Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING
James K. Whelan, Executive Deputy Commissioner

Adam Waitzman, Assistant Deputy Commissioner
Office of Procedures

POLICY BULLETIN #19-34-ELI

HRA/FAF SUMMER CAMP PILOT PROGRAM 2019

Date: June 26, 2019	**Subtopic(s):** Eligibility

The purpose of this policy bulletin is to inform Job Center Staff about a new Human Resources Administration (HRA) / Family Independence Administration (FIA) Summer Camp 2019 pilot project, developed in collaboration with the Fresh Air Fund (FAF). This policy bulletin is informational for all other staff.

The HRA/FAF Summer Camp 2019 pilot project is to provide children that are receiving Cash Assistance (CA), ages 10 through 13, the opportunity to participate in a HRA/FAF sleepaway camp or a Host Family program in the summer of 2019. It also offers:

- Enhanced FAF application services and support;
- Post-summer camp and post-Host Family celebration event(s); and
- A subsequent non-summer weekend at an FAF campsite following the summer camp or Host Family experience.

This pilot program is designed to connect eligible HRA Cash Assistance applicants/participants to a sleepaway summer camp experience and maintain interest in nature and the outdoors beyond the summer. HRA expects the HRA/FAF pilot program participants to reconnect to FAF and other available summer camp programs the following year.

Families with children ages 10 through 13 must first apply to FAF, and be accepted by FAF, in order to qualify for a “Camp Fees” grant from this HRA/FAF pilot program. The amount of the Camp Fees grant will not exceed $400 per child per year, and weekly amount of the grant per child will not exceed $200. As long as the child is receiving ongoing CA and has already been accepted by FAF, the payment to FAF can be made for the child.

Note: Camp fees is not a supportive service, even if the parent is not engaged in any work activity, the child can still be eligible for this supplemental grant.

The HRA/FAF pilot program is very limited with only 200 slots available. The Department of Homeless Services (DHS) along with HRA/FIA will do the outreach to the targeted population providing them with the 2019 HRA/FAF Flyer and the 2019 HRA/FAF General Information Packet. If the child's household is interested in applying for the grant, they must submit the 2019 Child Application HRA/FAF Pilot Program (completed, signed, dated and stamped by the child's Medical Doctor) to the Fresh Air Fund, Inc. at 633 Third Avenue, 14th Floor, New York, NY 10017. Slots for the program are filled on a first come, first served basis – after the application is determined complete.

See **Attachment A and Attachment B**

See **Attachment C**

If FAF approves the child to participate in the HRA/FAF pilot program, they will send the HRA/FAF Pilot Program Acceptance Letter with the Instructions for Completing and Submitting the HRA Form **W-137A** for HRA/FAF Summer Camp Program to the child's household. The child's household need to:

See **Attachment D**

- Fill out the Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137A**) indicating in Section II: Additional Allowances that they are requesting "Camp Fees" payable to "Fresh Air Fund" in the amount of $400 for the child that was approved by FAF (put the child's name), sign and date the form; and
- Email the completed **W-137A** with the HRA/FAF Pilot Program Acceptance Letter to SummerCamp@hra.nyc.gov.

See **Attachment E**

Note: This special submission process for the **W-137A** form is limited to the HRA/FAF Pilot program only.

Individuals requiring assistance in emailing the HRA/FAF Pilot Program Acceptance Letter and the **W-137A** form to SummerCamp@hra.nyc.gov should request assistance from FAF in submitting this document to HRA's Division of Job Support Services.

The JOS/Worker will:

See PD #14-14-OPE

- Process the Camp Fees request in accordance with the existing procedure for processing additional allowance requests;

- If the request is approved, issue a payment through the Paperless Alternate Module (PAM) with issuance code **G4** (Camp Fees) direct vendor to the "Fresh Air Fund, Inc." 633 Third Avenue, 14th Floor, New York, NY 10017.

Note: To be eligible for the "Camp Fees", the child must be active on the CA case, and the **W-137A** with the HRA/FAF Pilot Program Acceptance Letter must be submitted to SummerCamp@hra.nyc.gov.

- Complete the Paperless Office System (POS) Activity and send the case to the AJOSI for approval.

The AJOSI will approve the case and print the Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137B**) form. The **W-137B** will be sent to the child's household informing them that the $400 payment was made to FAF.

Effective Immediately

References:
NY Social Services Law 131-a(5)(d)
18 NYCRR 352.7(i)
TASB Chapter 16 Section G

Related Item:
PD #14-14-OPE

Attachments:

💻 Please use Print on Demand to obtain copies of forms.

Attachment A	2019 HRA/FAF Flyer
Attachment B	2019 HRA/FAF General Information Packet
Attachment C	2019 Child Application – HRA/FAF Pilot Program
Attachment D	HRA/FAF Pilot Program Acceptance Letter
Attachment E	Instructions for Completing and Submitting the HRA Form **W-137A** for HRA/FAF Summer Camp Program
W-137A	Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Rev. 4/27/17)

W-137A (S)	Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 4/27/17)
W-137B	Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Rev. 4/28/17)
W-137B (S)	Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 4/28/17)

Attachment A

ARE YOU READY FOR YOUR SUMMER ADVENTURE?

A FREE 8-14 DAY SLEEPAWAY SUMMER EXPERIENCE WITH A HOST FAMILY OR AT CAMP IN PARTNERSHIP WITH THE HUMAN RESOURCES ADMINISTRATION!

WHO CAN APPLY?
NYC CHILDREN AGES 10-13 WHOSE FAMILIES RECEIVE CASH ASSISTANCE.

VISIT FRESHAIR.ORG OR CALL 1-800-367-0003
APPLICATIONS AVAILABLE AT CHILD.FRESHAIR.ORG

All participants must meet The Fresh Air Fund's income eligibility guidelines to participate.

NYC Department of Social Services
Human Resources Administration
Department of Homeless Services

the Fresh Air fund
because a summer can last a lifetime

Attachment B

the *Fresh Air* fund

2019 Child Application

Thank you for applying! Spots for our **summer sleepaway programs** are filled when an application is determined complete. You can complete an online application at **child.freshair.org**. Please call **1-800-367-0003** if you have questions or need help completing the application. We are here to help!

Eligibility Criteria

Age
Unless noted, participant must be the age listed by 08/06/19.

Friendly Towns

NEW Applicants

7-12

Year old girls & boys

Returning children

(13-18 years old) can reapply

14+ must be reinvited by a previous host family or one from the same area

Camp

8-12 year old girls

8-15 year old boys

Career Awareness Program (CAP)/Camp Mariah (6th graders)

11-12 years old (by 06/27/19)

Income

Families are eligible if:

- Family receives Public Assistance (TANF/SNAP/Medicaid/ Section 8 Voucher).
- Total household income is no more than $20,000 above the USDA income guidelines.
- Child is currently in foster care.

$

Address

Children must live in and go to school in one of NYC's 5 boroughs.

Medical Form

Our 2 paged medical form must be **signed**, **dated**, and **stamped** by the doctor.

Friendly Towns Applicants:
The most recent physical exam must have happened **on or after 01/01/18**

Camp Applicants:
The most recent physical exam must have happened **on or after 06/01/18**

*DOE/DOH medical form is only accepted for Friendly Towns applicants

the *Fresh Air* fund

Attachment B

Other Information

Securing your spot

We expect to receive over 10,000 applications for Summer 2019. Spots are filled on a **first come, first served** basis - after the application is determined complete.

Submitting an application does not guarantee placement.

Sometimes, additional or updated information may be needed in order to make an application decision.

If in foster care, ensure that the application is signed by the person legally authorized to make decisions for the child.

All children must be able to participate in the full trip and use transportation arranged by The Fresh Air Fund.

