



# OFFICE OF POLICY, PROCEDURES, AND TRAINING

James K. Whelan, Executive Deputy Commissioner

Stephen Fisher, Assistant Deputy Commissioner  
Office of Procedures

## POLICY BULLETIN #18-15-OPE

**MONTHLY UPDATES: (CAS-406, EXP-75D, EXP-83G, EXP-84V, EXP-85A, FIA-16, FIA-25, FIA-27, FIA-28, FIA-29, FIA-34, FIA-50, FIA-85, FIA-1028F, FLY-932, HPA-62, HPA-65, HRA-123A, HRA-124, M-4G, M-50W, M-860, M-860Q, W-122E, W-130H, W-130U, W-134N, W-134R, W-138D, W-138EE, W-138GG, W-138PP, W-138QQ, W-138-R, W-139D, W-681, W-907HH, W-907RR)**

Date: March 2, 2018	Subtopic(s): Forms
Updated item	<p>The following form has been updated on edocs:</p> <ul style="list-style-type: none"> <li>“Pathway Home Host Family Authorization for Clearances and Release of Information” (<b>HPA-65</b>) the references to “Home for the Holidays” in the title and within the document were changed to “Pathway Home”.</li> </ul> <p>Ownership for the following forms were transferred:</p> <ul style="list-style-type: none"> <li>“TQH Consent” (<b>CAS-406</b>); form was transferred to Customized Assistance Service (CAS);</li> <li>“Notice to landlords in reference to questionnaire” (<b>W-907HH</b>) and “Notice of Appointment for Home Visit” (<b>W-907RR</b>) forms were transferred to The Investigation, Revenue and Enforcement Administration (IREA).</li> </ul>
Transfer of form ownership	<p>The following flyers and forms have been made obsolete:</p> <ul style="list-style-type: none"> <li>“Important notice enclosed. If you need help reading the notice, go to your Center” (<b>EXP-75D</b>);</li> <li>“Important Notice to Child-Only Case Participants” (<b>EXP-83G</b>);</li> <li>“Changes in Your Food Stamp Recertification Process” (<b>EXP-84V</b>);</li> <li>“It is Easier Than Ever to Apply for Supplemental Nutrition Assistance Program (SNAP)” (<b>EXP-85A</b>);</li> <li>“HEAP Alert” (<b>FIA-16</b>);</li> <li>“Business Opportunity” (<b>FIA-25</b>);</li> <li>“Food Stamp Reception” (<b>FIA-27</b>);</li> <li>“Please wait here. A food stamp worker will see you” (<b>FIA-28</b>);</li> </ul>
Obsolete items	

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

- “Food Stamp Center” (**FIA-29**);
- “Notice of Fairness Hearing” (**FIA-34**);
- “Notice of Proposed Class Action Settlement” (**FIA-50**);
- “Be Careful About Who Cares for Child” (**FIA-85**);
- Refusal of a Cash Assistance Application/Recertification Home Visit Appointment” (**FIA-1028f**);
- “Drop Box Instructions” (**FLY-932**);
- “Homebase CITYFEPS Referral” (**HPA-62**);
- “City Family Eviction Prevention Supplement (CITYFEPS) Approval Notice” (**HRA-123a**);
- “HRA Housing Assistance Questionnaire” (**HRA-124**);
- “Notice of Intent to Change Benefits: Public Assistance, Food Stamps and Medical Assistance Coverage and Services - (Quarterly Reporting System) (**M-4g**);
- “Information For Persons 65 Years Of Age And Older About Supplemental Security Income (SSI) Benefits” (**M-50w**);
- “Burial Policy” (**M-860**);
- “Additional Information Required To Indicate Categorical Eligibility For ADC” (**M-860q**);
- “Cash Assistance (CA) and Supplemental Nutrition Assistance Program (SNAP) Budgeting Changes From 2002 to 2010” (**W-122E**);
- “Notice of Forward of Application” (**W-130H**);
- “Organizations To Help You Find New Or Better Jobs” (**W-130U**);
- “Acknowledgement of Payment Received” (**W-134N**);
- “Response Letter to Participants Inquiry” (**W-134R**);
- “Notification of Work Requirement and Right to Contest (Supplemental Nutrition Assistance Program [SNAP] Participants)” (**W-138D**);
- “Notice of Appointment for Recertification Interview” (**W-138EE**);
- “Notice of Requirement to Provide Documentation of Earned Income at Recertification Interview” (**W-138GG**);
- “Notice of Requirement to Resolve Discrepancy at Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Recertification Interview” (**W-138PP**);
- “Notice of Requirement to Provide Documentation of Unearned Income at Recertification Interview” (**W-138QQ**);
- “Letter To Employer” (**W-138-R**);
- “Benefit Letter” (**W-139D**);
- “Request For Marriage Or Divorce Verification From Agencies Outside New York City” (**W-681**).

Center Directors must ensure that only the latest versions of forms (available on HRA eDocs) are used and that all previous and obsolete versions of the forms are removed from circulation and recycled.

*Effective Immediately*

**Attachments:**

<b>CAS-406</b>	TQH Consent
<b>HPA-65</b>	Pathway Home Host Family Authorization for Clearances and Release of Information
<b>W-907HH</b>	Notice to landlords in reference to questionnaire
<b>W-907RR</b>	Notice of Appointment for Home Visit
<b>EXP-75D</b>	Important notice enclosed. If you need help reading the notice, go to your Center ( <b>Obsolete</b> )
<b>EXP-83G</b>	Important Notice to Child-Only Case Participants ( <b>Obsolete</b> )
<b>EXP-84V</b>	Changes in Your Food Stamp Recertification Process ( <b>Obsolete</b> )
<b>EXP-85A</b>	It is Easier Than Ever to Apply for Supplemental Nutrition Assistance Program (SNAP) ( <b>Obsolete</b> )
<b>FIA-16</b>	HEAP Alert ( <b>Obsolete</b> )
<b>FIA-25</b>	Business Opportunity ( <b>Obsolete</b> )
<b>FIA-27</b>	Food Stamp Reception ( <b>Obsolete</b> )
<b>FIA-28</b>	Please wait here. A food stamp worker will see you ( <b>Obsolete</b> )
<b>FIA-29</b>	Food Stamp Center ( <b>Obsolete</b> )
<b>FIA-34</b>	Notice of Fairness Hearing ( <b>Obsolete</b> )
<b>FIA-50</b>	Notice of Proposed Class Action Settlement ( <b>Obsolete</b> )
<b>FIA-85</b>	Be Careful About Who Cares for Child ( <b>Obsolete</b> )
<b>FIA-1028f</b>	Refusal of a Cash Assistance Application/Recertification Home Visit Appointment ( <b>Obsolete</b> )
<b>FLY-932</b>	Drop Box Instructions ( <b>Obsolete</b> )
<b>HPA-62</b>	Homebase CITYFEPS Referral ( <b>Obsolete</b> )
<b>HRA-123a</b>	City Family Eviction Prevention Supplement (CITYFEPS) Approval Notice ( <b>Obsolete</b> )
<b>HRA-124</b>	HRA Housing Assistance Questionnaire ( <b>Obsolete</b> )
<b>M-4g</b>	Notice of Intent to Change Benefits: Public Assistance, Food Stamps and Medical Assistance Coverage and Services - (Quarterly Reporting System) ( <b>Obsolete</b> )

<b>M-50w</b>	Information For Persons 65 Years Of Age And Older About Supplemental Security Income (SSI) Benefits ( <b>Obsolete</b> )
<b>M-860</b>	Burial Policy ( <b>Obsolete</b> )
<b>M-860q</b>	Additional Information Required To Indicate Categorical Eligibility For ADC ( <b>Obsolete</b> )
<b>W-122E</b>	Cash Assistance (CA) and Supplemental Nutrition Assistance Program (SNAP) Budgeting Changes From 2002 to 2010 ( <b>Obsolete</b> )
<b>W-130H</b>	Notice of Forward of Application ( <b>Obsolete</b> )
<b>W-130U</b>	Organizations To Help You Find New Or Better Jobs ( <b>Obsolete</b> )
<b>W-134N</b>	Acknowledgement of Payment Received ( <b>Obsolete</b> )
<b>W-134R</b>	Response Letter to Participants Inquiry ( <b>Obsolete</b> )
<b>W-138D</b>	Notification of Work Requirement and Right to Contest (Supplemental Nutrition Assistance Program [SNAP] Participants) ( <b>Obsolete</b> )
<b>W-138EE</b>	Notice of Appointment for Recertification Interview ( <b>Obsolete</b> )
<b>W-138GG</b>	Notice of Requirement to Provide Documentation of Earned Income at Recertification Interview ( <b>Obsolete</b> )
<b>W-138PP</b>	Notice of Requirement to Resolve Discrepancy at Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP)Recertification Interview ( <b>Obsolete</b> )
<b>W-138QQ</b>	Notice of Requirement to Provide Documentation of Unearned Income at Recertification Interview ( <b>Obsolete</b> )
<b>W-138-R</b>	Letter To Employer ( <b>Obsolete</b> )
<b>W-139D</b>	Benefit Letter ( <b>Obsolete</b> )
<b>W-681</b>	Request For Marriage Or Divorce Verification From Agencies Outside New York City ( <b>Obsolete</b> )



New York City Human Resources Administration
Consent for Disclosure of Information

Client Name:

Read this form carefully before you sign your name. You may ask questions about anything you do not understand.

Federal and New York State law and regulations protect the confidentiality of your medical information, mental health information, Medicaid records, Cash Assistance records, Supplemental Nutrition Assistance Program records, domestic violence-related information, HIV-AIDS related information and alcohol and substance abuse treatment records. This form refers to all of this information together as your "personal information."

The New York City Human Resources Administration (HRA) will not share your personal information without obtaining your written consent, unless otherwise permitted or required by law.

SAMPLE

By signing this consent, you permit the following entities to review your personal information and to share it with each other, but only for the purposes described in this consent: HRA, New York City Department of Health and Mental Hygiene (DOHMH), Housing Preservation and Development (HPD), New York City Department of Homeless Services (DHS), The Mayor's Office of Operations, New York City Health and Hospitals Corporation (NYC H&H), New York State Office of Mental Health (SOMH), New York State Department of Health (NYS DOH), and New York State Office of Alcoholism and Substance Abuse Services (OASAS), Samaritan Village, BronxWorks, Inc., National Association of Drug Abuse Problems (NADAP) , Visiting Nurse Services of New York (VNSNY), and University Behavioral Associates (UBA).

Your personal information will be used for case management services (such as placement, evaluation, tracking, and technical assistance) and to determine your eligibility for various housing options. In addition, it may be shared with your housing provider if you are found eligible for and placed in supportive housing.

I authorize HRA and the entities named in this consent:

Horizontal lines for signature and name of referral source.

(add name of referral source and other sources of information)

to disclose to each other my medical records, mental health records, Medicaid records, Cash Assistance records, Supplemental Nutrition Assistance Program records, domestic violence-

related information, HIV-AIDS related information, alcohol and substance abuse treatment records additional information needed to complete my supportive housing application and information needed to connect me to case management services related to my housing placement.

I understand that I have the right to revoke this consent at any time by notifying HRA, in writing, that I no longer wish for my information to be disclosed for the purposes stated in this consent. I understand that I may revoke this consent except to the extent that action has already been taken based on this consent. Written revocation should be mailed to Lawanna Kimbro, Deputy Commissioner, Human Resources Administration of the City of New York, 150 Greenwich Street, 42<sup>nd</sup> Floor, New York, NY 10007.

I understand that signing this consent is voluntary and that my refusal to sign it will not affect my eligibility for Cash Assistance, Medicaid or Supplemental Nutrition Assistance Program benefits. I understand that failure to sign this consent may affect my ability to access supportive housing.

With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

**Date or Event on which this Authorization will expire:** This consent will terminate five (5) years after the date of a determination that I am eligible for supportive housing and services.

\_\_\_\_\_  
Name (*Print*)/ Authorized Representative Name (Print)

\_\_\_\_\_  
Signature of Client/ Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Authority to Sign on Behalf of Client

<sup>1</sup> The Health Insurance Portability and Accountability Act (HIPAA) of 1996 governs the privacy of Protected Health Information. If you believe your HIPAA rights have been violated, you may file a complaint with the Office for Civil Rights, Department for Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, NY 10228: (212) 264-3313 or (800) 368-1019; or fax (212) 264-3039.

<sup>2</sup> HRA, Customized Assistance Services, 150 Greenwich Street, 30<sup>th</sup> Fl, NY, NY 10007

**PATHWAY HOME HOST FAMILY AUTHORIZATION FOR CLEARANCES AND RELEASE OF INFORMATION**

<b><u>Primary Occupant (Print Name):</u></b>	<b><u>Social Security Number:</u></b>
<b><u>Primary Occupant Address:</u></b>	

**AUTHORIZATION FOR STATE CENTRAL REGISTER CLEARANCE AND ACS RECORD REVIEW**

By signing this form, I voluntarily consent for the New York City Administration for Children’s Services (ACS) to conduct a clearance of my name with the New York State Central Register of Child Abuse and Maltreatment (SCR). I further consent for ACS to conduct a review of records ACS maintains under my name and the name(s) of my child(ren), including child protective services (CPS) records, foster care records, and preventive services records. I understand that ACS will provide such clearance and records information to the New York City Department of Homeless Services (DHS).

**HOST FAMILY INFORMATION (INCLUDE ALL NAMES YOU ARE OR HAVE BEEN KNOWN BY)**

	<b><u>First Name</u></b>	<b><u>Last Name</u></b>	<b><u>Relationship to Primary Occupant</u></b>	<b><u>Gender</u></b>	<b><u>DOB</u></b>
1.	SAMPLE				
2.					
3.					
4.					
5.					
6.					
7.					

