asistencia en Efectivo (CA).

presupuesto del hogar del Programa de Asistencia de Nutrición Suplementaria (SNAP).

Expedido

Hemos expedido:

los beneficios en efectivo perdidos por usted a raíz de nuestra medida respecto a su caso. En concreto hemos expedido beneficios en efectivo a su tarjeta EBT en la cantidad de:

Cantidad	Período de Beneficios	
	Fecha Inicial	Fecha Final
\$		
\$		
\$		
\$		

alquiler directamente a su casero en la cantidad de:

Cantidad	Período de Beneficios	
	Fecha Inicial	Fecha Final
\$		
\$		
\$		
\$		

un suplemento de albergue (p.ej., FEPS) directamente a su casero en la cantidad de:

Cantidad	Período de Beneficios	
	Fecha Inicial	Fecha Final
\$		
\$		
\$		
\$		

Sección II: Medida(s) Tomada(s) (continuación)

Expedido (continuación)

- los beneficios de SNAP perdidos por usted a raíz de nuestra medida respecto a su caso. En concreto hemos expedido beneficios de SNAP a su tarjeta EBT en la cantidad de:

Cantidad	Período de Beneficios	
	Fecha Inicial	Fecha Final
\$		
\$		
\$		
\$		

- asignación para transporte en la cantidad de:

Cantidad	Período de Beneficios	
	Fecha Inicial	Fecha Final
\$		
\$		
\$		
\$		

SAMPLE

Presupuesto

- Puesto que se le otorgo "asistencia continua," usted no perdió ningún beneficio a raíz del aviso que nosotros le enviamos. No obstante:
 - su caso/línea ya está activo/a para beneficios recurrentes.
 - su caso/línea sigue cerrado/a o sancionado/a debido a cierre o sanción no relacionado.
- No hemos expedido ningún beneficio de Asistencia en Efectivo en este momento porque su caso/línea está cerrado/a por motivo no relacionado.
- No hemos expedido ningún beneficio de SNAP en este momento porque se ha vencido su período de certificación.
- NO** entrará en vigor el cambio del presupuesto, ni cambiarán sus beneficios. En adjunto se encuentra una copia de su actual presupuesto. En caso de que proyectemos algún nuevo cambio en su presupuesto, le enviaremos a usted por correo nuevo aviso para detallar el cambio.
- Su presupuesto se ha cambiado. Usted recibirá por correo nuevo aviso para detallar el cambio y los pasos a tomar en caso de que usted no esté de acuerdo con dicho cambio.

A partir del _____, su nueva concesión sumará \$ _____ quincenales.

Miscelánea	
<input type="checkbox"/>	Nosotros revisaremos/volveremos a evaluar su reclamación médica. Usted recibirá nueva cita para la revisión de dicha reclamación.
Otra circunstancia	
<input type="checkbox"/>	

Si usted no considera que nosotros hemos resuelto todas las cuestiones relacionadas con la Audiencia Imparcial, aún debería presentarse a la misma.

Si usted considera que la(s) medida(s) tomada(s) ha(n) resuelto todas las cuestiones relacionadas con esta Audiencia Imparcial, puede retirar su petición de Audiencia al llamar al (877) 209-1134, o al llenar por Internet el Formulario de OTDA de Retiro por Internet de Audiencia Imparcial , el cual está disponible en <http://otda.ny.gov/hearings/cancel>, o al usted presentarse en persona en el 14 Boerum Place, Brooklyn, NY 11201. Usted puede retirar su petición de audiencia imparcial para asuntos concernientes al programa de SNAP de cualquiera de los modos listados más arriba, excepto por teléfono.

SAMPLE

Representante de la Agencia	Núm. de Teléfono	Fecha
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