Submission Information

Submit your completed application and documents:

Online:	**child.freshair.org**
By email:	**apply@freshair.org**
By fax:	**212-681-0182**
In person/ by mail:	**The Fresh Air Fund** **633 Third Avenue, 14th Fl** **New York, NY 10017** **Attn: Community Outreach** Hours: 9am - 6pm; M-F
By Community Partners:	**www.FreshAir.org/find-an-agency** (to find an agency near you)

Please call **1-800-367-0003** if you have questions or need help completing the application. We are here to help!

Your child's summer placement is not confirmed until you hear from us.

Keep an eye out- Confirmation will be communicated by phone, text, email and/or mailed letter.

Call us to track your application.
DO NOT wait to hear from us.

Attachment B

Application Checklist

Please review this application checklist. The application should be submitted by **04/30/19**. If you have questions, please contact the Community Outreach team at **1-800-367-0003.**

Friendly Towns

- ☐ Page 1: Child & Family Information
- ☐ Page 2: Session Preference
- ☐ Page 3: Health Information
  Copy of Health Insurance Card(s) (front & back)
- ☐ Page 4 : Additional Child & Family Information
- ☐ Page 5: Food Service Form (new applicants)
- ☐ Page 6 & 7: Parental Consent & Release Form
- ☐ Medical Form
  Dated on or after 01/01/18
  DOE/DOH Medical Form is Accepted
- ☐ FT 1: Activities & Interests
- ☐ Passport, for Canada trips only

Camp

- ☐ Page 1: Child & Family Information
- ☐ Page 2: Session Preference
- ☐ Page 3: Health Information
  Copy of Health Insurance Card(s) (front & back)
- ☐ Page 4 : Additional Child & Family Information
- ☐ Page 5: Food Service Form (all applicants)
- ☐ Page 6 & 7: Parental Consent & Release Form
- ☐ The Fresh Air Fund Medical Form
  Dated on or after 06/01/18
  All Applicants - Fresh Air Fund Form required
  (DOE/DOH Medical form is **NOT** accepted)
- ☐ Meningococcal Meningitis Vaccination Form
- ☐ Vision Van Form

Supplemental Documents (Required if applicable)

- ☐ Legal Guardianship Papers (Court-approved)
- ☐ Evaluation Form
  Dated after 01/02/19 & received by 04/30/19
- ☐ Special Dietery Plan
- ☐ Foster Care Information Page
- ☐ Treatment Plan(s)
  Allergies/Asthma/Diabetes/Seizure Disorder

Please call the Community Outreach Team periodically to track the progress of your child's application.
Do NOT submit this page with your child's application.

Attachment B

Attachment B

Summer Food Service Program: Information for Parents
Summer 2019

This insert relates to Page 5 of the Child Application. Read it carefully and keep it for your records.

The Fresh Air Fund participates in the Summer Food Service Program. Meals are provided to all children free of charge. Federal funds help cover the costs of meals provided to all eligible children. (For The Fund to be eligible to receive reimbursement for meals at a camp, children must meet the income guidelines for reduced price meals in the National School Lunch Program). Children in households that receive food stamps or benefits under the Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance to Needy Families (TANF) are automatically eligible for the program. The following 2018-2019 income eligibility standards will be used for determining eligibility for reimbursement:

Household Size	**Income Eligibility Guidelines**		
	Yearly	*Monthly*	*Weekly*
1	$22,459	$1,872	$ 432
2	$30,451	$2,538	$ 586
3	$38,443	$3,204	$ 740
4	$46,435	$3,870	$ 893
5	$54,427	$4,536	$1,047
6	$62,419	$5,202	$1,201
7	$70,411	$5,868	$1,355
8	$78,403	$6,534	$1,508
For each additional family member, add:	*$ 7,992*	*$ 666*	*$ 154*

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

Meals will be provided at site(s) and times as follows:

- Camps Anita Bliss Coler (ABC), Hayden Marks Memorial, Hidden Valley, and Tommy will serve Breakfast at 8:00am, Lunch at 12:30pm, and Dinner at 6:00pm on the following dates:

  Thursday, June 27, 2019 - Friday, July 5, 2019
  Monday, July 8, 2019 - Friday, July 19, 2019
  Monday, July 22, 2019 - Friday, August 2, 2019
  Monday, August 5, 2019 - Friday, August 16, 2019

- Camp Mariah will serve Breakfast at 8:00am, Lunch at 12:30pm; and Dinner at 6:00pm on the following dates:

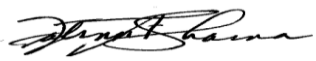
  Thursday, June 27, 2019 - Friday, July 19, 2019
  Friday, July 26, 2019 - Friday, August 16, 2019

Please fill out the enclosed “Summer Food Service Program Form” (Page 5) and include it in your application.

This institution is an equal opportunity provider. Persons interested in receiving more information should contact:
The Fresh Air Fund, 633 Third Avenue, 14th floor, New York, NY 10017 Telephone: 212-897-8900

To file a complaint of discrimination, complete the USDA Program Discrimination Complaint Form (AD-3027) found online at: **https://www.ascr.usda.gov/complaint_filing_cust.html**, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:
1) mail: USDA, Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410.
2) fax: (202) 690-7442
3) email: program.intake@usda.gov



Signature of Authorized Representative

11/01/2018

Date

Attachment B

2019 Income Guidelines for Families Participating in Fresh Air Fund Programs

The Fresh Air Fund's income guidelines are based on the United States Department of Agriculture's guidelines for reduced price meals. We accept applications from families earning up to $20,000 per year over the published USDA income guidelines. These guidelines are released annually, and are printed on the other side of this page. The size of a family's household should be calculated including children.

We work hard to serve as many New York City children as possible every year, but since spaces in host families and at camp are limited we can only accept applications for those who meet these guidelines.

Families that earn more than $20,000 per year above the USDA income guidelines are not eligible for any Fresh Air Fund programs. Alternative summer programs can be found by contacting organizations such as the American Camp Association, available at *www.acacamps.org* or *1-800-777-CAMP*.

Attachment B

Meningococcal Meningitis: Information for Camp Applicants Only

This insert is referred to in the Child Application.
Please read it carefully and keep it for your own records.

November 1, 2018

New York State Public Health Law (NYS PHL) §2167 and Subpart 7-2 of the State Sanitary Code requires overnight children's camps to distribute this information about meningococcal disease (meningitis) and its vaccination to the parents and guardians of all campers who attend camp for 7 or more consecutive nights.

The Fresh Air Fund is required to keep a record of the following information for each camper:

- A response to receipt of meningococcal disease and vaccine information signed by the camper's parent or guardian; AND EITHER
- A record of meningococcal meningitis immunization OR
- An acknowledgment of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,000 – 1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who live, another 11%-19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16-21 years old. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of the meningococcal vaccine is important for people at highest risk.

There are two kinds of meningococcal vaccines in the U.S.:

- Meningococcal conjugate vaccine (**MCV4**) is the preferred vaccine for people 55 years of age and younger. For example, 2 MCV4 vaccines are Menactra™ and Menveo™.

  The Centers for Disease Control and Prevention recommend two doses of MCV4 for all adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

  If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

- Meningococcal polysaccharide vaccine (**MPSV4**) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55. The trade name of MPSV4 is Menomune.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

Information about the availability and cost of the vaccine can be obtained from your health care provider. In addition, the New York State Department of Health has informed The Fresh Air Fund that the vaccine is covered once for each recipient in fee-for-service Medicaid and/or each enrollee in a Medicaid managed care plan. The Fresh Air Fund does not offer meningococcal immunization services.