**AUTHORIZATION FOR RELEASE OF INFORMATION RELATED TO SCR CLEARANCE, ACS RECORDS AND PUBLIC ASSISTANCE**

In connection with my participation in the Pathway Home (PH) Program, I authorize the New York City Human Resources Administration (HRA), ACS, and DHS to disclose information as set forth on this form:

In accordance with federal and New York State law, I understand that:

1. The confidentiality of my records and those of my children is protected under federal and/or state law and regulations.
2. Signing this authorization is voluntary. My cash assistance application, eligibility, or continued receipt of benefits is not conditioned upon my authorization of this disclosure.
3. I understand that any confidential information disclosed based on this authorization may be re-disclosed by the recipient and the confidentiality of such information may no longer be protected by federal or state law.
4. I authorize the release of the following information:
  - the status of my cash assistance case, if any;
  - my cash assistance case number, if any;
  - the amount of my monthly cash assistance shelter allowance, if any;
  - information contained in records ACS maintains under my name and the name(s) of my child(ren), including child protective services (CPS) records, foster care records, preventive services records; and
  - the existence of any indicated (i.e., substantiated) reports of child abuse or maltreatment for which I am the subject and information related to any such reports.

5. I authorize HRA, ACS, and/or DHS to release the above referenced information to \_\_\_\_\_.  
(PH Program Applicant)

6. I have the right to revoke this authorization at any time by writing to:

PH Rental Assistance Program  
NYC Human Resources Administration  
150 Greenwich Street, 36th Floor  
New York, NY 10007

I understand that I may revoke this authorization except to the extent that: (1) action has already been taken based on this authorization or (2) the information negatively affects the applicant and the agencies need to use the information to defend an administrative appeal by the applicant and any resulting litigation.

7. I consent for ACS and ACS provider agencies to access my home on all active ACS cases.

8. I understand that this authorization will expire at the conclusion of the above-identified PH Program Applicant's participation in the PH program or when the PH Program Applicant moves out of my home, whichever is earlier, except that where the information negatively affects the applicant and the agencies need to use the information to defend an administrative appeal by the applicant and any resulting litigation, the expiration shall not expire until the conclusion of such appeal and resulting litigation.

**I affirm that all information provided above is accurate and true.**

SAMPLE

\_\_\_\_\_  
Signature of Primary Occupant

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Occupant Eighteen Years Old or Over

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Occupant Eighteen Years Old or Over

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Occupant Eighteen Years Old or Over

Date: \_\_\_\_\_



Date: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Participant's Address: \_\_\_\_\_  
QC No.: \_\_\_\_\_

We are writing to you for information about the shelter expenses and household composition of the person named above who is in receipt of Cash Assistance and Supplemental Nutrition Assistance Program (SNAP) benefits.

According to our files, you are the landlord of record. Please complete the questionnaire on page 2 and return it to us within five (5) days in the enclosed business reply envelope.

If you are no longer the landlord, please indicate below the name and address of the new landlord and date he/she took possession of the property:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date of Possession: \_\_\_\_\_

Thank you for your cooperation in this matter.

Very truly yours,

\_\_\_\_\_  
Eligibility Monitoring Reviewer  
\_\_\_\_\_  
Telephone Number  
\_\_\_\_\_  
OEM Fax Number  
\_\_\_\_\_  
OEM Supervisor  
\_\_\_\_\_  
Supervisor Telephone Number

## SHELTER/HOUSEHOLD QUESTIONNAIRE

(The OEM Reviewer is to complete the following items: B-1, enter review month. C-7, enter name(s) of others who may be residing in the household, if applicable).

### A. SHELTER DESCRIPTION:

1. Please indicate type of dwelling occupied by participant (check appropriate item):

- Apartment    
  House    
  Trailer    
  Room in private home    
  Hotel/motel room

2. Please indicate name and telephone number of superintendent:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

### B. SHELTER EXPENSES:

1. How much was the rent for the month of: \_\_\_\_\_ ? \$ \_\_\_\_\_

2. Was the rent paid for that month?  No  Yes If Yes, Paid by:  Cash  Check  Money Order

3. Effective date of last rent increase: \_\_\_\_\_ Previous rent \$ \_\_\_\_\_

Day          Month          Year

4. Is rent subsidized?  No  Yes If Yes, Amount: \$ \_\_\_\_\_

Subsidizing Agency

5. Does the rent include any of the following? (check appropriate item(s))

- Heat    
  Electricity    
  Meals    
  Cooling fuel

6. If heat is not included in rent, please check type of fuel used to heat home:

- Natural gas    
  Oil    
  Electricity

7. Was lease signed?  No  Yes \_\_\_\_\_

Date                                  Period                                  Person

### C. HOUSEHOLD COMPOSITION:

1. How many persons reside in the above indicated dwelling? \_\_\_\_\_

2. What are their names? \_\_\_\_\_

\_\_\_\_\_

3. How long have the above named person(s) resided at the address listed? \_\_\_\_\_

4. Does the above named have a telephone?  No  Yes Number: \_\_\_\_\_

5. To the best of your knowledge, is the above named employed?  No  Yes

If Yes, where: \_\_\_\_\_

Employer's Name                                  Address

6. Does the above named perform any services for you for which he/she receives a lower rent?  
 No  Yes

7. Does the above named, and/or \_\_\_\_\_ and/or \_\_\_\_\_  
reside at the above address?  No  Yes

### D. TENANT'S FINANCIAL REFERENCES: \_\_\_\_\_

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Telephone Number: \_\_\_\_\_



Date: \_\_\_\_\_

Job Center: \_\_\_\_\_

Address: \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

OEEM Caseworker/  
Auditor: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

### Notice of Appointment for Home Visit

**SAMPLE**

Your Cash Assistance/Supplemental Nutrition Assistance Program (SNAP) case has been selected for a review by the Office of Eligibility and Employment Monitoring (OEEM). The OEEM Caseworker/Auditor named above will visit you at your home on \_\_\_\_\_ between the hours of \_\_\_\_\_ and \_\_\_\_\_.

Please call the telephone number listed above as soon as you receive this letter, to confirm the appointment date. If the scheduled appointment date or time is inconvenient for you, please call us immediately to arrange another appointment.

**Please have the following information and documents available at the time of the home visit:**

- Birth Certificates, Baptismal Certificates or proof of citizenship for all household members, including SNAP recipients
- Social Security cards for all household members
- Proof of alien status (if applicable), e.g., Alien Registration Card
- Marriage Certificate
- Absent parent information/child support verification
- Rent recipients; NYCHA rent book; lease; name, address and telephone number of landlord
- Documentation of subsidized housing (if applicable)
- Statement from Primary Tenant of rent charged, and who resides in apartment
- Proof of ownership for one, two or three-family house
- Employment wage statements
- Social Security and Worker's Compensation award notices
- Statements of any other benefits/awards, (e.g., Veterans, Unemployment Insurance Benefits)
- Bank books; insurance policies
- Clinic cards for children not in school
- Current utility and telephone bills

Sincerely,

\_\_\_\_\_  
OEEM Caseworker/Auditor

\_\_\_\_\_  
Telephone Number

Fecha: \_\_\_\_\_

Centro de Trabajo: \_\_\_\_\_

Dirección: \_\_\_\_\_

Nombre del Caso: \_\_\_\_\_

Número del Caso: \_\_\_\_\_

Trabajador(a) del Caso/  
Auditor(a) de OEEM: \_\_\_\_\_

Número de Teléfono: \_\_\_\_\_

### Aviso de Cita para Visita al Hogar

Su caso de Asistencia en Efectivo/Programa de Asistencia de Nutrición Suplementaria (SNAP) ha sido seleccionado para una revisión por parte de la Oficina de Seguimiento de Elegibilidad y de Empleo (Office of Eligibility and Employment Monitoring – OEEM). El trabajador(a) Social/Auditor(a) de OEEM nombrado más arriba le visitará su hogar el \_\_\_\_\_ entre las horas de \_\_\_\_\_ y \_\_\_\_\_.

Favor de llamar al número de teléfono indicado más arriba tan pronto reciba esta carta para que se pueda confirmar la fecha de su cita. Si la fecha o la hora de la cita programada no le es conveniente, favor de llamarnos inmediatamente para concertar otra cita.

SAMPLE

#### Favor de tener disponible la siguiente información y documentos a la hora de la visita al hogar:

- Actas de Nacimiento, Certificados de Bautismo, o prueba de ciudadanía de todos los miembros de su hogar, incluyendo los beneficiarios de SNAP.
- Tarjeta de Seguro Social para todos los miembros del hogar.
- Prueba de Condición de Extranjero, si corresponde, por ejemplo la Tarjeta de Registro de Extranjero.
- Acta de Matrimonio
- Información del/la padre/madre ausente/verificación de manutención de niños.
- Recibos de alquiler; libro del alquiler de NYCHA; contrato de arrendamiento; el nombre, la dirección y el número telefónico del casero.
- Documentación de vivienda subsidiada (si corresponde).
- Declaración del inquilino principal que especifique cuánto paga de alquiler, y quiénes residen en el apartamento.
- Prueba de titularidad para una casa de una, dos o tres familias.
- Estado mensual de salario.
- Notificación del otorgamiento de beneficios de Seguro Social e Indemnización del Trabajador.
- Estado de cualquier otro beneficio/concesión, (por ejemplo, Beneficios de Seguro de Desempleo, para Veteranos).
- Libretas bancarias; pólizas de seguros.
- Tarjetas clínicas de niños que no asisten a la escuela.
- Cuentas actuales de servicios públicos y de teléfono.

Atentamente,

\_\_\_\_\_  
Trabajador(a)/Auditor(a) de OEEM

\_\_\_\_\_  
Número Telefónico

**Important notice enclosed. If you need help reading the notice, go to your Center.**

The enclosed notice informs you of your right to a conciliation meeting to try to address the city's allegation that you failed to comply with work requirements. If you would like a conciliation appointment, please go to your Center on the date and time stated on the notice.

**Aviso importante adjunto. Si necesita ayuda para leer el aviso, remítase a su Centro.**

Por el aviso adjunto se le informa a usted de su derecho de una reunión de conciliación para tratar el alegato de la ciudad que usted no cumplió los requisitos de trabajo. Si usted desea una cita de reconciliación, favor de presentarse a su Centro en la fecha y hora indicadas en el aviso. **(Spanish)**

مرفق إخطار هام. إذا كنت بحاجة إلى مساعدة في قراءة الإخطار، يرجى الذهاب إلى المركز التابع له. يعلمك الإخطار المرفق بحقك في عقد موعد مصالحة في محاولة لمواجهة إدعاء المدينة بأنك فشلت في الامتثال لمتطلبات العمل. إذا كنت تريد عقد موعد مصالحة، يرجى الحضور إلى المركز التابع له في التاريخ والوقت المذكورين في الإخطار. **(Arabic)**

隨附一份重要通知。如果您需要協助閱讀這份通知，請前往您的服務中心。

隨附的通知告知您有權利舉行調解會談試圖回應市政府單位對您不遵守工作要求的指控。如果您想舉行這項調解會談，請於通知上註明的日期和時間前往您的中心。 **(Chinese)**

**OBSOLETE**

**Avi enpòtan anekse. Si w bezwen èd pou li avi sa a, ale nan Sant ou.**

Avi anekse a enfòmè w sou dwa w pou yon reyinyon konsiliasyon pou eseye adrese akizasyon vil la ke w te echwe pou konfòmè avèk kondisyon travay yo. Si w ta renmen yon reyinyon konsiliasyon, tanpri ale nan Sant ou sou dat la ak lè a ki endike sou avi a. **(Haitian Creole)**

중요 통지서가 동봉되어 있습니다. 통지서를 읽는 데 도움이 필요하시면 센터를 방문해 주십시오.

동봉된 통지서는 귀하가 업무 요건을 준수하지 않았다는 시의 주장에 대응할 수 있도록 조정 회의에 관련된 귀하의 권리를 알려 드립니다. 조정 회의 예약 일정을 잡고 싶으시면 통지서에 나와 있는 날짜와 시간에 센터를 방문해 주십시오. **(Korean)**

**Прилагается важное извещение. Если без посторонней помощи Вы не можете прочитать извещение, обратитесь в местный Центр.**

В прилагаемом извещении содержится информация о вашем праве на встречу с целью урегулирования конфликта, возникшего в связи с заявлением муниципалитета о том, что вы не выполнили должностные требования. В извещении указаны дата и время посещения Центра, если Вам нужна такая встреча. **(Russian)**

### Important Notice to Child-Only Case Participants

Your case is now active at the Family Services Call Center (Center 17). Staff at Center 17 are available to address many of your service needs over the telephone and/or via mail. Please call Center 17 at **(718) 752-3937** if you need assistance and a qualified staff member will evaluate your situation.

You will continue to receive in-person service at:

[Empty rectangular box for in-person service location]

Please note that if the payee on your case has an emergency or wishes to apply for ongoing cash assistance, s/he may go to any Job Center for assistance.

Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Center: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

This is to inform your household about changes in your recertification process for Food Stamp (FS) benefits.

Currently you are required to recertify semiannually for the continued receipt of FS benefits. Both semiannual recertifications are conducted **in person**. In order to eliminate any disruptions in your work day that may be caused by appearing in person for your Food Stamp recertification, the following changes have been made:

- **Effective immediately**, one of your two semiannual recertifications will now be made by mail. Instead of a recertification appointment, you will be sent the Periodic Report (**LDSS-4310**) form. This form must be completed and returned by \_\_\_\_\_.

Along with the Periodic Report you must send **verification** of all **income received** in the FS household for the **four weeks prior to returning the mailer**, as well as documents supporting any reported changes.

**Failure to return the Periodic Report and verification documents as required will result in the termination of your FS benefits.**

- For the second semiannual recertification you will now have the choice of either recertifying in person or by phone. The instructions about how to proceed if you decide to recertify by phone will be included in the recertification notice.