Please complete the Meningococcal Vaccination Response Form and return it along with your application and medical forms to:

The Fresh Air Fund
633 Third Avenue, 14th Floor
New York, NY 10017

To learn more about meningitis and the vaccine, please consult your child's physician or your student health service. You can also find information about the disease on the websites of the:

- New York State Department of Health: www.health.state.ny.us;
- The Centers for Disease Control and Prevention: www.cdc.gov/vaccines/vpd-vac/mening/default.htm, and
- The American College Health Association: www.acha.org.

Attachment B

Notice of Privacy Practices

Luxottica Retail including:
- LensCrafters
- EYEXAM of California

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information.

Please Review It Carefully

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next visit or it can be viewed in the store or on our Web site.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a medical or optical dispensary record that is the physical property of Luxottica Retail.

How We May Use or Disclose Your Health Information

For Treatment

We may use or disclose your health information to an optometrist, ophthalmologist, optician or other healthcare providers providing treatment to you for:
- the provision, coordination, or management of health care and related services by health care providers;
- consultation between health care providers relating to a patient/customer;
- the referral of a patient for health care from one health care provider to another; or
- appointment reminders and recall information.

For Payment

We may use and disclose your health information to others for purposes of processing and receiving payment for treatment and services provided to you. This may include:
- billing and collection activities and related data processing;
- actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
- medical necessity and appropriateness of care reviews, utilization review activities; and
- disclosure to consumer reporting agencies of information relating to collection of payments.

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of staff to:
- evaluate the performance of our associates;
- assess the quality of service, product and care in your case and similar cases;
- learn how to improve our facilities and services;
- conduct training programs or credentialing activities; and
- determine how to continually improve the quality and effectiveness of the products, service and care we provide.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall notices (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

Fundraising

We may use your information to contact you to raise funds or materials for the LensCrafters Foundation including its **Give The Gift Of Sight** program.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location or your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, photos, or other similar forms of health information.

Required by law

We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:
- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence;
- to assist law enforcement officials in their law enforcement duties; or
- to assist public health officials avert a serious threat to the health or safety of you or any other person.

Decedents

Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Attachment B

Organ/Tissue Donation
Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research
We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Government Functions
Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation
Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Marketing Health Products or Services
We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

Your Authorization
In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Health Information Rights

Access
You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may be asked to make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice setting forth the specific information to which you desire access. If you request an alternative format, provided that it is practicable for us to produce the information in such format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosures made prior to April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication
You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment
You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. You may obtain a form to request an amendment to your health information by using the contact information listed at the end of this Notice.

Electronic Notice
If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

If you have any questions or complaints, please contact:

Privacy Office
Luxottica Retail
4000 Luxottica Place
Mason, Ohio 45040
Phone: 513-765-4321
Email: privacyoffice@luxotticaretail.com

Thank you for entrusting Luxottica Retail with your eye care and eye wear needs.

LUXOTTICA RETAIL

Attachment C

PAGE 1 | The Fresh Air Fund: Child & Family Information | 2019 CHILD APPLICATION—HRA/FAF PILOT PROGRAM

Application Type: ☐ Repeat ☐ New

Program *(Select 1)*: ☐ Friendly Towns ☐ Summer Camp ☐ Camp Junior ☐ Career Awareness ☐ Unsure

Please do not cover barcode →

Child Information

Please **PRINT** clearly and use **INK** pen.

Cash Assistance #: _____

Shelter Name: _____

First Name: _____ **Last Name:** _____

Nickname: _____ **Gender:** ☐ Male ☐ Female ☐ Other:_____

Date of Birth: ___ (MONTH) – ___ (DAY) – 2 0 ___ ___ (YEAR)

Age: 10 11 12 13 **Other:** ____

Home Address: _____ **Apt #:** _____

City: _____ **Borough:** _____ **Zip:** _____

School Name: _____ **School Borough:** _____ **2018-2019 Grade:**_____

Type: ☐ Public ☐ Charter ☐ Parochial/Religious ☐ Independent/Private ☐ Other: _____

1. **Has your child ever spent the night away from home?** ☐ Yes ☐ No **If Yes, how many nights?** _____
2. **Child's T-shirt Size:** *(Pick one)* **Youth:** ☐ S ☐ M ☐ L **Adult:** ☐ S ☐ M ☐ L ☐ XL
3. **If applying for the first time, how did you hear about us?**
   ☐ Friend/Family ☐ Website ☐ School ☐ Ad ☐ Flyer ☐ Community Agency ☐ Other: _____

Household Information

Please **PRINT FIRST** then **LAST NAME**. Those listed below **must be authorized** to pick up the child.

Parent / Guardian 1: _____ ☐ **Currently living with child**

Cell (: _____ Other (: _____ Email:_____

* **Relationship to child:** ☐ Mother ☐ Father ☐ Other: _____

Parent / Guardian 2: _____ ☐ **Currently living with child**

Cell (: _____ Other (: _____ Email:_____

* **Relationship to child:** ☐ Mother ☐ Father ☐ Other: _____

* ***Please note*: *If you are the Legal Guardian, you must provide a copy of court–approved guardianship papers.***

Emergency Contacts

Please list information for **three adults** who we can contact if we are unable to reach you about this application or during your child's trip. All contacts **MUST BE 18 YEARS OR OLDER** and **MUST BE AUTHORIZED TO PICK UP YOUR CHILD**.

	Contact name *(**not** a parent or guardian listed above)*	**Relationship**	**18 or older?**	**Phone numbers** (e.g. cell, home, work)
1.			☐ **Yes** ☐ **No**	
2.			☐ **Yes** ☐ **No**	
3.			☐ **Yes** ☐ **No**	

OFFICIAL USE ONLY

Partnering Agency: DSS/HRA/DHS

Date Received by FAF: _____

Source: ☐ **Walk-in** ☐ **Mail** ☐ **Email** ☐ **Fax** ☐ **Agency Partner** ☐ **School Event** ☐ **Street Outreach** ☐ **Phone**

Attachment C

Must be Completed by Parent/Legal Guardian

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____
MONTH DAY YEAR

Please complete information for all programs of interest
We will try to accommodate your choices
Note: Placement is not guaranteed

Friendly Towns/Host Family Program (First time applicants: Boys & Girls 7—12)

My child is available to travel as follows:
(Check all that apply)

- ☐ Early July — June 27 - July 13
- ☐ Late July — July 15 - July 31
- ☐ Early August — August 1 - August 10
- ☐ Mid-Late August — August 12 - August 23

I am interested in my child visiting a family in the following area(s):
(Check all that apply)

- ☐ Connecticut
- ☐ Delaware
- ☐ Maine
- ☐ Maryland
- ☐ Massachusetts
- ☐ New Hampshire
- ☐ New Jersey
- ☐ New York
- ☐ North Carolina
- ☐ Pennsylvania
- ☐ Not Sure / No Preference
- ☐ Rhode Island
- ☐ Virginia
- ☐ Vermont
- ☐ West Virginia
- ☐ Ontario, Canada

Returning Participants Only:
Does your child want to return to their Summer 2018 host family if they are available?
☐ Yes ☐ No

If interested in child visiting a family in Canada:

Does child have a valid U.S. passport? ☐ Yes ☐ No

If yes, when does it expire? _____/_____/_____
****Include a copy of your child's passport****

Summer Camp (First time applicants: Boys & Girls 7—12)

Please indicate session preferences by putting 1-4 in the boxes.
1 = 1st Choice 4 = 4th Choice

- Session 1 ☐ June 28 - July 5 (9 days)
- Session 2 ☐ July 9 - July 19 (11 days)
- Session 3 ☐ July 22 - August 2 (12 days)
- Session 4 ☐ August 5 - August 16 (12 days)

Junior's Camp (Boys & Girls 9-13; must live in Bronx)

Please indicate session preferences by putting 1-4 in the boxes.
1 = 1st Choice 4 = 4th Choice

- Session 1 ☐ June 28 - July 5 (9 days)
- Session 2 ☐ July 9 - July 19 (11 days)
- Session 3 ☐ July 22 - August 2 (12 days)
- Session 4 ☐ August 5 - August 16 (12 days)

Career Awareness Program/Camp Mariah
(Boys & Girls must be 11-12 and in the 6th grade)

If applying for the first time, please indicate session preferences:
1 = 1st Choice 2 = 2nd Choice

- Session 1 ☐ June 27 - July 19 (23 days)
- Session 2 ☐ July 26 - August 16 (22 days)

Returning campers will attend the same session as Summer 2018

All Camp Applicants:

Once the Camp Program is full, please consider my child for the Friendly Towns Program

☐ Yes ☐ No

Please Note: All children must participate in the full trip and use The Fresh Air Fund arranged transportation. Sessions/trips are not allowed to start late or end early.

Attachment C

Must be Completed by Parent/Legal Guardian

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____
MONTH DAY YEAR

Services

1. Mark all SERVICE(S) your child receives:

- ☐ IEP (Individualized Education Plan)
- ☐ Counseling/ Therapy (in or out of school)
- ☐ 504 Accommodations. Please explain: _____
- ☐ Other: _____
- ☐ None

2. Mark all service PROVIDER(S) your child sees:

- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Social Worker
- ☐ Other: _____
- ☐ None

If you marked any of the above, call 1-800-367-0003 to get The Fresh Air Fund's Evaluation Form

Is your child in English Language Learner (ELL) classes in school? ☐ **Yes** ☐ **No**

If Yes, what native language(s)? _____

Health Insurance

A clear copy (front and back) of your child's health insurance card(s) is required

3. Check one of the following:

☐ **Child has private health insurance (e.g. through my employer or the open market)**
Does this policy include dental coverage? ☐ **Yes** ☐ **No**

☐ **Child has health insurance through NYS Medicaid**
If applicable, check provider and submit copy of insurance card with Medicaid card:

☐ **HealthFirst** ☐ **MetroPlus**
☐ **Fidelis** ☐ **Other:** _____

☐ **Child does not have health insurance**

☐ **Child is in foster care**

Other

4. Has/does your child:

		YES	NO
A.	Had a recent injury, illness or infectious disease?	☐	☐
B.	Had a chronic or recurring illness/condition?	☐	☐
C.	Have asthma?	☐	☐
D.	Ever been hospitalized?	☐	☐
E.	Ever had surgery?	☐	☐
F.	Had frequent headaches?	☐	☐
G.	Ever had a head injury?	☐	☐
H.	Ever been knocked unconscious?	☐	☐
I.	Ever had frequent ear infections?	☐	☐
J.	Ever been diagnosed with a heart murmur?	☐	☐
K.	Ever had seizures?	☐	☐
L.	Had skin problems (e.g. itching, acne, eczema)?	☐	☐
M.	Been treated for head lice in last six months?	☐	☐
N.	Ever had problems with diarrhea/constipation?	☐	☐
O.	Ever had an eating disorder?	☐	☐
P.	Wear glasses, contacts or protective eye wear?	☐	☐
Q.	If female, begun to menstruate?	☐	☐
	If not, does she know about the menstrual cycle?	☐	☐
R.	Know how to swim? (If yes, no explanation needed)	☐	☐
S.	Have a fear of being in the water?	☐	☐
T.	Have a fear of being around animals?	☐	☐
U.	Wet his/her bed?	☐	☐
	If yes, how often? _____		
	If yes, is it a medical issue?	☐	☐
V.	Have motion sickness?	☐	☐

Please explain all 'Yes' answers. Include the question number and the most recent occurrence.

_____

_____

Attachment C

Must be Completed by Parent/Legal Guardian

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____
MONTH DAY YEAR

Additional Health Information

1. **Does your child have any dietary restrictions (e.g. vegetarian, no pork, lactose intolerant, gluten-free)?**

   ☐ **Yes** ☐ **No** If Yes, please explain:_____

   These dietary restrictions are due to:

   ☐ Allergies/Medical Condition(s) ☐ Religious Beliefs ☐ Personal Preferences ☐ Other _____

2. **Does your child have any of the following?** *(check all that apply)*

   ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Seizure Disorder ☐ None

   If any are checked, please explain: _____

3. **Is your child currently taking any medication?**

   ☐ **Yes** ☐ **No** If Yes, please list: _____

Epi-Pen

1. **Has an epi-pen been prescribed for your child?** ☐ **Yes** ☐ **No** If yes, why? _____
2. **Date epi-pen was last used?** ___/_____/_____
3. **Does your child know how to inject him/herself?** ☐ **Yes** ☐ **No**

Please note: If an epi-pen is prescribed, it is required during Fresh Air Fund trip

Household Information

1. **Preferred language to communicate with The Fresh Air Fund:**

   ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Korean ☐ Other: _____

2. **Language(s) spoken at home:** *(check all that apply)*

   ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Korean

   ☐ French ☐ French Creole ☐ Arabic ☐ Bengali ☐ Other:_____

3. **Race/Ethnicity:** *(check all that apply)*

   ☐ African American/Black ☐ African ☐ American Indian/Alaskan Native ☐ Asian ☐ South Asian

   ☐ Hispanic/Latino ☐ White ☐ Other: _____ ☐ Prefer not to say

4. **Country/Countries of origin:** _____
5. **Household type:** ☐ Single parent/guardian ☐ Two parents/guardians ☐ Other: _____ ☐ Prefer not to say
6. **Total number of people in the household:** _____
7. **Do you receive public assistance?** ☐ **Yes** ☐ **No** If Yes, check all that apply

   ☐ TANF ☐ SNAP ☐ Section 8 ☐ Medicaid ☐ Other:_____

8. **Is your family currently homeless?** ☐ **Yes** ☐ **No** If Yes, where are you living?

   ☐ In a shelter ☐ With family/friends ☐ Other:_____ ☐ Prefer not to say

Attachment C

Must be completed by Parent/Legal Guardian

Please do not cover barcode →

PART 1.	PART 2.	
Enter Child's First & Last Names	**Enter Case #** if child receives SNAP/TANF/FDPIR. Then go to Part 4.	**Check If Child Is in Foster Care** Children in foster care are eligible for free/reduced-price meals regardless of household income. Then go to Part 4.
		☐

PART 3. Total Household Gross Income. If child does not receive SNAP/TANF/FDPIR and is not in foster care, please tell us how much you earn and how often it is received.

List all earnings from: work; welfare; child support; alimony; pensions; Social Security; retirement; SSI; VA benefits; or other income sources. Include frequency (e.g. yearly, monthly, bi-weekly, or weekly). Then go to Part 4.

Name(s)	Gross Income by Source								
Enter the name of each person living in your household ↓	Income from Work before Deductions		Income from Welfare, Child Support, or Alimony		Income from Social Security, Pension, Retirement, SSI, or VA Benefits		All Other Income		Check if NO Income
	$	Frequency	$	Frequency	$	Frequency	$	Frequency	
									☐
									☐
									☐
									☐
									☐
									☐
									☐

PART 4. Signature and Social Security Number (Parent/Guardian must sign). Then go to Part 5.

A parent/guardian living in the household must sign this form. The person signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See statement in the information packet.)

I certify that all information on this application is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify [check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____

Date: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - _____ ☐ I do not have a Social Security Number

Must be completed & signed

PART 5. ETHNICITY & RACIAL IDENTITY (Optional)

Mark one ethnic identity	Mark one or more racial identities
☐ Hispanic or Latino ☐ Non-Hispanic or Latino	☐ Asian ☐ Black of African American ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

DO NOT WRITE BELOW THIS PART. IT IS FOR OFFICIAL USE ONLY.