Fecha: \_\_\_\_\_  
Número del Caso: \_\_\_\_\_  
Nombre del Caso: \_\_\_\_\_  
Centro: \_\_\_\_\_  
Número de Teléfono: \_\_\_\_\_

Por la presente le informamos a su hogar de los cambios al proceso de recertificación de sus beneficios de Cupones para Alimentos.

Actualmente se requiere que usted se recertifique cada seis meses para continuar recibiendo beneficios de Cupones para Alimentos. Ambas recertificaciones semestrales se realizan **en persona**. Los siguientes cambios se han efectuado para eliminar cualquier interrupción en su día laboral por tener que presentarse en persona para recertificarse a fin de recibir beneficios de Cupones para Alimentos:

- **Vigente de inmediato** una de las dos recertificaciones semestrales ahora se llevará a cabo por correo. En vez de una cita de recertificación, se le enviará el formulario Informe Periódico (**LDSS-4310 SP**). Este informe tiene que ser llenado y devuelto a más tardar el \_\_\_\_\_.

Junto con el formulario Informe Periódico usted tiene que mandar además **comprobantes** de todo **ingreso recibido** en el hogar de Cupones para Alimentos durante las **cuatro semanas anteriores a la fecha en que mandó de vuelta todo el paquete de documentación**. También tiene que mandar documentos que puedan ayudarle a confirmar cualquier cambio reportado.

**El no devolver el Informe Periódico y comprobantes como debido, resultará en la terminación de sus beneficios de Cupones para Alimentos.**

- Para la segunda recertificación semestral, usted tendrá la opción de poder recertificarse en persona o por teléfono. Las instrucciones para el trámite, si decide recertificarse por teléfono, serán incluidas en el aviso de recertificación.



## It is Easier Than Ever to Apply for Supplemental Nutrition Assistance Program (SNAP)

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

You recently applied for the School Meals program and may be eligible for SNAP Benefits. Enclosed is a form that lists information on SNAP eligibility and how to file a SNAP application. The form also includes the address and hours of operation for the SNAP Centers in all five boroughs of New York City. If you wish to receive an application by mail, please call **311**.

Please note that if you have a hardship that prevents you from coming to a SNAP Center (elderly or disabled, job-related or child care/travel problems), once we receive your signed application, arrangements can be made to conduct the eligibility interview by phone.

果您沒辦法閱讀這封信，但是想知道有關糧食券的更多資訊的話，請致電311。

Si w pa kapab li lèt sa a, men w ta renmen gen plis enfòmasyon sou Koupon pou Achte Manje, tanpri rele nan 311.

Если Вы не можете прочитать это письмо, но хотели бы получить дополнительную информацию о продуктовых талонах, позвоните по телефону 311.

إذا لا تستطيع قراءة هذه الرسالة ولكنك ترغب في معرفة المزيد عن برنامج الكوبونات الغذائية فيرجى الاتصال بالرقم 311.

귀하가 이 편지를 읽을 수 없지만 푸드 스탬프에 대해서 더 자세히 알고 싶으면 311번으로전화하십시오.

## Solicitar Programa de Asistencia de Nutrición Suplementaria (SNAP) Ahora es Más Fácil que Nunca

**NOTA:** A partir del 29 de agosto, toda referencia al Programa de Cupones para Alimentos en este aviso se denominará el Programa de Asistencia de Nutrición Suplementaria (SNAP), y toda referencia a Cupones para Alimentos se denominará beneficios de SNAP.

Recientemente usted presentó solicitud al programa de comidas escolares y puede ser elegible para Beneficios de SNAP. Adjunto se encuentra un formulario que lista información sobre elegibilidad de SNAP y como presentar una solicitud de SNAP. El formulario también incluye la dirección y las horas de operación de todos los Centros de SNAP en los cinco condados de la Ciudad de Nueva York. Si usted desea recibir una solicitud por correo, favor de llamar al **311**.

Por favor tenga presente que si usted está pasando dificultades que le impiden venir al Centro de SNAP (problemas relacionado con la vejez, incapacidad, trabajo, cuidado infantil, transporte), una vez recibamos su solicitud firmada, se podrán hacer arreglos para realizar a entrevista de elegibilidad por teléfono.

果您沒辦法閱讀這封信，但是想知道有關糧食券的更多資訊的話，請致電311。

Si w pa kapab li lèt sa a, men w ta renmen gen plis enfòmasyon sou Koupon pou Achte Manje, tanpri rele nan 311.

Если Вы не можете прочитать это письмо, но хотели бы получить дополнительную информацию о продуктовых талонах, позвоните по телефону 311.

إذا لا تستطيع قراءة هذه الرسالة ولكنك ترغب في معرفة المزيد عن برنامج الكوبونات الغذائية فيرجى الاتصال بالرقم 311.

귀하가 이 편지를 읽을 수 없지만 푸드 스탬프에 대해서 더 자세히 알고 싶으면 311번으로 전화하십시오.

# HEAP ALERT!!

## RE M I N D E R

***THE "HEAP" SEASON IS NOW OPEN!!***

***YOU MAY BE ELIGIBLE FOR A "HEAP GRANT" THROUGH THE HOME ENERGY ASSISTANCE PROGRAM IF:***

- YOU ARE A LOW INCOME HOUSEHOLD.
- YOU OWN OR RENT AND PAY UTILITIES AND HEATING DIRECTLY.
- YOU ARE A RENTER WHOSE HEATING COST IS INCLUDED IN YOUR RENT.

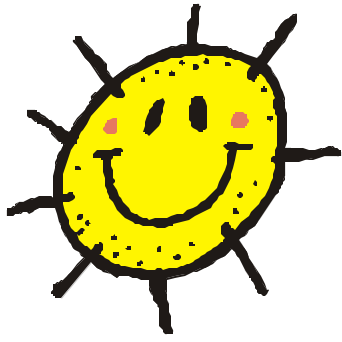
***YOU MAY ALSO BE ELIGIBLE FOR AN EMERGENCY "HEAP GRANT" IF:***

- YOU ARE SHORT OF FUEL OR HAVE A HEAT RELATED UTILITY DISCONNECTION.
- YOU ARE THE TENANT AND CUSTOMER ON RECORD.

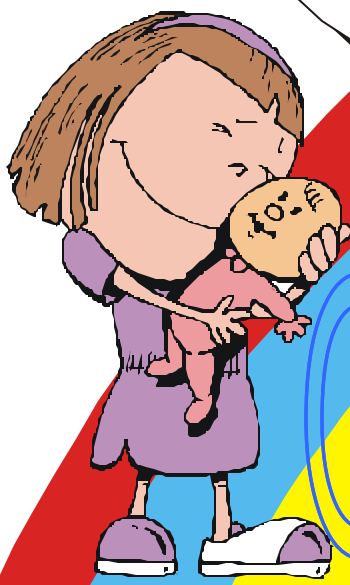
**CONTACT YOUR IS/JC FOR ADDITIONAL INFORMATION/  
ASSISTANCE REGARDING THE HOME ENERGY  
ASSISTANCE PROGRAM "HEAP" OR CALL:**

HRA / HEAP  
(212) 227-2810

# Business Opportunity



How would you like to make more money?



**OBSOLETE**  
Enroll Today  
to Become a  
Registered  
Child Care Provider!



- Increase your earning potential
- Gain valuable business experience
- Become part of a growing profession
- FREE toy kit

Call Today!  
1 (888) 469-5999



# Food Stamp Reception

(Arabic) منطقة الاستقبال لشؤون الكوبونات الغذائية ("فود ستامبس")

糧食券接待處 (Chinese)

**Accueil pour bons d'aliments** (French)

**Sal Antre Koupon pou Manje** (Haitian Creole)

푸드 스탬프 접수 창구 (Korean)

**Приём по вопросам продуктовых талонов  
(фудстемпов)** (Russian)

Quaày tieáp taân veà phieáu thöïc phaãm (Vietnamese)

(Yiddish) פוד סטעמפ אויפנאמע

**Please wait here. A food stamp worker will see you.**

الرجاء الانتظار هنا. سيجتمع معك عامل الكوبونات الغذائية  
("فود ستامبس") (Arabic)

請在此等候。糧食券工作人員將會來見您。 (Chinese)

**Attendez ici s'il vous plait. Un Travailleur de bon d'aliments vous recevra.** (French)

**Tanpri tann la a. Yon travayè sosyal koupon pou manje pral wè ou.** (Haitian Creole)

여기서 기다리십시오. 푸드 스탬프 센터 직원이 나올  
것입니다. (Korean)

**Пожалуйста, подождите здесь. Сотрудник, занимающийся фудстемпами, вызовет вас.**  
(Russian)

Xin chôø taiï ñaây. Nhaân vieân lo phieáu thöïc  
phaãm seõ ra  
gaëp quyù vò. (Vietnamese)

**ביטע ווארט דא. א פוד סטעמפ ארבעטער וועט  
איין קומען זען.**  
(Yiddish)

**F-19 Food Stamp Center**  
**22E. 34 Street**

**F-19** مركز شؤون الكوبونات الغذائية ("فود ستامبس")

**22E. 34 Street** (Arabic)

**F-19**糧食券中心

**22E. 34 Street** (Chinese)

**Centre de bons d'aliments F-19**

**22E. 34 Street** (French)

**F-19 Sant Koupon pou Manje**

**22E. 34 Street** (Haitian Creole)

**F-19**푸드스탬프 센터

**22E. 34 Street** (Korean)

Центр по оформлению продуктовых талонов

(фудстемпов) **F-19**

**22E. 34 Street** (Russian)

Trung tâm phiếu thực phẩm **F-19**

**22E. 34 Street** (Vietnamese)

**F-19** פוד סטעמפ צענטער

**22E. 34 Street** (Yiddish)



## NOTICE OF FAIRNESS HEARING

### TO ALL PERSONS WHO NEW YORK CITY'S HUMAN RESOURCES ADMINISTRATION (HRA) SANCTIONED, ON OR AFTER JANUARY 1, 2000 FOR FAILURE TO COMPLY WITH CHILD SUPPORT COOPERATION REQUIREMENTS.

This notice tells you about the settlement of a class action called Acevedo v. Tumer, 01 Civ. 6014 (SHS), that was brought on behalf of individuals who were sanctioned by HRA for failure to comply with Office of Child Support Enforcement ("OCSE") cooperation requirements. It is pending before Judge Sidney H. Stein in the United States District Court for the Southern District of New York. On March 19, 2004 the Court will hold a hearing to decide if the settlement is fair, reasonable and adequate. If you are part of the class but do not think that the settlement is fair, reasonable and adequate then you can object to the settlement by writing to us or by coming to the fairness hearing.

Under the terms of the settlement, HRA has agreed to:

- give those who are sanctioned for failure to cooperate with OCSE a notice that contains the following information: (a) the date of the failure to cooperate; (b) the name of the person who failed to cooperate; (c) what the failure to cooperate was; and (d) the phone number to contact to report good cause and to initiate the process of complying and lifting the OCSE sanction.
- publish a flyer that explains how to lift OCSE sanctions.
- lift OCSE sanctions within seven (7) business days of receipt of information from OCSE of compliance with OCSE;
- send to those who received an OCSE sanction between January 1, 2000 and the effective date of the settlement a notice reiterating their right to ask for an administrative fair hearing to challenge the sanction; and
- monitor its compliance with the settlement.

Further, the New York State Office of Temporary and Disability Assistance (OTDA) has agreed to review the results of any reviews and monitoring conducted pursuant to the settlement (if provided to them by HRA) and take appropriate action in relation to HRA as OTDA may determine to be necessary.

This notice is not the settlement; it is only a summary of the settlement. To see a copy of the proposed settlement, or to ask questions, call or fax, to: Acevedo Settlement Line, New York Legal Assistance Group, 122 East 59th Street, New York, NY 10022, Tel: (212) 750-0800, Ext. 620, Fax: (212) 750-0820.

To object to the settlement, write a letter to the address listed above, with a copy to the court, by February 18, 2004, saying why you think it is unfair. The address of the court is: The Honorable Sidney H. Stein, 500 Pearl Street, New York, NY 10007.

The fairness hearing will be held before Judge Stein on March 19, 2004, at 9:30 AM. The hearing will be in Courtroom 23A, 500 Pearl Street, New York, NY 10007.

Subway Directions: 4, 5, or 6 to Brooklyn Bridge; M or J to Chambers Street; N or R to City Hall and walk 2 blocks east; or A, C, E, 1, 2, 3 or 9 to Chambers Street and walk 3-4 blocks east.

**IMPORTANT NOTE:** You do not have to do anything right now to take advantage of this settlement. Instead, you can wait until HRA sends you another notice about asking for a Fair Hearing to take advantage of the terms of the settlement.



## **NOTICE OF PROPOSED CLASS ACTION SETTLEMENT**

**DID YOU HAVE YOUR TAX REFUND TAKEN TO PAY FOR AN OLD PUBLIC ASSISTANCE DEBT BETWEEN MAY 23, 1997 AND DECEMBER 31, 1998?**

**IF SO, YOU MAY BE ELIGIBLE TO HAVE THIS TAKING REVIEWED BECAUSE OF THE COURT CASE DESCRIBED BELOW.**

This notice is to tell you about a possible settlement in a class action lawsuit called Watts v. Wing, Index Number 119832/00 (Supreme Court, New York County).

That lawsuit is about the fact that, in 1997 and/or 1998, the New York State Office of Temporary and Disability Assistance ("OTDA") took all or part of some people's state tax refunds because it decided that these people owed it money for past overpayments of public assistance (also known as welfare).

Before a state agency can take someone's state tax refund to repay a debt, the agency must follow certain rules. Because lawyers for the people whose tax refunds were taken believed that OTDA had not followed all the rules, they filed the Watts case on behalf of these people ("plaintiffs") to challenge OTDA's actions.