Total Income: _____ Per: ☐Week, ☐ Every 2 Weeks, ☐Twice A Month, ☐Month, ☐Year Household size:_____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: ☐ **Free** ☐ **Reduced** ☐ **Denied**

Reason: _____

Determining Official's Signature:_____ Date: _____

Confirming Official's Signature: _____ Date: _____

Verifying Official's Signature: _____ Date: _____

Annual Income Conversion:
Weekly x 52
Every 2 Weeks x 26
Twice A Month x 24
Monthly x 12

the Fresh Air fund
because a summer can last a lifetime™

Instructions for completing Page 5 of the Child Application

Income Eligibility Form for the Summer Food Service Program

If you need help completing the form, please contact us at 1-800-367-0003.

IF YOUR HOUSEHOLD GETS SNAP, TANF or FDPIR, FOLLOW THESE INSTRUCTIONS

Part 1: Enter child's first and last names

Part 2: Enter SNAP, TANF or FDPIR case number

Part 3: Skip

Part 4: Sign the form and provide all information

- ☐ Enter last four digits of Social Security Number or "0000"
- ☐ If you do not have a Social Security Number, check the box next to "I do not have a Social Security Number"

Part 5: Answer this question if you choose to

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS

Part 1: Enter child's first and last names

Part 2: Check the box indicating the child is in foster care

Part 3: Skip

Part 4: Sign the form and provide all information

- ☐ Enter last four digits of Social Security Number or "0000"
- ☐ If you do not have a Social Security Number, check the box next to "I do not have a Social Security Number"

Part 5: Answer this question if you choose to

ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS

Part 1: Enter child's first and last names

Part 2: Skip

Part 3: To report total household income

- ☐ **Column 1 – Name(s):** Enter first and last names of all household members
- ☐ **Column 2 – Gross Income by Source:** For each household member, enter the amount received in the "$" column under the source of income for that person. Then enter how often that amount is received in the "Frequency" column. (e.g. $25,000 Yearly)
  - For "*Income from Work*" be sure to enter the gross income, not the take-home pay - gross income is the amount earned before taxes and other deductions (see your pay stub or ask your employer)
    - If self-employed, enter income after expenses - this is for your business/farm/rental property
  - For "*Income from Welfare, Child Support, or Alimony*" enter the amount each person received
  - For "*Income from Social Security, Pension, Retirement, Supplemental Security Income, or Veteran's Benefits*" enter the amount each person got for such source(s)
  - For "*All Other Income*" enter Workers' Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and/or any other income
    - Do not include income from SNAP, FDPIR, WIC, Federal education benefits and foster payments received by the family from the placing agency
    - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income
  - If a household member does not have an income, check the box indicating 'no income'

Part 4: Sign the form and provide all information

- ☐ Enter last four digits of Social Security Number or "0000"
- ☐ If you do not have a Social Security Number, check the box next to "I do not have a Social Security Number"

Part 5: Answer this question if you choose to

Attachment C

Must be Signed by Parent/Legal Guardian

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____
MM DD YYYY

As the parent/guardian of the above-named child ("My Child"), I agree that My Child may participate in The Fresh Air Fund's (The Fund) summer sleepaway programs and associated activities ("Fresh Air Activities") in either Fishkill, NY or along the East Coast and Southern Canada, as more fully described in The Fund's promotional materials. I permit My Child to travel between The Fund's designated transportation hubs and the assigned program location by bus, train, automobile, plane, taxi, car service, subway, or any other means necessary. I understand that participating in Fresh Air Activities is wholly voluntary. Additionally, I permit My Child to participate in Fresh Air Activities including, but not limited to: camping, swimming, boating, rope and challenge courses, biking, hiking, and other activities described and shown in brochures and other marketing materials.

I understand that I may receive as much information from The Fund with respect to The Fresh Air Activities as I deem desirable and will have the opportunity to discuss the Fresh Air Activities with members of The Fund's staff and/or volunteers prior to My Child participating in The Fresh Air Activities. I understand that I am responsible for making my own independent assessment of the risks to My Child of participation in Fresh Air Activities, including the risks associated with travel, camping, swimming, boating, rope and challenge courses, biking, hiking and other activities included in Fresh Air Activities.

I am aware that travel and the activities included in Fresh Air Activities can be dangerous and can involve risks of serious injury and even death. I understand that, although Fund Agents (as defined below) will chaperone Fresh Air Activities, My Child will be unsupervised at times during participation. I agree that The Fund is not an insurer of the health or safety of My Child. I also agree that The Fund does not assume responsibility for spontaneous and unforeseen events that may occur during My Child's participation in Fresh Air Activities.

I am aware that The Fresh Air Fund conducts short surveys with youth participants to get feedback on things like what they liked or didn't like and to understand if the program helped their personal development. Your child's participation in these activities is voluntary. We do not anticipate that participation will result in distress on the part of your child. If you would like further information about our program evaluation work or if you do not want your child to participate in these activities, please contact The Fresh Air Fund at (212) 897-8900 or email us at: programevaluation@freshair.org prior to your child's program start date.

In consideration of The Fund permitting My Child to participate in Fresh Air Activities:

I, on behalf of My Child, myself, my spouse, my domestic partner and all other family members and the heirs, agents, executors, administrators, representatives and assigns of each of the foregoing and all persons claiming under them (collectively, the "Child Parties"), assume all risks involved in Fresh Air Activities. I agree that neither The Fund nor any of its former, current and future directors, officers, employees, volunteers, affiliates and agents (each of the foregoing, a "Fund Agent") (including each Fund Agent who participates in the planning, organization or implementation of The Fresh Air Fund Activity) shall have any responsibility for any injury to person or property, illness, loss of life or property, liability, damage, expense or other adverse event that may occur during Fresh Air Activities, other than as the direct consequence of any gross negligence or willful misconduct of The Fund or any Fund Agent.

I, on behalf of My Child and the other Child Parties, agree that neither The Fund nor any of its former, current and future directors, officers, employees, volunteers, affiliates and agents (each of the foregoing, a "Fund Agent") (including each Fund Agent who participates in the planning, organization or implementation of Fresh Air Fund Activity) shall have any responsibility for any injury to person or property, illness, loss of life or property, liability, damage, expense or other adverse event that may occur during Fresh Air Activities, other than as the direct consequence of any gross negligence or willful misconduct of The Fund or any Fund Agent. I understand that, as a result of my executing this release, I and the other Child Parties shall be forever barred from suing or otherwise asserting a claim, demand or cause of action against The Fund and The Fund Agents to the extent provided above.

I hereby represent and warrant to The Fund that I am authorized to sign this Consent and Release Form on behalf of Child Parties and to bind them hereby.

Signature: _____ Date: _____/_____/_____

Print Name: _____

Must be Signed by Parent/Legal Guardian

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____ (MONTH DAY YEAR) **Parent Signature:** _____

As the parent/guardian of the above-named child, my signature/electronic signature on Page 6 and on this page affirm that:

A) I give the following permissions to The Fresh Air Fund:

1. To use photos and/or videos of my child and his/her first name in public relations efforts, including, but not limited to print and electronic media and ads, and social media platforms. This permission extends to The Fresh Air Fund's cooperating organizations.
2. To contact third party providers (e.g. caseworkers, counselors, therapists, social workers, medical physicians, or referring agencies - community based organizations, schools, churches, and hospitals) as identified in the application or evaluation consent form, if a consultation is necessary to complete the application.
3. To receive information regarding my child from their service provider if s/he has an IEP and/or is receiving services (special education, supportive services, therapy, counseling, psychiatric/psychological services, etc.).
4. To discuss my child's health history with the medical provider indicated on the medical form submitted with the application.
5. To share my child's health form and medical information directly with a third-party program (e.g. camp) if the Host Family in the Friendly Towns Program sends my child to a third-party program during his/her trip.

B) Should my child require medical treatment during his/her participation, The Fresh Air Fund and its Agents have the following permissions:

6. To provide the Host Family with a copy of my child's health insurance card while s/he is in the Friendly Towns Program.
7. Full authority to take the actions deemed necessary to ensure my child's physical and mental health and safety, including: delivering routine and ensuring emergency health care; dispensing/administering medications; and seeking medical, dental, or vision treatment for my child, if necessary, while s/he is away.
8. To release any medical or other records necessary for treatment, referral, billing, or insurance purposes by The Fresh Air Fund to other medical personnel treating my child.
9. To obtain medical care and treatment as may be deemed necessary for the health and safety of my child by duly licensed physicians, nurses, or qualified medical personnel of any hospital, urgent care facility, or clinic.
10. To share my child's health record with duly licensed physicians, nurses, or qualified medical personnel of any hospital, urgent care facility, or clinic.
11. To share my child's health insurance information (medical and/or dental) with any provider of medical services to my child.
12. To use my child's health insurance as the primary coverage for any medical treatment s/he receives while participating in The Fresh Air Fund's program(s).
13. To receive billing and receipt information, and discharge papers once services are rendered by medical professional(s).

C) I acknowledge that:

14. I am responsible for my child's transportation to and from his/her program's departure and return site, and that s/he will only be released to an adult, aged 18 or older, named on Page 1 or 2 of this application. I acknowledge that only those participants who are 17 years of age or older may sign themselves out upon arrival at the return site with prior parental permission.
15. I have read, or have had explained to me, information about meningococcal meningitis disease and vaccination included in the application's information packet, and I confirm that I understand the risks of not having my child vaccinated.
16. My child may use sunscreen s/he has brought to Camp/Friendly Town or that Camp/Friendly Town has supplied, which is approved by the FDA for over-the-counter use to avoid overexposure to the sun. Sunscreen may be applied by camp staff or host volunteer if my child requests.
17. In addition to calls from The Fresh Air Fund's staff and volunteers, information may be sent by email, text or automated phone calls.
18. My child must comply with all program rules and standards including, but not limited to: house/cabin rules; cell phones, electronics and technology; and pool safety. His/her failure to do so may result in an early end to his/her summer experience. I understand that in the event of an early return, I will be required to pick my child up from The Fresh Air Fund's office and participate in an exit interview with my child and a Fresh Air Fund Social Worker.
19. My child's health insurance will be the primary coverage for any medical treatment s/he receives while participating in The Fresh Air Fund program, and that I may be responsible for fees for hospital, nursing, medical and surgical services that exceed the amounts covered by my child's health insurance.
20. Depending on the nature of the illness or condition, it may be necessary for my child to return home early from his/her summer experience for medical treatment.

Attachment C

FT 1 | The Fresh Air Fund: Activities & Interests | 2019 CHILD APPLICATION

Must be Completed by Parent/Legal Guardian

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____
MONTH DAY YEAR

Adjustments

Has your child been adjusting to any of the following changes in the last year?

☐ New school ☐ New brother/sister ☐ Loss of a close friend ☐ Divorce or separation of parents
☐ Death of: _____ ☐ Other changes: _____

My child prefers: ☐ Large Groups ☐ Small Groups ☐ No Preference

Swimming & Animals

Does your child know how to swim? ☐ **Yes** ☐ **No**

Does your child have a fear of being in the water? ☐ **Yes** ☐ **No** → If Yes, explain _____

_____

Is your child afraid of or uncomfortable around animals? ☐ **Yes** ☐ **No** → If Yes, explain _____

_____

Favorite Activities/Interests

What are your child's favorite activities and/or interests? ***(Check all that apply)***

☐ Sports ☐ Watching TV/Movies ☐ Nature/Hiking/Fishing
☐ Swimming/Water Activities ☐ Reading ☐ Playing Outdoors
☐ Video/Computer Games ☐ Bike Riding ☐ Arts & Crafts
☐ Cooking/Baking ☐ Camping ☐ Gardening

☐ Other *(Please Explain)* _____

What are your child's favorite foods? _____

Use this space to provide any additional information about your child that you feel would be helpful for our staff or host families to know: _____

_____

My child is generally *(check all that apply)*: ☐ Active ☐ Athletic ☐ Attached to Parent/Guardian

☐ Cheerful ☐ Curious ☐ Easily Frustrated ☐ Easy Going ☐ Fearful ☐ Happy

☐ Immature ☐ Independent ☐ Irritable ☐ Joyful ☐ Mature ☐ Outgoing

☐ Quiet ☐ Sad ☐ Shy ☐ Talkative ☐ Other _____

During my child's visit, we prefer that *(check all that apply)*:

1. The family has ☐ 3 or more children ☐ 1-2 children ☐ No children ☐ No preference
2. The family has children that are ☐ OLDER ☐ YOUNGER ☐ SAME AGE ☐ No preference

Attachment C

Attachment C

Must be Completed & Signed by Parent/Legal Guardian

Please do not cover→

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____
MONTH DAY YEAR

Meningococcal Meningitis Vaccination Response Form

New York State Public Health Law requires that a parent or guardian of a child who attends an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

1. Check one box and sign below.

☐ My child has had the meningococcal conjugate vaccine -MCV4 (ex. Menactra or Menveo).

Date received: _____/_____/_____
MONTH DAY YEAR

[Note: The Centers for Disease Control and Prevention recommends two doses of MCV4 for all adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 and 12, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, the booster is not needed.]

☐ My child is not 11 years old yet and does not require the meningococcal Meningitis Vaccination.

☐ My child will not obtain immunization against meningococcal meningitis disease. I have read, or have had explained to me, the information about meningococcal meningitis disease and vaccination. I understand the risks of not receiving the vaccination.

Signature: _____ **Date:** _____/_____/_____
MONTH DAY YEAR

Print Name: _____

Email Address: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Attachment C

Camp 2 | **The Fresh Air Fund: Vision Van Form** | **2019 CHILD APPLICATION**

Must be Completed & Signed by Parent/Legal Guardian

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: ____/_____/_____
MONTH DAY YEAR

OneSight
Giving the gift of sight

Vision Van Consent

If attending our Camping Program, your child may be eligible to receive a **free eye examination and pair of glasses** through our partnership with OneSight, a leading vision care nonprofit which provides comprehensive eye exams and stylish glasses, if needed. **Both the examination and eyewear will be donated by OneSight.**

PLEASE SELECT ONE OPTION IN EACH SECTION BELOW AND SIGN AND DATE THIS FORM.

☐ I Do ☐ I Do Not **Give my permission for my child to receive a free eye exam and glasses,** if needed, at the OneSight Vision Clinic at camp this summer.

☐ I Do ☐ I Do Not **Give my permission for the optometrist to perform a dilated fundus exam** during the examination process at the OneSight Vision Clinic.

A dilated fundus exam is a thorough exam of the peripheral retina aided by the use of topical dilating eye drops. This procedure is used to diagnose abnormalities of the retina such as detachments, tears, tumors, infections, hemorrhages and genetic abnormalities. The dilating drops will leave the pupils dilated for approximately four hours. During this period the patient may experience blurry vision and light sensitivity. Reading may be difficult during this time period.

☐ I Do ☐ I Do Not **Give my permission for my child to be filmed or photographed** and understand that my decision will not affect whether my child receives an eye exam or glasses at the Clinic.

Release of Liability

I release and discharge from any and all claims, demands and liability arising out of this event or any use granted herein the officers, directors, employees, agents, affiliates, and/or assigns of the following groups: The Fresh Air Fund personnel; the independent optometrist(s) who perform the eye exam; any co-sponsoring agency; and OneSight. By signing below, acknowledgment is given of receipt of OneSight's Notice of Privacy Practices. *(See General Information packet.)*

Signature of Parent/Legal Guardian: _____ **Date:** _____/_____/_____
MONTH DAY YEAR

Vision Van Health History

In order to help facilitate the eye exam, please complete this brief health history for your child.