Now, the lawyers for the plaintiffs and for the State have agreed on a procedure to address this problem in a document known as a "settlement agreement." In general, under the settlement agreement, people whose state tax refunds were taken have the opportunity to ask OTDA to review their cases. If someone asks for a review by completing and submitting a postage-paid form to OTDA, his or her file will be reviewed to see if all the rules were followed before the person's tax refund was taken. If the rules were not followed, OTDA will return some or all of the tax refund taken.

If you had all or part of your state income tax refund taken by OTDA after May 23, 1997 and before January 1, 1999 to collect a past overpayment of public assistance without adequate prior notice of the debt or the threatened taking, then you are a plaintiff in the case and you have the right to ask OTDA for a review of your public assistance case file. You will receive a notice in the mail and a form on which to ask for a review at a future time. You do not need to do anything to get a review of your own case until you receive this notice and form in the mail.

The settlement agreement must be approved by the court and has not yet received such approval. On December 16, 2005 at 9:30 a.m the court will have a hearing to decide whether to approve the settlement agreement as a fair deal for the plaintiffs. The hearing will take place at:

**Courtroom of Hon. Rosalyn Richter  
Supreme Court, New York County  
60 Centre Street, Room 418  
New York, New York 10017**

Your attorneys will urge the court to approve the settlement agreement. If you wish to, you can come to court on that day to tell the judge what you think of the settlement agreement, but you do not have to. You can also write to the judge to tell her what you think of the settlement, but you do not have to. You can write to her at the following address:

**Hon. Rosalyn Richter  
Supreme Court, New York County  
60 Centre Street, Room 563  
New York, New York 10007**

Your letter must be postmarked no later than December 5, 2005 for your comments to be considered by the court.

To get copies of the settlement agreement, you can call the lawyers for the class plaintiffs at:

New York Legal Assistance Group at (212) 613-5008

**“I thought taking care of a baby would be easy, but it takes a lot of patience.”**

**OBSOLETE**

**Be Careful About Who Cares For Your Child.**

**If you suspect that a child is being abused or neglected, call 311  
In case of an emergency, call 911**

Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Center: \_\_\_\_\_

### Refusal of a Cash Assistance Application/Recertification Home Visit Appointment

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

The Human Resources Administration (HRA) offered you a Home Visit appointment on \_\_\_\_\_ because you claimed to be unable to come to an HRA Center. You have refused this offer of a Home Visit appointment.

For Cash Assistance (CA) you are required to have an in-person application/recertification interview. Failure to report to a Job Center or allow an HRA Representative to interview you in your home will result in the denial of your application for CA, or the closing of your CA case.

If you are currently in receipt of CA and want to request an additional allowance or make a change to your case, you may do so by mail, telephone, or fax to your Job Center.

If you wish to apply or recertify for Supplemental Nutrition Assistance Program (SNAP) benefits, you may submit an application or recertification by mail, fax, or by Authorized Representative. You also may file an application online or designate an authorized representative who can apply or recertify for you. However, you must have an eligibility interview. You or your Authorized Representative can complete the eligibility interview over the telephone or in person at a SNAP Center.

# DROP-BOX INSTRUCTIONS

## STEP 1

Make copies of the document(s).

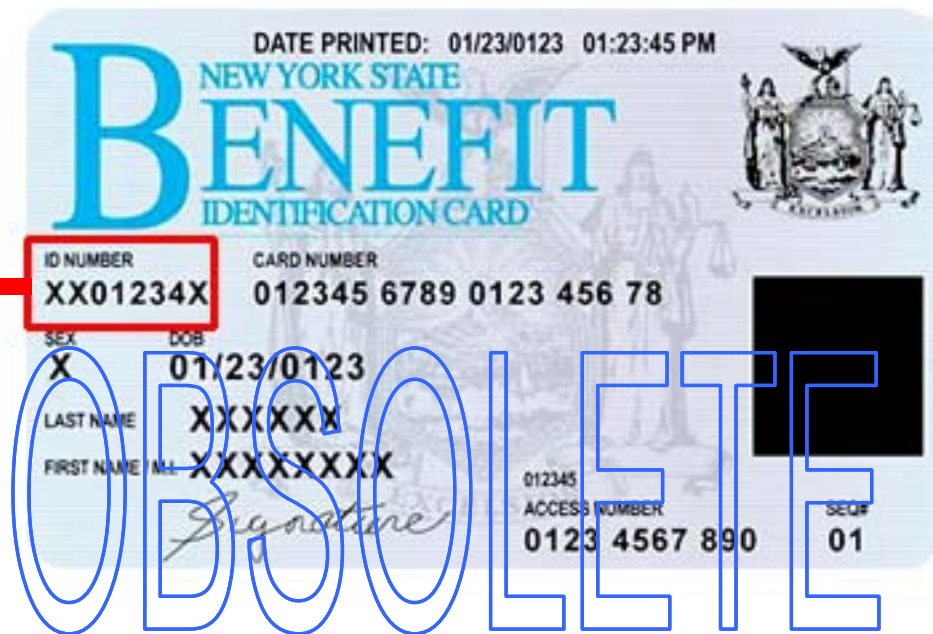
## STEP 2

Write your Name, Case Number and/or Client Identification Number (CIN) on the copies and the envelope.

## STEP 3

Place the copies in the envelope and drop it into the box.

**Please Note:**  
The **CIN Number** is the same as "**ID Number**" on the left side of the Benefit Identification Card.



# INSTRUCCIONES PARA EL BUZÓN

## PASO 1

Haga copias del (de los) documento(s).

## PASO 2

Escriba su Nombre, Número del Caso y/o Número de Identificación del Cliente (CIN) en el sobre y las copias.

## PASO 3

Introduzca las copias en el sobre y deposítelo en el buzón.

**Por favor note:**  
El **Número CIN** es lo mismo que el "**Número de Identificación**" en el lado izquierdo de la Tarjeta de Identificación de Beneficios.



Date: [Redacted]

RE: [Redacted]

Homebase CARES #: [Redacted]

This letter is to inform you that Mr. / Ms. [Redacted] is eligible to apply for the CITYFEPS program. Compared to standard FEPS, CITYFEPS offers higher rentals and is administered by the City of New York. Landlords agreeing to rent to CITYFEPS clients will receive the full first month's rent in advance plus three additional months of the CITYFEPS rent supplement and a \$1000 lease signing bonus\*. Brokers will receive a 15% annual rent broker's fee.\*

\*Bonus and 15% broker's fee currently available through March 31, 2017.

Based on his/her family composition, the maximum rent that Mr. /Ms. [Redacted] may qualify for under CITYFEPS is \$[Redacted] per month. Mr. /Ms. [Redacted] must receive a lease or agreement in writing for one year (or possibly two years if the tenant will be receiving "preferential" rent) in order for us to proceed with an application, but may not move into the apartment until approved. In addition, Mr. /Ms. [Redacted]

- will need the following documents from your office:
- (1) Signed agreement to accept the HRA Security Voucher form
  - (2) Signed HRA Broker's agreement, if applicable
  - (3) Pre-Lease/agreement to rent apartment
  - (4) Copy of Broker's License, if applicable

If you have any questions, please contact our office at the numbers or address provided. We thank you in advance for your kind consideration in this matter.

Sincerely,

(provider agency name)

[Redacted Signature]

Homeless Prevention CITYFEPS Assistance Program

*CITYFEPS Program Maximum Rent Chart*

Standard rent maximum chart. Please see rent maximum indicated below for this family.

Household Size	1	2	3	4	5	6	7	8	9	10
Max Rent	\$1,213	\$1,268	\$1,515	\$1,515	\$1,956	\$1,956	\$2,197	\$2,197	\$2,530	\$2,530

**If you have not used this letter to obtain a CITYFEPS apartment within four months of the date noted above, your eligibility for CITYFEPS will need to be reviewed by this agency.**

Date: \_\_\_\_\_  
 Client Name: \_\_\_\_\_  
 CA Case Number: \_\_\_\_\_  
 CITYFEPS Provider: \_\_\_\_\_

### CITY FAMILY EVICTION PREVENTION SUPPLEMENT (CITYFEPS) APPROVAL NOTICE

Your application for a CITYFEPS rent supplement, dated \_\_\_\_\_, has been **approved** as follows:

Address for which CITYFEPS is approved: \_\_\_\_\_

1. Approved Apartment Rent:	
2. Number of Individuals in Household Receiving Cash Assistance:	
3. Number of Individuals in Household with Income Not Receiving Cash Assistance:	
4. Standard Cash Assistance Shelter Allowance for Your Household:	
5. Monthly Contribution from Household Members not receiving Cash Assistance:	
6. CITYFEPS Rent Supplement (which HRA will pay to the Landlord):	
7. Approved Rent Arrears Grant	
8. Approved Payment of Legal & Marshal Fees	

You are responsible for paying directly to the Landlord a Total Monthly Client Contribution of \$ \_\_\_\_\_, calculated as follows:

(1) 30% of the income from household members not on Cash Assistance or their pro-rata share of the rent, whichever is less:

PLUS

(2) the shortage from the Standard Cash Assistance Shelter Allowance if your household does not receive the maximum shelter allowance:

Please note that this approval is limited to your current situation and may be subject to change.

- Any changes to the number of individuals on the CA case, the household's shelter allowance or the income of household members not on CA may change your Monthly Client Contribution and CITYFEPS rent supplement amount.
- You will be responsible for notifying HRA of any changes to your household composition, income or amount of rent within 10 days.
- If a household member is sanctioned and your Cash Assistance Shelter benefits are reduced, your CITYFEPS rent supplement amount will also be reduced. You will be responsible for paying the excess rent directly to the Landlord for the duration of the sanction.
- The CITYFEPS rent supplement amount will be discontinued if the family no longer has a CA case or no longer has a child under 18 years of age, or under 19 years who is a full-time student regularly attending a secondary school, or the equivalent level of vocational or technical training.
- A household receiving a CITYFEPS rent supplement may not move to a new residence and maintain eligibility for CITYFEPS except with the prior approval of HRA.
- Continued CITYFEPS rent supplement payments are subject to the availability of funding.

OBSOLETE

**RIGHT TO A REVIEW OF OUR DETERMINATIONS**

**DO YOU THINK WE ARE WRONG? (IF SO, CONTACT HRA IMMEDIATELY)**

If you think our decision is wrong, you should talk with your case manager. If we made a mistake, we will correct it.

If you are not satisfied with the explanation your case manager gives you, you can request a review conference with HRA and/or an administrative appeal hearing to obtain a review of the decision. Often, the quickest way to have the decision reviewed is by requesting a conference with HRA. **An agency review conference must be requested within 60 days of the issuance of this determination.**

**HOW TO REQUEST A REVIEW CONFERENCE**

It is very easy to request a review conference. Just call (929) 221-0043 and say that you are requesting a review conference about your eligibility for the CITYFEPS program. One will be scheduled as soon as possible.

**WHAT TO EXPECT AT A REVIEW CONFERENCE**

At a review conference, we will discuss our decision with you. Sometimes this is the fastest way to solve any problem you may have. If you have documents that show there was an error, you can explain the error to us and we will direct you regarding the fastest way to change or update your information.

If you are not satisfied with the results of the review conference, you are still entitled to an administrative appeal. **Your time to request an appeal will be extended until 60 days after the date of your review conference.**

**ADMINISTRATIVE APPEAL PROCESS**

**Deadline for requesting an appeal:** You have 60 days from the date of this notice or the date of your conference to request an Administrative Appeal.

**How to Ask for an Administrative Appeal Hearing:**

You can ask for an administrative appeal by **mail**, by **fax**, or by **email**. If you cannot reach HRA by fax or email, please write to CITYFEPS Appeals, 150 Greenwich Street, New York, NY 10007 to ask for an administrative appeal before the deadline. All requests for administrative appeals must be in writing.

**(1) MAIL:** Send a copy of **ALL FOUR PAGES OF THIS NOTICE**, completed, to:  
**CITYFEPS Appeals**  
150 Greenwich Street, 36th Floor  
New York, NY 10007  
(Please keep a copy for yourself.)

**I want an administrative appeal. I do not agree with the City's decision.**  
(You may explain why you disagree below, but you do not have to include a written explanation.)

Print Name: \_\_\_\_\_ Case Number: \_\_\_\_\_  
Name M.I. Last Name

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**(2) FAX:** Fax a copy of **ALL FOUR PAGES OF THIS NOTICE** to: **917-639-0313**.  
(While residing in the shelter, your provider will make the shelter's fax machine available during regular business hours to request an appeal.)

**(3) E-MAIL:** Scan and E-mail **ALL FOUR PAGES OF THIS NOTICE**  
to: **RACC@hra.nyc.gov**

### **What to Expect at an Administrative Appeal Hearing**

HRA will send you a notice that tells you when and where the appeal hearing will be held.

At the hearing, you will have a chance to explain why you think the 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.

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.

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

If you have a disability and need a reasonable accommodation, such as sign language interpretation, assistance for a visual impairment or some other accommodation, to participate in a conference or hearing, please make this request on this form.

### **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 advocacy group. For contact information for Legal Aid or other advocacy groups or the names of other lawyers, check your Yellow Pages under "Lawyers" or check the internet equivalent.

### **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 HRA, we will send you free copies of the documents from your files which we will give to the hearing officer at the hearing. Also, if you call, write or fax us, we will send you free copies of other specific documents which you think you may need to prepare for your appeal hearing. To ask for documents or to find out how to look at your file, call HRA at **929-221-0043** or write HRA at **CITYFEPS Programs, 150 Greenwich Street, 36th Floor, New York, NY 10007**.

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 an administrative appeal, how to see your file, or how to get additional copies of documents, call HRA at **(929) 221-0043** or write to **CITYFEPS Programs, 150 Greenwich Street, 36th Floor, New York, NY 10007**.

### **Further Appeal Rights**

If you think the hearing officer's decision is wrong, you will have the right to appeal the hearing officer's decision to a higher-level manager within HRA. Information on how to take a further appeal will be included in the hearing officer's decision.

OBSOLETE

HRA-124  
7/15/15

## HRA Housing Assistance Questionnaire

HRA would like to help you move out of shelter and into your own housing.  
This questionnaire will assist us in working with you on your housing plan.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Public Assistance Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Family Size: Adults \_\_\_\_\_ Children \_\_\_\_\_

### Reason for Homelessness

1. Is this your first time in shelter?  Yes  No. How long have you been residing in shelter? \_\_\_\_\_

2. What is the situation that caused you to seek shelter:  
 Eviction  Foreclosure  Domestic Violence  other \_\_\_\_\_

### Housing Plan

3. What is your current plan for leaving shelter and finding an apartment?  
\_\_\_\_\_  
\_\_\_\_\_

4. What steps have you taken towards this goal?  
\_\_\_\_\_  
\_\_\_\_\_

5. Have you applied for an apartment and been rejected because of your credit report?  Yes  No

6. Were you ever evicted from Public Housing? \_\_\_\_\_

7. Do you have any special housing needs? \_\_\_\_\_

### Housing Search

8. What methods are you currently using to secure permanent housing?  Realtor  Craigslist  
 Other: \_\_\_\_\_

9. What services do you feel would best aid you in your apartment search?  
\_\_\_\_\_

10. What is your current work schedule? \_\_\_\_\_

11. What would be the best time to search for and view apartments? \_\_\_\_\_

### Income

Gross Monthly income: \$ \_\_\_\_\_

Net Monthly income: \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

SSI: Amount: \_\_\_\_\_

### Debt

#### Credit Cards

Name/Type: \_\_\_\_\_

Name/Type: \_\_\_\_\_

Monthly Payment: \$ \_\_\_\_\_ Balance: \$ \_\_\_\_\_

Monthly Payment: \$ \_\_\_\_\_ Balance: \$ \_\_\_\_\_

Name/Type: \_\_\_\_\_

Name/Type: \_\_\_\_\_

Monthly Payment: \$ \_\_\_\_\_ Balance: \$ \_\_\_\_\_

Monthly Payment: \$ \_\_\_\_\_ Balance: \$ \_\_\_\_\_

Name/Type: \_\_\_\_\_

Name/Type: \_\_\_\_\_

Monthly Payment: \$ \_\_\_\_\_ Balance: \$ \_\_\_\_\_

Monthly Payment: \$ \_\_\_\_\_ Balance: \$ \_\_\_\_\_

#### Payroll Deductions (monthly)

OBSOLETE

Child Support: \$ \_\_\_\_\_ Alimony: \$ \_\_\_\_\_ Pension/Bank Loan: \$ \_\_\_\_\_ Other Deductions: \$ \_\_\_\_\_

IRS Garnishment: \$ \_\_\_\_\_ Other Garnishment: \$ \_\_\_\_\_

#### Past Housing Related Debt

Utility Arrears: \$ \_\_\_\_\_ Rental Arrears: \$ \_\_\_\_\_ Storage: \$ \_\_\_\_\_ Small Claims Judgment: \$ \_\_\_\_\_

### Personal Expenses

Cell Phone: \$ \_\_\_\_\_ Tuition: \$ \_\_\_\_\_ Student/Personal Loan(s): \$ \_\_\_\_\_ Transportation: \$ \_\_\_\_\_

Child Care: \$ \_\_\_\_\_ Car Note: \$ \_\_\_\_\_ Car Insurance: \$ \_\_\_\_\_ Health/Life Insurance: \$ \_\_\_\_\_

Food: \$ \_\_\_\_\_ Entertainment/Other: \$ \_\_\_\_\_

### Credit History (if Known)

FICO Credit Score \_\_\_\_\_ as of (date last checked) \_\_\_\_\_

If you haven't already done so, please utilize one of the below websites to get your free annual credit report:

Annual Credit Report.com (<https://www.annualcreditreport.com/index.action>)

Free Credit Report.com (<https://www.freecreditreport.com>)

Credit Karma.com (<https://www.creditkarma.com/>)



Date: \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Caseload: \_\_\_\_\_

IS/Job Center: \_\_\_\_\_

Telephone number for conference and record access:  
\_\_\_\_\_

FH&C  
For questions or help call your worker at the telephone number below.

**Notice of Intent to Change Benefits: Public Assistance, Food Stamps and Medical Assistance Coverage and Services - (Quarterly Reporting System)**

This NOTICE is to tell you that this agency intends to CHANGE YOUR BENEFIT(S). The changes are explained below next to the boxes that have been checked .

**Public Assistance**

**DISCONTINUE** your public assistance grant effective \_\_\_\_\_.

The reason for this action is:

You failed to complete and return your Quarterly Report for the quarter \_\_\_\_\_ . We have enclosed a reporting form for you to complete (in case you have lost or not received the first one we sent you). If you complete and return it to us by \_\_\_\_\_ , we will not discontinue your public assistance.

You failed to answer all of the questions on your Quarterly Report for the quarter \_\_\_\_\_ , which we are returning to you with this notice. If you complete the items marked in RED on the Quarterly Report and return it to us by \_\_\_\_\_ , we will not discontinue your public assistance.

You failed to sign and date your Quarterly Report for the quarter \_\_\_\_\_ , which we are returning to you with this notice. If you sign and date the report and return it to us by \_\_\_\_\_ , we will not discontinue your public assistance.

You failed to supply verification required for your Quarterly Report for the quarter \_\_\_\_\_ . If you supply the items indicated below and return it to us by \_\_\_\_\_ , we will not discontinue your public assistance.

We need more information about your earnings. Please have your employer complete and sign the enclosed form and return it to us.

Other (Specify) \_\_\_\_\_ .

The LAW(S) and/or REGULATION(S) which allows us to do this is 18 NYCRR 351.24

**Food Stamps**

**DISCONTINUE** your food stamp benefits for the same reason as we are discontinuing your public assistance.

The LAW(S) and/or REGULATION(S) which allows us to do this is 18 NYCRR 387.17

**Medical Assistance**

**CONTINUE** the medical assistance coverage for all members of your household except for \_\_\_\_\_ . You will continue to receive medical assistance entitling the eligible individuals to full services.

**DISCONTINUE** your medical assistance coverage for the same reason we are discontinuing your public assistance.

The LAW(S) and/or REGULATION(S) which allows us to do this is 18 NYCRR 360-2.6

**Services: Social Services participants - A loss of public assistance and medical assistance benefits will require redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact your service worker for further information.**

Worker/Date

Telephone Number

Supervisor/Date

**Attention:** If you are receiving public assistance, food stamps, or medical assistance, you may be eligible for a discount on your telephone service. For information on LIFELINE, call Verizon, toll free at 1 (800) 799-6874

**You Have The Right To Appeal This Decision**

We will review this decision with you if you call us at the above telephone number and ask for a LOCAL CONFERENCE. You also have the right to ask for a STATE FAIR HEARING within 60 days of the date on the top of this Notice for Public Assistance and Medical Assistance issues. You have 90 days to request a STATE FAIR HEARING on Food Stamp issues. You must meet this deadline to request a STATE FAIR HEARING even if you ask for a LOCAL CONFERENCE first. The STATE FAIR HEARING is held by the New York State Office of Temporary and Disability Assistance. If you request a STATE FAIR HEARING before the effective date of this Notice, you will continue to receive your benefits unchanged until the STATE FAIR HEARING decision is issued.

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

## Conference and Fair Hearing Information

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

### STATE FAIR HEARING

**Deadline for Request:** If you want the State to review our decision, you must ask for a fair hearing within 60 days from the date of the notice for Public Assistance, Medical Assistance and Social Services issues and 90 days for Food Stamp issues.

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

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

**(1) TELEPHONE:** (212) 417-6550. (Please have this notice with you when you call).

-OR-

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

-OR-

**(3) FAX:** Send a copy of the notice, with this side completed, to FAX Number: (518) 473-6735.

-OR-

**(4) WALK-IN:** Bring a copy of the notice, with this side completed, to a New York State Office of Temporary and Disability Assistance office listed below:  
14 Boerum Place, Brooklyn  
109 East 16th Street, Manhattan, 3rd floor  
330 West 34th Street, Manhattan, 3rd floor.

I want a fair hearing. The Agency's action is wrong because \_\_\_\_\_

**OBSOLETE**

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the Fair Hearing, the applicant/participant or their representative has the opportunity to present written and oral evidence, establish facts and circumstances and to question or refute the evidence presented by the local agency. Your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing.

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

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will send you free copies of the documents from your files, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will send you free copies of other documents from your files which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call the Fair Hearing and Conciliation (FH&C) Unit at the telephone number found on the front, or write to your Income Support/Job Center at the address listed at the top of this notice. If you want copies of documents from your case file, you should ask for them ahead of time.

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



Date \_\_\_\_\_

**INFORMATION FOR PERSONS 65 YEARS OF AGE AND OLDER ABOUT SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS**

Supplemental Security Income (SSI) is a program run by the Social Security Administration which provides monthly checks to individuals 65 years of age and older who have low or no income, even if the individual has no work history to qualify for other benefits from Social Security. SSI is also provided to individuals 65 years of age and older who are non-citizens admitted for permanent residence.

**OBSOLETE**

**Safety Net Assistance (SNA) Cases and Family Assistance (FA) Cases:**

If you are in receipt of Safety Net Assistance or Family Assistance, you are required to apply for SSI benefits at your local Social Security Administration Office. However, if your case is a Family Assistance case and your application for SSI is approved, you have the choice of either accepting SSI benefits, or continuing to receive public assistance. If you choose to remain on public assistance, please be aware that there is a **60-month lifetime limit for receiving Family Assistance (FA) cash benefits. Safety Net Assistance (SNA) cases do not have this choice.**

Please call the Social Security Administration no later than 10 days from receipt of this notice, to schedule an appointment to file an application for SSI benefits (see instructions below).

**Failure to apply for SSI may result in the discontinuance of your cash assistance benefits.**

**How to Apply**

Call **1-800-772-1213** to set up an appointment with a Social Security Representative. Press "0" for Operator, or stay on the line. Call between the hours of 7 A.M. and 7 P.M. Monday through Friday. Instructions are provided in English and Spanish. If you are hearing impaired, call 1-800-325-0778 for the Teletypewriter (TTY) number.

**What to bring:**

- Social Security card, or an official record of applicant's Social Security number
- Birth certificate, or other proof of age

I have received a copy of this notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR EVR USE ONLY**

Corrected D.O.B. \_\_\_ / \_\_\_ / \_\_\_      Corrected SSN \_\_\_ - \_\_\_ - \_\_\_\_\_

Fecha \_\_\_\_\_

## INFORMACIÓN ACERCA DE INGRESOS SUPLEMENTALES DEL SEGURO SOCIAL(SSI) PARA PERSONAS DE 65 AÑOS DE EDAD O MÁS

Ingresos Suplementales del Seguro Social (SSI) es el programa dirigido por la Administración del Seguro Social que provee cheques mensuales a personas de 65 años de edad o más de bajos ingresos o sin ningunos ingresos, aún cuando la persona no tiene historia de trabajo para calificar para recibir beneficios del Seguro Social. También se le provee SSI a personas de 65 años de edad o más que no son ciudadanos americanos pero que han sido admitidos para la residencia permanente.

### Casos de Asistencia Red de Seguridad (SNA) y Casos de Asistencia para Familias (FA):

Si usted está recibiendo Asistencia Red de Seguridad o Asistencia para Familias, usted está requerido a solicitar beneficios de SSI en las oficinas locales de la Administración del Seguro Social. Sin embargo, si su caso es un caso de Asistencia para Familias y su solicitud para SSI es aprobado, usted tiene la opción de aceptar los beneficios de SSI o de continuar recibiendo asistencia pública. Si escoge permanecer en asistencia pública, favor de quedar informado **que existe un límite de por vida de 60 meses para recibir beneficios en efectivo de Asistencia para Familias (FA). Los casos de Asistencia Red de Seguridad (SNA) no tienen ésta opción.**

Favor de llamar a la Administración del Seguro Social no más tarde de 10 días a partir de la fecha de recibir ésta notificación, para programar una cita y completar una solicitud para SSI (vea las instrucciones abajo).

**El no solicitar SSI puede resultar en la discontinuación de sus beneficios de asistencia en efectivo.**

### Cómo Solicitar

Llame al **1-800-772-1213** para programar una cita con un(a) Representante del Seguro Social. Oprima "0" para hablar con la operadora, o permanezca en la línea. Llame entre las horas de 7:00 A.M. y 7:00 P.M. de lunes a viernes. Se proveen instrucciones en inglés y en español. Si usted tiene un impedimento auditivo, llame al 1-800-325-0778 para el número del Escritor-téletipo (TTY).

### Lo que debe traer:

- Tarjeta del Seguro Social o el comprobante oficial del número de Seguro Social del solicitante
- Certificado de Nacimiento u otra prueba de la edad

He recibido una copia de ésta notificación.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_

### FOR EVR USE ONLY

Corrected D.O.B. \_\_\_ / \_\_\_ / \_\_\_      Corrected SSN \_\_\_ - \_\_\_ - \_\_\_\_\_





HUMAN RESOURCES ADMINISTRATION  
OFFICE OF CONSTITUENT & COMMUNITY AFFAIRS  
OFFICE OF BURIAL CLAIMS  
151 LAWRENCE STREET - 5TH FLOOR  
BROOKLYN, NEW YORK 11201-5208

## BURIAL POLICY

If a person, whether or not a public assistance recipient, dies leaving insufficient resources to pay burial expenses, and there are no relatives or friends liable or willing to pay such expenses, the Department will pay no more than \$800 towards a funeral which costs no more than \$1,400 excluding the cost of cremation or grave and grave opening. The cost of burying the remains (ashes), subsequent to cremation, is not excludable. If the bill exceeds this amount, the Department will make no payment.