Does your child or any immediate family member (parent, grandparent, sibling) have any of the following?

Diabetes ☐ No ☐ Yes, If yes, who? _____

Glaucoma ☐ No ☐ Yes, If yes, who? _____

High Blood Pressure ☐ No ☐ Yes, If yes, who? _____

Does your child currently wear glasses? ☐ No ☐ Yes

Has your child ever worn glasses? ☐ No ☐ Yes

Does your child have any known ALLERGIES? ☐ No ☐ Yes, If yes, please list: _____

Is your child currently taking any MEDICATION? ☐ No ☐ Yes, If yes, please list: _____

Please list any known problems or symptoms your child has in regards to his/her vision and/or eye health: _____

_____

Attachment C

Medical 1 | **The Fresh Air Fund: Medical Form** | **2019 CHILD APPLICATION**

REQUIRED: Must be Completed by Doctor/Qualified Medical Personnel

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: ____/____/____ (MONTH / DAY / YEAR) Gender: ☐ Male ☐ Female ☐ Other: _____

This page MUST be completed by a Doctor or qualified Medical Personnel.
Note: All listed medications will be required for check-in.
A copy of the official immunization record is required.

Child's Doctor Information

Doctor's Full Name: _____ **Doctor's Telephone (:** _____-_____-_____

Doctor's Address: _____ **Doctor's Fax (:** _____-_____-_____

Allergies

List all known allergies and **describe reaction and authorized treatment** of the reaction in each case:

Allergen	Reaction/Symptoms	Treatment/Medication/Dosage
Food allergy: (e.g. peanuts, shellfish, berries etc.)		☐ **OTC:** _____ ☐ **Prescription:** _____ ☐ **Epi Pen required** ☐ **No medication**
Environmental allergy: (e.g. pollen, dander etc.)		☐ **OTC:** _____ ☐ **Prescription:** _____ ☐ **Epi Pen required** ☐ **No medication**
Medication allergy: (e.g. Penicillin, etc.)		☐ **OTC:** _____ ☐ **Prescription:** _____ ☐ **Epi Pen required** ☐ **No medication**

Asthma Information

Does this child have asthma/RAD? ☐ **Yes** ☐ **No**

If Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Is the child prescribed asthma medication? ☐ **Yes** ☐ **No**

If Yes, please check medication(s): ☐ Albuterol ☐ Ventolin ☐ Qvar ☐ Flovent ☐ Singulair ☐ Other: _____

Does child have an **Asthma Treatment Plan**? ☐ **Yes** ☐ **No** If Yes, please provide a copy

Date of last asthma-related emergency room visit:
____/____/____ (MONTH / DAY / YEAR)

Behavioral Information

Please indicate if child has ever been diagnosed with any of the following: ☐ **ADHD** ☐ **Anxiety** ☐ **Depression** ☐ **None**

☐ **Behavioral/Cognitive Disorder** ☐ **Other** _____

If Yes and medication is prescribed, please list:

_____

Diabetes Information

Does this child have diabetes? ☐ **Yes** ☐ **No**

If Yes: ☐ Type 1 ☐ Type 2

Is the child currently taking insulin? ☐ **Yes** ☐ **No**

If Yes, please provide Diabetes treatment or action plan.

If Yes, please attach diabetes action form/plan.

TB Mantoux Test

Date of test: ____/____/____ (MONTH / DAY / YEAR) Result: ☐ **Positive** ☐ **Negative**

If Positive, chest x-ray result: _____

Does this child take TB meds? ☐ **Yes** ☐ **No**

If Yes, please list medication: _____

Since: ____/____/____ (MONTH / DAY / YEAR) & Regimen: ☐ **3 mo.** ☐ **6 mo.** ☐ **9 mo.**

This child is no longer contagious and can participate in a residential community ☐ **Yes** ☐ **No**

Health History

Has this child had any of the following?

☐ Sickle Cell ☐ Lyme Disease ☐ High Cholestrol
☐ Diabetes ☐ Seizure Disorder ☐ Mumps
☐ Heart Disease ☐ Rheumatic Fever ☐ Hepatitis
☐ Measles ☐ Chicken Pox
☐ German Measles ☐ Tuberculosis
☐ Congenital or Acquired Heart Disorder
☐ Speech, Hearing, or Visual Impairment
☐ Other Communicable Diseases* *(indicate below)*
* _____
☐ Other _____

Continue on next page. Doctor signature, stamp, and date required.

Attachment C

Medical 2 | **The Fresh Air Fund: Medical Form** | **2019 CHILD APPLICATION**

REQUIRED: Must be Completed by Doctor/Qualified Medical Personnel

Please do not cover barcode →

Child's First Name: _____ **Child's Last Name:** _____

Child's Date of Birth: _____/_____/_____
MONTH DAY YEAR

Routine Medications

Please list *ALL* medications currently and routinely taken (including prescription, non-prescription or over-the-counter).

☐ This child **does not** take medications on a routine basis

☐ This child **does** take medications on a routine basis. Please list medications below.

Medication name	Route	Dosage	Frequency	Diagnosis/Comments

Other Authorized Medications

The following medications are available in the camp infirmary and will be dispensed at the discretion of medical personnel, unless otherwise noted by the child's healthcare provider.

As this child's healthcare provider you authorize that (**unless otherwise noted in "Remarks"**) the medications listed below can be dispensed at the discretion of medical personnel at camp and/or a host parent in Friendly Town per dosage, schedule and route indicated on the label.

Drug Name	Indications	Remarks
Tylenol (or generic acetaminophen)	Pain or fever	
Ibuprofen	Pain or fever	
Robitussin/Jr. (or generic)	Cough	
Chloraseptic (or generic)	Sore throat	
Children's Mylanta (or generic antacid)	Upset stomach	
Milk of Magnesia (or generic laxative)	Constipation	
Mucinex/Jr. (or generic)	Congestion	
Visine (or generic)	Eye redness / irritation	
Sudafed (or generic)	Nasal congestion / Eustachian tube congestion	
Claritin (or generic)	Nasal congestion / Seasonal allergy symptoms	
Benadryl (or generic diphenhydramine)	Allergic reactions (hives, insect bites)	
Antibiotic Ointment	Superficial cuts / abrasions	
Hydrocortisone Cream	Allergic reactions (contact dermatitis, insect bites)	
Calamine Lotion (or generic)	Allergic reactions (hives, insect bites)	

Health Examination/Findings

Weight: _____ Height: _____ BP: _____

This child is able to participate in a physically active program, including swimming ☐ **Yes** ☐ **No**

Does this child have any restrictions, physical limitations, developmental or learning delays?

☐ **None (within normal limits)**

☐ **Yes - please fill out the rest of this section:**

☐ **Physical** ☐ **Cognitive** ☐ **Behavior/Social/Emotional** ☐ **Communication/Language** ☐ **Other**

Please explain:_____

Doctor's Signature & Stamp

I certify that the medical history of this child is correct, and that he or she has medical clearance to engage in all activities, except for those noted on this form. In addition I authorize that (unless otherwise noted in "**Remarks**" above) medications listed under Other Authorized Medications section can be dispensed at the discretion of medical personnel at camp and/or a host parent in Friendly Town per dosage, schedule and route indicated on the label.

Doctor's Stamp

Doctor's Signature: _____ **Date of Examination:** _____/_____/_____
MM DD YYYY

Date of Exam must be after June 1, 2018

Attachment D

the Fresh Air fund
because a summer can last a lifetime™

Date

Parent Name
Address
City, State, Zip

Dear Parent Name,

Congratulations! **CHILD's NAME** is approved by The Fresh Air Fund for participation in the Summer 2019 HRA/FAF Pilot Program. The summer sleepaway experience details are provided below. You will receive a more detailed confirmation packet in the mail in the next 7 to 14 days.