Any asset (whether or not previously assigned to the Human Resources Administration) available to the deceased, any amount which a legally responsible relative (spouse or parent of a minor child) is deemed able to pay, and any amount paid or to be paid by any other source, will be taken into account in computing the payment.

### In order to process a claim, we require:

- 1) Application form (M-860w) completed, signed by the applicant, and notarized.
- 2) One original certified copy of the Certificate of Death.
- 3) A true copy of the Statement of Goods and Services Selected. The required sequential number must appear on the document.
- 4) A copy of the cemetery or crematory bill, itemizing all charges.
- 5) Two original itemized funeral bills signed by the Funeral Director and notarized.
- 6) The funeral bills must be stamped "Paid-in-Full" if the charges have been paid.
- 7) Two original completed Funeral Director's Affidavit forms (M-860n) signed by the Funeral Director and notarized if there is money still owed to the funeral establishment.
- 8) Information and documentation regarding the decedent's available assets, and those of the applicant, if he/she is a legally responsible relative, will be required in all cases.
- 9) The Agency reserves the right to request any other documentation, which may be necessary to make a determination of eligibility, based upon the particular facts and circumstances of the case.

**\* The application for burial allowance must be submitted within 60 days of the date of death. The party who arranged the funeral, or a duly authorized representative, must file the application in person, at the address stated above. The applicant must present photo-identification, verifying his/her identity, at the time of application.**

## ADDITIONAL INFORMATION REQUIRED TO INDICATE CATEGORICAL ELIGIBILITY FOR ADC

**DECEDENT'S NAME:** \_\_\_\_\_

**B.C. #:** \_\_\_\_\_

1. Date of Birth of Deceased: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Age of the Deceased \_\_\_\_\_

3. Is there a child under age eighteen (18) in the deceased's household? Yes \_\_\_\_ No \_\_\_\_

4. Was the deceased a member of an ADC household but not receiving ADC cash at time of death because he/she was sanctioned or an illegal alien? Yes \_\_\_\_ No \_\_\_\_

If yes, furnish the name of the head of the household, and the case number.

Case Name: \_\_\_\_\_

Case #: \_\_\_\_\_

5. Was the deceased at least six (6) months pregnant at the time of death? Yes \_\_\_\_ No \_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Cash Assistance (CA) and Supplemental Nutrition Assistance Program (SNAP)  
Budgeting Changes From 2002 to 2010  
(for use with the automated CA and SNAP calculator)**

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

Year	Budgeting Change	Type of Change	Effective Date	Change Also Impacts
2002	<b>CA Earned Income Disregard (EID)</b>	<ul style="list-style-type: none"> <li>CA EID increased to 50%</li> </ul>	6/1/2002	<ul style="list-style-type: none"> <li>CA Gross Income Test (GIT)</li> <li>CA Poverty Guideline Test (PGT)</li> <li>CA Net Income Test (NIT)</li> </ul>
	<b>SNAP benefits</b>	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$367</li> <li>Boarder/lodger exclusion increased to \$139 for one and \$256 for two persons</li> <li>Personal care shelter amount reduced by \$4</li> </ul>	10/1/2002	<ul style="list-style-type: none"> <li>Net income eligibility levels</li> <li>Zero Benefit Levels</li> <li>Thrifty Food Plan (TFP) SNAP benefit amounts</li> <li>Excess shelter maximum and standard deduction amounts</li> </ul>
2003	<b>CA EID</b>	<ul style="list-style-type: none"> <li>CA EID increased to 51%</li> <li>CA Poverty Guidelines</li> </ul>	6/1/2003	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>
	<b>SNAP benefits</b>	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$378</li> <li>Boarder/lodger exclusion increased to \$141 for one and \$259 for two persons</li> <li>Personal care shelter amount reduced by \$2</li> <li>SNAP table amounts for the 130% GIT</li> </ul>	10/1/2003	<ul style="list-style-type: none"> <li>Net income eligibility levels</li> <li>Zero Benefit Levels</li> <li>Thrifty Food Plan (TFP) SNAP benefit amounts</li> <li>Excess shelter maximum and standard deduction amounts</li> </ul>
	<b>Shelter allowances</b>	<ul style="list-style-type: none"> <li>Increase in CA standard shelter allowances for households with children and pregnant females</li> </ul>	11/1/2003	<ul style="list-style-type: none"> <li>CA NIT</li> </ul>
2004	<b>CA EID</b>	<ul style="list-style-type: none"> <li>CA EID reduced to 43%</li> <li>CA Poverty Guidelines</li> </ul>	6/1/2004	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>
	<b>SNAP benefits</b>	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$388</li> <li>Boarder/lodger exclusion increased to \$149 for one and \$274 for two persons</li> <li>Personal care shelter amount reduced by \$2</li> <li>SNAP table amounts for the 130% GIT</li> </ul>	10/1/2004	<ul style="list-style-type: none"> <li>Net income eligibility levels</li> <li>Zero benefit levels</li> <li>TFP SNAP benefit amounts</li> <li>Excess shelter maximum and standard deduction amounts</li> </ul>

**Cash Assistance (CA) and Supplemental Nutrition Assistance Program (SNAP)  
Budgeting Changes From 2002 to 2010**  
(for use with the automated CA and SNAP calculator)

Year	Budgeting Change	Type of Change	Effective Date	Change Also Impacts
2005	CA EID	<ul style="list-style-type: none"> <li>Gross earned/unearned income of CA applicants/participants cannot exceed the 2005 Federal Poverty Guidelines</li> <li>CA EID increased to 45%</li> <li>CA Poverty Guidelines</li> </ul>	6/1/2005	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>
	SNAP benefits	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$400</li> <li>Boarder/lodger exclusion increased to \$152 for one and \$278 for two persons</li> <li>SNAP table amounts for the 130% GIT</li> </ul>	10/1/05	<ul style="list-style-type: none"> <li>SNAP standard deduction</li> <li>Excess shelter maximum and standard deduction amounts</li> <li>TFP SNAP benefit amounts</li> <li>Zero benefit levels</li> <li>Net income eligibility levels</li> </ul>
2006	SNAP Standard Utility Allowances (SUA)	<ul style="list-style-type: none"> <li>SUA Level 1 increased to \$577</li> <li>SUA Level 2 increased to \$256</li> </ul>	2/1/2006	<ul style="list-style-type: none"> <li>TFP SNAP benefit amounts</li> </ul>
	CA EID	<ul style="list-style-type: none"> <li>CA EID increase to 47%</li> <li>CA Poverty Guidelines</li> </ul>	6/1/2006	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>
	SNAP benefits	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$417</li> <li>Boarder/lodger exclusion increased to \$155 for one and \$284 for two persons</li> <li>SNAP table amounts for the 130% and 165% GIT</li> </ul>	10/1/2006	<ul style="list-style-type: none"> <li>SNAP standard deduction</li> <li>Excess shelter maximum and standard deduction amounts</li> <li>Net income eligibility levels</li> <li>TFP SNAP benefit amounts</li> </ul>
2007	CA EID	<ul style="list-style-type: none"> <li>CA EID increased to 48%</li> <li>CA Poverty Guidelines</li> </ul>	6/1/2007	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>
	SNAP benefits	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$431</li> <li>Boarder/lodger exclusion increased to \$162 for one and \$298 for two persons</li> <li>SNAP table amounts for the 130% and 165% GIT</li> </ul>	10/1/2007	<ul style="list-style-type: none"> <li>SNAP standard deduction</li> <li>Excess shelter maximum and standard deduction amounts</li> <li>Net income eligibility levels</li> <li>TFP SNAP benefit amounts</li> </ul>

**Cash Assistance (CA) and Supplemental Nutrition Assistance Program (SNAP)  
Budgeting Changes From 2002 to 2010**  
(for use with the automated CA and SNAP calculator)

Year	Budgeting Change	Type of Change	Effective Date	Change Also Impacts
2008	CA EID	<ul style="list-style-type: none"> <li>CA EID increased to 50%</li> <li>CA Poverty Guidelines</li> </ul>	6/1/2008	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>
	SNAP benefits	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$446</li> <li>Boarder/lodger exclusion increased to \$176 for one and \$323 for two persons</li> <li>SNAP table amounts for the 130%, 165%, and 200% GIT</li> </ul>	10/1/2008	<ul style="list-style-type: none"> <li>SNAP standard deduction</li> <li>Excess shelter maximum and standard deduction amounts</li> <li>Net income eligibility levels</li> <li>TFP SNAP benefit amounts</li> </ul>
2009	SUA	<ul style="list-style-type: none"> <li>SUA Level 1 increased to \$781</li> <li>SUA Level 2 increased to \$308</li> </ul>	2/1/2009	<ul style="list-style-type: none"> <li>TFP SNAP benefit amounts</li> </ul>
	SNAP benefits	<ul style="list-style-type: none"> <li>Boarder/lodger exclusion increased to \$200 for one and \$367 for two persons</li> </ul>	4/1/2009	<ul style="list-style-type: none"> <li>TFP SNAP benefit amounts</li> </ul>
	CA EID	<ul style="list-style-type: none"> <li>CA EID increased to 52%</li> <li>CA Poverty Guidelines</li> </ul>	6/1/2009	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>
	CA	<ul style="list-style-type: none"> <li>10% increase to the Basic Allowance</li> </ul>	7/1/2009	
	SNAP benefits	<ul style="list-style-type: none"> <li>Maximum excess shelter deduction increased to \$459</li> <li>SNAP table amounts for the 130%, 165%, and 200% GIT</li> </ul>	10/1/2009	<ul style="list-style-type: none"> <li>SNAP standard deduction</li> <li>Excess shelter maximum and standard deduction amounts</li> <li>Net income eligibility levels</li> </ul>
2010	CA	<ul style="list-style-type: none"> <li>10% increase to the Basic Allowance</li> </ul>	7/1/2010	<ul style="list-style-type: none"> <li>CA GIT</li> <li>CA PGT</li> <li>CA NIT</li> </ul>

OBSOLETE

Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Case Name: \_\_\_\_\_

### Notice of Forward of Application

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

We are writing to you regarding your recent Supplemental Nutrition Assistance Program (SNAP) application which we received in the mail.

Normally, a responsible member of an applying household must report to this office for an in person interview as part of the SNAP eligibility determination process. However, we have determined that your household qualifies for a special certification procedure wherein the requirement for an office interview is waived.

We have forwarded your application to:

- SSI SNAP Center F-15  
233 Schermerhorn Street  
Brooklyn, New York 11201  
Telephone Number 1-718-722-4009
  
- Homebound Office F-63  
98 Flatbush Avenue  
Brooklyn, New York 11217  
Telephone Number 1-718-237-4821

The above checked (✓) office will process your application. The office will contact you if they require additional information to determine your eligibility for SNAP. You will be notified of the acceptance or rejection of your application within 30 days from the date we first received your application in this office. If you are found eligible you will also receive SNAP benefits from that date.

## Organizations To Help You Find New or Better Jobs

### Church Avenue Merchants Block Association (CAMBA)

885 Flatbush Avenue, 3<sup>rd</sup> Floor  
Brooklyn, New York 11226  
Contact: Wendy Ortiz  
Telephone: (718) 282-5575  
Travel Directions:

“Q” (Diamond) or “Q” (Circle) train to Church Avenue. When exiting station, turn left and walk four (4) blocks to Flatbush Avenue. The building is at the corner of Flatbush and Church Avenues.

### CWE/Nexus Project

13-15 W. 28<sup>th</sup> Street, 3<sup>rd</sup> Floor  
New York, New York 10001  
Contact: Linda Nelson  
Telephone: (212) 447-8505  
Travel Directions:  
#1 or #9 train, or “N” or “R” train to 28<sup>th</sup> Street. The office is between 5<sup>th</sup> Avenue and Broadway.

### National Puerto Rican Forum Inc.

1910 Webster Avenue, 2<sup>nd</sup> Floor  
Bronx, New York 10457  
Contact: Wendy Acevedo  
Telephone: (718) 716-1300  
Travel Directions:  
#4 train to Burnside Avenue. Take #42 bus to Tremont Avenue. Building is at the corner of Webster and Tremont Avenues; or: “D” train to Tremont Avenue. Walk four (4) blocks east to Webster Avenue; or #2 or #5 train to Tremont Avenue. Take #40 or #42 bus to Webster Avenue.

### New York Urban League Inc./Career Builders

2090 7<sup>th</sup> Avenue, 6<sup>th</sup> Floor  
New York, New York 10027  
Contact: Priscilla Chisolm  
Telephone: (212) 749-8061  
Travel Directions:  
#2 train to 125<sup>th</sup> Street. Walk one (1) block toward 7<sup>th</sup> Avenue and Adam Clayton Powell Boulevard. The building is between 124<sup>th</sup> and 125<sup>th</sup> Streets, next to White Castle restaurant.

### Consortium for Worker Education Inc.

275 7<sup>th</sup> Avenue, 27<sup>th</sup> Floor  
New York, New York 10001  
Contact: Natasha Lifton  
Telephone: (212) 647-1900  
Travel Directions:  
#1 or #9 train to 28<sup>th</sup> Street. Walk one (1) block to 27<sup>th</sup> Street.

### The Doe Fund

2960 Frederick Douglass Boulevard  
New York, New York 10039  
Contact: Thomas Palega, Venetia Leak, Kalilla Davis  
Telephone: (212) 491-9710, 0791, 9706  
Travel Directions:  
“D” train to 155<sup>th</sup> Street and 8<sup>th</sup> Avenue. Cross the street directly in front of the train station.

### North Brooklyn Business Resource Center (NBBRC)/St. John the Baptist RC Church

75 Lewis Avenue (between Willoughby Avenue and Hart Street), 4<sup>th</sup> Floor  
Brooklyn, New York 11206  
Contact: Juan Blass or Princess Bryson  
Telephone: (718) 602-0519  
Travel Directions:  
By Subway:  
“J” or “M” train to Myrtle Avenue and Broadway. Walk up Myrtle Avenue one (1) block to Lewis Avenue. Go left two (2) blocks to Willoughby Avenue.

#### By Bus:

B54 Myrtle Avenue Bus to Myrtle & Lewis Avenues. Walk two (2) blocks to Willoughby Avenue; or B38 Dekalb Avenue Bus (on Lafayette Avenue) to Lewis Avenue. Walk three (3) blocks to Hart Street; or B40 or B46 Bus to Willoughby Avenue. Walk up Willoughby Avenue 1½ blocks.

## Organizaciones para Ayudarle a Encontrar Nuevos o Mejores Trabajos

### Church Avenue Merchants Block Association (CAMBA)

885 Flatbush Avenue, 3<sup>er</sup> Piso  
Brooklyn, New York 11226  
Contacto: Wendy Ortiz  
Teléfono: (718) 282-5575  
Direcciones de Viaje:  
Tren "Q" (Diamante) o "Q" (Círculo) hasta  
Church Avenue. Cuando salga de la  
estación, doble a la izquierda y camine  
cuatro (4) cuadras hasta Flatbush Avenue.  
El edificio está en la esquina de Flatbush y  
Church Avenues.

### CWE/Nexus Project

13-15 W. 28<sup>th</sup> Street, 3<sup>er</sup> Piso  
New York, New York 10001  
Contacto: Linda Nelson  
Teléfono: (212) 447-8505  
Direcciones de Viaje:  
Tren #1 o #9, o "N" o "R" hasta la 28<sup>th</sup>  
Street. La oficina se encuentra entre 5<sup>th</sup>  
Avenue y Broadway.

### National Puerto Rican Forum Inc.

1910 Webster Avenue, 2<sup>do</sup> Piso  
Bronx, New York 10457  
Contacto: Wendy Acevedo  
Teléfono: (718) 716-1300  
Direcciones de Viaje:  
Tren #4 hasta Burnside Avenue. Tome el  
autobús #42 hasta Tremont Avenue. El  
edificio se encuentra en la esquina de  
Webster y Tremont Avenues; o: Tren "D"  
hasta Tremont Avenue. Camine cuatro (4)  
cuadras hacia el este hasta Webster Avenue;  
o el tren #2 o #5 hasta Tremont Avenue.  
Tome el autobús #40 o #42 hasta Webster  
Avenue.

### New York Urban League Inc./Career Builders

2090 7<sup>th</sup> Avenue, 6<sup>to</sup> Piso  
New York, New York 10027  
Contacto: Priscilla Chisolm  
Teléfono: (212) 749-8061  
Direcciones de Viaje:  
Tren #2 hasta 125<sup>th</sup> Street. Camine una (1)  
cuadra hacia 7<sup>th</sup> Avenue y Adam Clayton  
Powell Boulevard. El edificio está entre

124<sup>th</sup> y 125<sup>th</sup> Streets, próximo al restaurante  
White Castle.

### Consortium for Worker Education Inc.

275 7<sup>th</sup> Avenue, 27<sup>mo</sup> Piso  
New York, New York 10001  
Contacto: Natasha Lifton  
Teléfono: (212) 647-1900  
Direcciones de Viaje:  
Tren #1 o #9 hasta 28<sup>th</sup> Street. Camine una  
(1) cuadra hasta 27<sup>th</sup> Street.

### The Doe Fund

2960 Frederick Douglass Boulevard  
New York, New York 10039  
Contacto: Thomas Palega, Venetia  
Leak, Kalilla Davis  
Teléfono: (212) 491-9710, 0791, 9706  
Direcciones de Viaje:  
Tren "D" hasta 155<sup>th</sup> Street y 8<sup>th</sup> Avenue.  
Cruce la calle directamente frente a la  
estación del tren.

### North Brooklyn Business Resource Center (NBBRC)/St. John the Baptist RC Church

75 Lewis Avenue (entre Willoughby Avenue  
y Hart Street), 4<sup>to</sup> Piso  
Brooklyn, New York 11206  
Contacto: Juan Blass o Princess Bryson  
Teléfono: (718) 602-0519  
Direcciones de Viaje:  
Por Subterráneo:  
Tren "J" o "M" hasta Myrtle Avenue y  
Broadway. Camine en Myrtle Avenue una  
(1) cuadra hasta Lewis Avenue. Doble a la  
izquierda y camine dos (2) cuadras hasta  
Willoughby Avenue.

Por Autobús:

Autobús B54 Myrtle Avenue hasta Myrtle &  
Lewis Avenues. Camine dos (2) cuadras  
hasta Willoughby Avenue; o autobús B38  
DeKalb Avenue (en Lafayette Avenue) hasta  
Lewis Avenue. Camine tres (3) cuadras  
hasta Hart Street; o B40 o Autobús B46  
hasta Willoughby Avenue. Camine 1 cuadra  
y media en Willoughby Avenue.





Food Stamp Program Claims Unit  
Lock Box C-9041  
Brooklyn N.Y. 11201

Date: \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Center: \_\_\_\_\_

**OBSOLETE**

For questions or help call: (718) 722-4694.

Dear Sir/Madam:

This acknowledges your payment of \$ \_\_\_\_\_ .

Your new balance is \$ \_\_\_\_\_ . Please remit your next payment in the enclosed postage paid envelope. Have the check or money order made out to the City of New York Food Stamp Program.

You repaid the amount owed in full.

If this box is checked, we owed you benefits from past months in the amount of \$ \_\_\_\_\_ . We've therefore used this amount to offset the amount you owed us.

Remarks/Other: \_\_\_\_\_

Sincerely,  
Director,  
Food Stamp Fiscal Program

Fecha: \_\_\_\_\_

Nombre del Caso: \_\_\_\_\_

Número del Caso: \_\_\_\_\_

Centro: \_\_\_\_\_

**Para preguntas o ayuda llame al (718) 722-4694.**

**OBSOLETE**

Estimado(a) Señor(a):

Esto acusa recibo de su pago de \$ \_\_\_\_\_.

Su nuevo balance es \$ \_\_\_\_\_. Favor de remitir su proximo pago en el sobre franqueado adjunto.  
Remita un cheque o giro postal a nombre de: City of New York Food Stamp Program.

Usted reembolso la cantidad completa adeudada.

Si ésta casilla es marcada, le debíamos beneficios de meses pasados en la cantidad de \$ \_\_\_\_\_. Por lo tanto  
hemos utilizado ésta cantidad para contrarrestar la cantidad que usted nos debía.

Comentarios/Otro: \_\_\_\_\_

Atentamente,  
Director,  
Food Stamp Fiscal Program

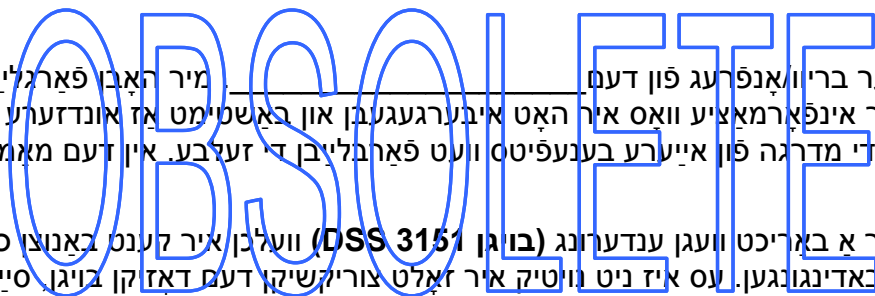


Date: \_\_\_\_\_ דאַטע:

Case Name: \_\_\_\_\_ נאָמען פֿון ענין:

Case Number: \_\_\_\_\_ נומער פֿון ענין:

Address: \_\_\_\_\_ אַדרעס:



מיר האָבן באַקומען אייער בריוו/אָנפֿרעג פֿון דעם  
אין קאָמפּיוטער מיט דער אינפֿארמאַציע וואָס איר האָט איבערגעגעבן און באַשטימט אַז אונדזערע טעקעס און אייער  
אינפֿארמאַציע שטימען. די מדרגה פֿון אייערע בענעפיטס וועט פֿאַרבלײַבן די זעלבע. אין דעם מאַמענט דאַרף מען גאַרניט  
ענדערן אין אייער ענין.

מיר לעגן בײַ אַ בוּיגן פֿאַר אַ באַריכט וועגן ענדערונג (בוּיגן **DSS 3151**) וועלכן איר קענט באַנוצן כדי צו באַריכטן וועגן  
ענדערונגען אין אייערע באַדינגונגען. עס איז ניט נויטיק איר זאָלט צוריקשיקן דעם דאָזיקן בוּיגן. סײַדן עפעס בײַט זיך אין  
די באַדינגונגען פֿון אייער הויזגעזינד.

אויב איר ווילט וואָס פֿרעגן וועגן אייער ענין, רופֿט אָן אייער שפּײַז מאַרקעס צענטער אויף: \_\_\_\_\_  
(טעלעפֿאָן נומער)

We received your recent correspondence/inquiry on \_\_\_\_\_. We have checked our computer files against the information you provided and have determined that our files and your information are in agreement. Your benefit level remains the same. No changes in your case are necessary at this time.

We are enclosing a Change Report (**Form DSS 3151**), which you may use to report changes in your household circumstances. It is not necessary to return this form unless there has been a change in your household circumstances.

If you have a question regarding your case you can call your Food Stamp Center at \_\_\_\_\_.  
(telephone number)

Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Caseload: \_\_\_\_\_  
Unit Name: \_\_\_\_\_  
Worker Name: \_\_\_\_\_  
Worker Telephone: \_\_\_\_\_  
General Telephone  
for Questions: \_\_\_\_\_  
FH&C Telephone: \_\_\_\_\_

### Notification of Work Requirement and Right to Contest (Supplemental Nutrition Assistance Program [SNAP] Participants)

**NOTE:** Beginning August 29, 2012, any reference to the Food Stamp Program shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

**The Agency has determined that you are required, or must continue, to participate in work activities as of the date indicated above.**

**A. You are required to participate in work activities unless you are exempt from the SNAP work requirements.**

**Exemptions from the SNAP work requirements apply to individuals who are:**

- Younger than 16 years of age or 60 years or older.
- Medically verified as being physically or mentally unable to work.
- A person 16 or 17 years of age who is not the head of household or who is attending school or an employment training program on at least a half-time basis.
- A parent, guardian or any adult responsible for the care of a child under the age of six (6) years.
- A parent or other household member needed in the home to care for an incapacitated person.
- A student enrolled at least half-time in any recognized school, training program, or institution of higher education, provided you have met the student eligibility criteria for SNAP participants.
- A refugee participating at least half-time in a program approved or funded by the Federal Office of Refugee Resettlement.
- A recipient of, or applicant for, unemployment compensation who is required to register for work as part of the application process.
- A participant in a drug or alcohol treatment program who is deemed to be unable to work, or is otherwise engaged in a substance abuse treatment program to the extent that assignment of work activities is impractical.
- A person employed 30 hours per week or receiving weekly earnings equal to the Federal minimum wage multiplied by 30 hours.
- An applicant for Social Security Supplemental Income (SSI) and SNAP benefits under the joint processing provisions.
- A person who is already complying with Temporary Assistance to Needy Families (TANF) work rules.

**As a SNAP work-rules-required individual, you are subject to the Supplemental Nutrition Assistance Program Employment and Training (SNAP ET) work rules. You are also subject to the Able-Bodied Adults Without Dependents (ABAWD) SNAP eligibility requirements unless you are:**

- An individual under the age of 18.
- A person age 50 through 59 years.
- Unable to work in competitive employment for at least 80 hours per month due to a physical or mental limitation.
- An adult residing in a SNAP household containing a child who has not yet reached his/her 18th birthday, including a parent and any adult, regardless of responsibility.
- Pregnant, as documented by a physician, regardless of the month of pregnancy.

**You have been found to have work limitations on the type of work you can do.**

**How to Request a Reasonable Accommodation**

If you have a physical, mental health or learning problem that makes it difficult for you to:

- complete HRA forms,
- travel to your new center, or
- meet other HRA requirements,

you have a right to ask HRA for help. This help is called a reasonable accommodation. If you need help, you can call **(718) 784-2922**. If you asked for help and you think you did not get the help you needed, you can file a complaint. To file a complaint, you can write to: ADA Compliance Officer, Office of Legal Affairs, **180 Water Street, 16th Floor, NY 10038** or fax your complaint to **(212) 331-5023**. If it is difficult for you to submit a complaint in writing, you may call **(212) 331-4640** for assistance.

- You will receive a separate notice explaining your limitations; and
- We will consider your work limitations when making your work assignment.

#### **B. Duties of a Person Required to Work**

You are expected to meet one (1) or more of the requirements listed below as assigned by this Agency. The purpose of these requirements is to assist you in finding and keeping a job so that you will no longer be in need of SNAP benefits. The legal basis for these requirements may be found in Section 18 NYCRR 385.3.

- You must accept referral to, and take part in, the Work Experience Program (WEP) when appropriate.
- You must accept referral to, or offer of, any employment in which you are able to engage.
- You must accept referral to, or enrollment in, an appropriate educational, vocational, job search or other employment-related training program, if necessary to improve your ability to secure employment.
- You must participate in the development of a child care plan when necessary.
- You must notify this Agency if your participation in any employment activity changes.

**If you without good cause do not comply with the requirements assigned to you, you may be disqualified from receiving SNAP benefits for a period of up to six (6) months, and until you are willing to comply.**

#### **C. How to Contest an Employability Determination/Your Right to a Conference/Fair Hearing**

If you have any questions about the determination that you are required to participate in work activities, you may have a conference to review this action. You may request a conference at the Center where you were called in for your employability assessment. The right to a conference is separate from the right to a Fair Hearing, and does not affect your right to a Fair Hearing, which is described on page 3 of this form.

**D. How to Contest a Work Assignment Based on Medical Limitations**

If you think that your work assignment is inconsistent with your medical limitations, you must still report to the work assignment and learn what the assignment is. If you still believe that the work assignment is medically inappropriate, you should utilize the available mechanisms to try to work out any disagreements, including consulting with your Supervisor at the work site and advising him/her of your concerns. If your Supervisor is unable to resolve the matter to your satisfaction, then you have the right to a conference. You may request a conference at the Center where you were called in for your employability assessment. If you are still dissatisfied, you are entitled to request a Fair Hearing. Please see the instructions on page 3 on how to schedule a Fair Hearing.

You may refuse to perform the work, without loss of benefits, while pursuing your grievance through each stage of the process, from complaining to your Supervisor to obtaining a Fair Hearing decision. During the time it takes for the Fair Hearing on your work assignment to be decided, you will continue to receive your SNAP benefits unchanged, even if you refuse to perform the work.

**PARTICIPANT'S STATEMENT:**

**I have read the above requirements and notices and I have reviewed them with my Worker.**

---

Participant's Signature/Date

JOS/Worker/Date

**OBSOLETE**

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

## Conference and Fair Hearing Information

### CONFERENCE

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

### STATE FAIR HEARING

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

- (1) **TELEPHONE:** Call **(800) 342-3334**. (Please have this notice in hand when you call.)
- (2) **WRITE:** Send a copy of the entire notice, with the "Fair Hearing Request" section completed, to:  
Office of Administrative Hearings  
New York State Office of Temporary and Disability Assistance  
**P.O. Box 1930, Albany, NY 12201**  
(Please keep a copy for yourself.)
- (3) **FAX:** Fax a copy of the entire notice, with the "Fair Hearing Request" section completed, to: **(518) 473-6735**.
- (4) **IN PERSON:** Bring a copy of the entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at:  
**14 Boerum Place, Brooklyn, NY 11201**.
- (5) **ONLINE:** Complete an online request form at: <http://www.otda.state.ny.us/oa/for ms.asp>

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

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

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

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

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

**FAIR HEARING REQUEST**

**Continuing Your Benefits:** If our decision affects your benefits and you ask for a Fair Hearing within ten (10) days of the date of this notice, we will restore your benefits to the level that they were at before this notice, until a Fair Hearing decision is issued. However, in no event will SNAP benefits be continued if you failed to recertify the SNAP case. In addition, SNAP benefits cannot be continued beyond the last date of the SNAP certification period (See 18 NYCRR § 358-3.6). If you lose the Fair Hearing, you will have to pay back any benefits you received, but should not have received, 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:

If you lose the Fair Hearing, you will have to pay back any benefits you received, but should not have received, 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 benefits the same until the Fair Hearing decision is issued.**

**Deadline:** If you want the State to review our decision, you must ask for a Fair Hearing within ninety (90) days from the date of the notice for SNAP issues.

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

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

OBSOLETE

Print Name: \_\_\_\_\_ Case Number: \_\_\_\_\_  
Name M.I. Last Name

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Date:

Fecha: \_\_\_\_\_

Case Name:

Nombre del Caso: \_\_\_\_\_

Case Number:

Número del Caso: \_\_\_\_\_

SNAP Center:

Centro de SNAP: \_\_\_\_\_

Address:

Dirección: \_\_\_\_\_

## Notice of Appointment for Recertification Interview

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

The New York State Department of Labor has informed us that you are currently employed. Your SNAP case record does not reflect this employment or does not reflect the full amount of earnings from this employment.

It is important that we discuss this matter with you. Please report to this office by: \_\_\_\_\_

When you report, bring this letter and your four (4) most recent paystubs. If the amount you earn is not always the same, bring your eight (8) most recent paystubs. If you are no longer employed please bring with you a letter from the employer verifying that you are no longer employed and the date and amount of your last pay and your Unemployment Insurance records.

At the interview we will redetermine your eligibility to continue to receive SNAP benefits. In addition to the employment information requested above, also bring the documents listed on the enclosed Notice of Documentation Received/Required (**Form W-120D**).

If you have any questions please call: \_\_\_\_\_

If you do not report for this interview by the date above your benefits will expire and you will not receive SNAP benefits beginning: \_\_\_\_\_

**OBSELETE**

## Aviso de Cita para Entrevista de Recertificación

**NOTA:** A partir del 29 de agosto, toda referencia al Programa de Cupones para Alimentos en este aviso se denominará el Programa de Asistencia de Nutrición Suplementaria (SNAP), y toda referencia a Cupones para Alimentos se denominará beneficios de SNAP.

El Departamento de Trabajo del Estado de Nueva York nos ha informado que usted está trabajando actualmente. Su expediente de SNAP no refleja éste empleo o no refleja la cantidad total de su ingreso por empleo.

Es importante que discutamos este asunto con usted. Favor de presentarse a ésta oficina para el: \_\_\_\_\_.

Cuando usted se presente, traiga esta carta y cuatro (4) talonarios de pago más recientes. Si la cantidad que usted gana no es siempre la misma, traiga sus ocho (8) talonarios más recientes. Si ya no está trabajando, favor de traer una carta del empleador que verifica que usted ya no está trabajando y la fecha y la cantidad de su último pago y sus expedientes de su Seguro por Desempleo.

En la entrevista, determinaremos su elegibilidad para continuar recibiendo beneficios de SNAP. Además de la información antedicha, traiga los documentos listados en el Aviso de Documentación Recibida/Requerida (Formulario **W-120D**) adjunto.

Si tiene cualquier pregunta, favor de llamar a: \_\_\_\_\_.

Si no se presenta a esta entrevista para la fecha indicada arriba, sus beneficios se vencerán y no recibirá beneficios de SNAP a partir del: \_\_\_\_\_.

### Notice of Requirement to Provide Documentation of Earned Income at Recertification Interview

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

Dear Participant:

We have been informed through a computer match using your Social Security number that you have received earned income from the employer(s) listed below:

Name of Employer: \_\_\_\_\_  
Amount of Earnings: \_\_\_\_\_ Period: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_  
Amount of Earnings: \_\_\_\_\_ Period: \_\_\_\_\_

**OBsolete**

Your SNAP record does not reflect this income or does not reflect the full amount of this income.

We will ask you to verify your income from employment at the time of your recertification interview. If you are still employed, please bring in paystubs for the four (4) most recent weeks. If the amount you earn is not always the same, please bring in paystubs for the eight (8) most recent weeks. If you are no longer employed, please bring in a letter from the employer stating that you are no longer employed, and bring your unemployment insurance records.

**IMPORTANT: We will notify you of the time and place of your recertification interview in a separate letter.**

Please bring this letter with you when you report for your recertification interview.

(Vea al Dorso)

### **Nota del Requisito para Proveer Documentación de Ingreso Salarial en la Entrevista de Recertificación**

**NOTA:** A partir del 29 de agosto, toda referencia al Programa de Cupones para Alimentos en este aviso se denominará el Programa de Asistencia de Nutrición Suplementaria (SNAP), y toda referencia a Cupones para Alimentos se denominará beneficios de SNAP.

Estimado/a Participante:

Hemos sido informados mediante un cotejo informático de su número de Seguro Social que usted ha recibido ingreso salarial del/ de los empleador(es) listados abajo:

Nombre del empleador: \_\_\_\_\_

Cantidad de ingreso: \_\_\_\_\_ Período: \_\_\_\_\_

Nombre del empleador: \_\_\_\_\_

Cantidad de ingreso: \_\_\_\_\_ Período: \_\_\_\_\_

Su expediente de SNAP no refleja este ingreso o no refleja la cantidad total de este ingreso.

Nosotros le pediremos que verifique su ingreso salarial actual en su entrevista de recertificación. Si usted está aún empleado, favor de traer los cuatro (4) talones de paga más recientes. Si la cantidad que gana no es siempre la misma, favor de traer los ocho (8) talones de paga más recientes. Si usted ya no está empleado, favor de traer una carta del empleador que afirme que usted ya no está empleado, y traiga su expediente de seguro de desempleo.

**IMPORTANTE: Nosotros le notificaremos de la hora y del lugar de su entrevista de recertificación por una carta separada.**

Favor de traer esta carta consigo cuando usted se presente a la entrevista de recertificación.

(See reverse)

Date: \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

### Notice of Requirement to Resolve Discrepancy at Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Recertification Interview

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

We have received information through a computer match that is not the same as the information in your SNAP record as indicated below:

- You have been receiving SNAP benefits under case number \_\_\_\_\_ at Center location \_\_\_\_\_.
- You were married on \_\_\_\_\_.
- Death of \_\_\_\_\_ on \_\_\_\_\_.
- Placement of \_\_\_\_\_ on \_\_\_\_\_ by (agency) \_\_\_\_\_.
- The Social Security Administration has informed us that the Social Security number we have recorded for \_\_\_\_\_ is incorrect.
- Other (specify): \_\_\_\_\_

We will ask you to discuss the above matter at your recertification interview. Please bring in any correspondence or documentation you have relating to this matter.

**IMPORTANT: We will notify you of the time and place of your recertification interview in a separate letter.**

Please bring this letter with you when you report for your recertification interview.

Date: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Case Number: \_\_\_\_\_

### Notice of Requirement to Provide Documentation of Unearned Income at Recertification Interview

**NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits.

We have been informed through a computer match using your Social Security number that you have received unearned income from the source(s) listed below:

Source of Income:	_____
Amount of Income:	_____
Source of Income:	_____
Amount of Income:	_____

Period: \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

Period: \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

**OBSOLETE**

Your Supplemental Nutrition Assistance Program (SNAP) case file does not reflect this income or does not reflect the full amount of this income.

We will ask you to verify your income at the time of your recertification interview. Please bring in a current award letter, check (or copy of it), or other correspondence which indicates the source of the income, the amount of the income, and the period income was/is received. Please also bring in verification of any other income received by you or any other member of your household.

**IMPORTANT: We will notify you of the time and place of your recertification interview in a separate letter.**

Please bring this letter with you when you report for your recertification interview.



*The City of New York*  
**Human Resources Administration  
Family Independence Administration  
Food Stamp Program**

Date
Name
Case Number
Address
Social Security Number

**OBsolete**

**Abstract of Section 143 of the N.Y. State Social Services Law**  
Employers are required to furnish to the Department of Social Services information concerning wages, salaries, earnings or other income of any applicant for or recipient of assistance.

Dear Sir or Madam:

According to information we have received, the person named above is/was in your employ during the year(s) \_\_\_\_\_  
in the position of \_\_\_\_\_.

Please complete the reverse and return this letter to us in the enclosed self-addressed, stamped envelope.

If the above named person is no longer employed by you, please provide us with the following information:

Date Last Employed: \_\_\_\_\_

Last Known Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

New Employer and Address (if known): \_\_\_\_\_

Signature/Title

Date

Very truly yours,

Thank you for your cooperation.

Eligibility Specialist

## Employment Earnings Questionnaire

Date employment began: \_\_\_\_\_

Date employment ended: \_\_\_\_\_

Please Enter the Gross Earnings and Hours Worked for the Last two Months:

Pay Period	Pay Date	Gross Pay	No. of Hours Worked	Pay Period	Pay Date	Gross Pay	No. of Hours Worked
Month				Month			

Name and Address of Union

BOSTON

Number of Exemptions: \_\_\_\_\_ Married  Single  Give there any tips? Yes  No

Amount of tips per week \$ \_\_\_\_\_

Does this employee regularly work overtime? Yes  No  Indicate days \_\_\_\_\_ Hours \_\_\_\_\_ per week

Is this employee employed elsewhere either full or part time? Yes  No

If yes, what is the name and address of other employer: \_\_\_\_\_

Date: \_\_\_\_\_

Case Number: \_\_\_\_\_

Case Name: \_\_\_\_\_

Job Center: \_\_\_\_\_

**Benefit Letter**

**OBsolete**

The above-named client is eligible to receive a monthly rent allowance above the regular maximum allowance available to Cash Assistance clients. We can provide this rent grant after receiving a lease or letter that verifies that the client lives at the address and pays rent in the amount stated.

\_\_\_\_\_  
Worker

\_\_\_\_\_  
Date





Date:	
Case Name:	
Case Type/Case Number:	Caseload:
Center, Division, or Borough Office:	
Location Address:	
Worker's Name (block print):	
Worker's Telephone Number: ( )	

**Request for Marriage or Divorce Verification from Agencies Outside New York City**  
(PRINT ALL INFORMATION)

**Marriage**       **Divorce, Annulment, or Legal Separation**

To complete an official study of the family identified, we require  verification or a  photocopy of certificate of the vital statistics indicated above. Please return this form with the verification recorded in the space at the bottom (or photocopy of certificate, if requested) in the enclosed business reply envelope.

**Marriage or Divorce Record (BLOCK PRINT ALL INFORMATION)**

Name of Man	Last	(other surnames known by)			First	Middle
Name of Woman	Last	(Maiden other surnames known by)			First	Middle
Date and place of marriage or divorce	Month	Day	Year	City	County	State
Address at time of marriage				Birthplace State and Country	Birth Date Mo. Day Year	Previous Marital Status
Man						
Woman						

**Additional Facts for Divorce Record (BLOCK PRINT ALL INFORMATION)**

Present Address				Former address (as in court records)		
Man						
Woman						
Type of Final Decree	<input type="checkbox"/> Divorce	<input type="checkbox"/> Annulment	<input type="checkbox"/> Legal Separation	Court of Record	In favor of <input type="checkbox"/> Man <input type="checkbox"/> Woman	
Custody of children awarded to	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other	If "Other", name and relationship		
Support ordered in decree	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> If "Yes" Amount \$	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	

**Report of Searching Agency**

Verified	Not Found	Corrections or Additions Noted (Use reverse side if necessary)	
Certificate No. _____	<input type="checkbox"/>		
Date Issued _____			
Signature	Title	Date	