To confirm your spot in the HRA/FAF Pilot Program, you must submit form **W-137A** (Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only)) along with this acceptance letter to **SummerCamp@hra.nyc.gov** for HRA approval. Please let us know if you need assistance submitting the W-137A to HRA.

Please call us at **1-800-367-0003** if you have any questions or concerns.

We are excited to see CHILD's NAME this summer! Thank you for choosing The Fresh Air Fund for your child's Summer 2019 sleepaway experience!

Sincerely,

Tara N. Gardner Director of Community Outreach, Partnerships & Support Services

---

Experience Details:

Child's Name:

Cash Assistance #:

FAF Program:

Scheduled Experience Dates:

633 third avenue fl14
new york, ny 10017

EXECUTIVE DIRECTOR Fatima Shama

t 800 367 0003
t 212 897 8900

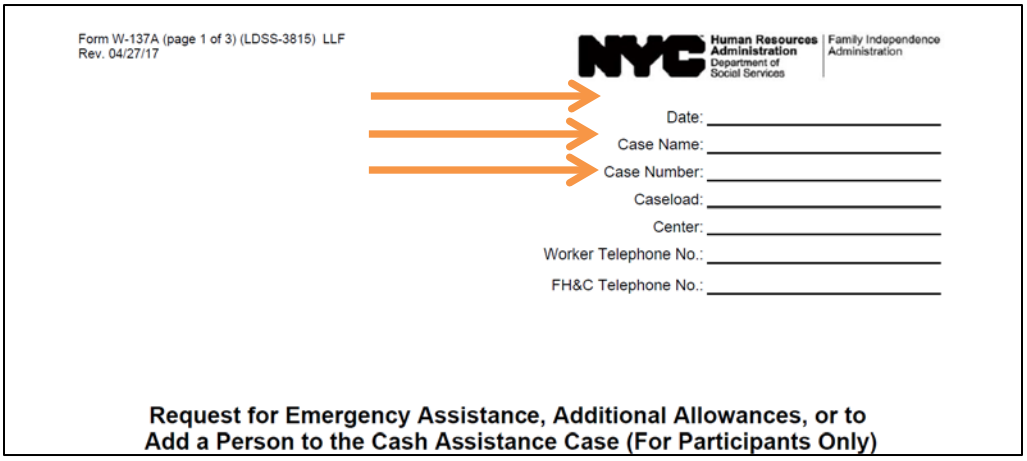
www.FreshAir.org

twitter.com/freshairfund facebook.com/freshairfund linkedin.com/company/the-fresh-air-fund instagram.com/thefreshairfund

Attachment E

Instructions for Completing and Submitting the HRA Form W-137A for HRA/FAF Summer Camp Program

Step 1: On top of Page 1 of Form W-137A, write in today's date for "Date", the household head name for "Case Name", and the HRA Cash Assistance Case # in "Case Number".



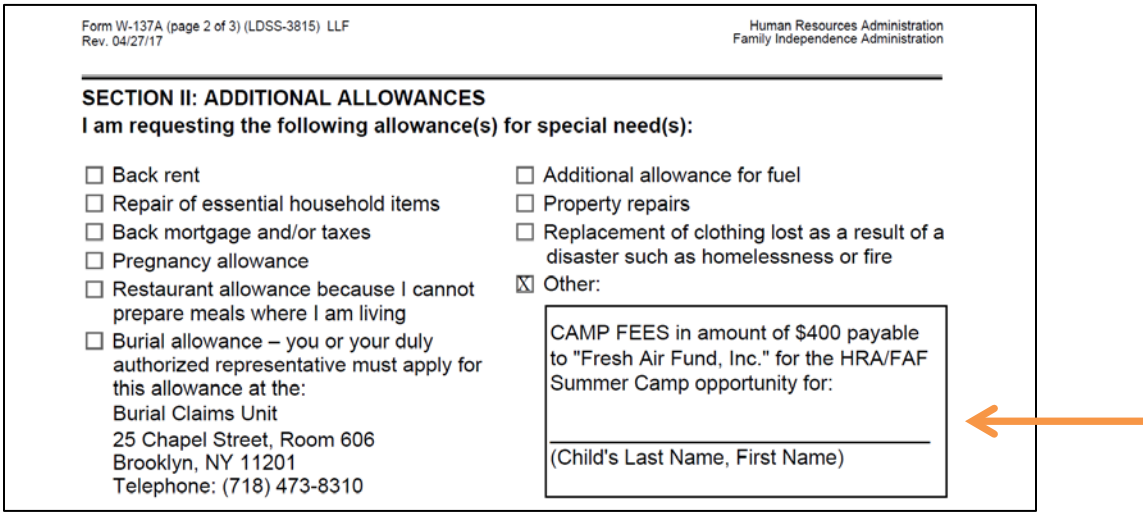
Form W-137A (page 1 of 3) (LDSS-3815) LLF
Rev. 04/27/17

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____
Case Name: _____
Case Number: _____
Caseload: _____
Center: _____
Worker Telephone No.: _____
FH&C Telephone No.: _____

Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only)

Step 2: On Page 2 of Form W-137A, write in the Child's First and Last Name in this field:



Form W-137A (page 2 of 3) (LDSS-3815) LLF
Rev. 04/27/17

Human Resources Administration
Family Independence Administration

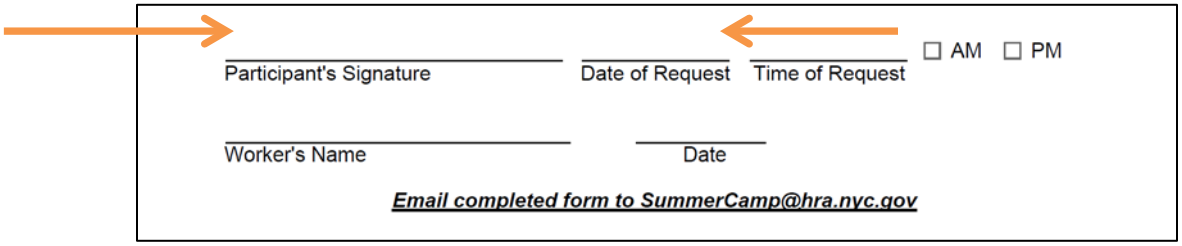
SECTION II: ADDITIONAL ALLOWANCES
I am requesting the following allowance(s) for special need(s):

- ☐ Back rent
- ☐ Repair of essential household items
- ☐ Back mortgage and/or taxes
- ☐ Pregnancy allowance
- ☐ Restaurant allowance because I cannot prepare meals where I am living
- ☐ Burial allowance – you or your duly authorized representative must apply for this allowance at the:
  Burial Claims Unit
  25 Chapel Street, Room 606
  Brooklyn, NY 11201
  Telephone: (718) 473-8310
- ☐ Additional allowance for fuel
- ☐ Property repairs
- ☐ Replacement of clothing lost as a result of a disaster such as homelessness or fire
- ☒ Other:

CAMP FEES in amount of $400 payable to "Fresh Air Fund, Inc." for the HRA/FAF Summer Camp opportunity for:

_____
(Child's Last Name, First Name)

Step 3: On Page 3 of Form W-137A, sign and date this form:



_____ _____ _____ ☐ AM ☐ PM
Participant's Signature Date of Request Time of Request

_____ _____
Worker's Name Date

Email completed form to SummerCamp@hra.nyc.gov

Step 4: Email a PDF version this completed form, or send pictures of all three (3) completed pages to: SummerCamp@hra.nyc.gov; Fresh Air Fund can assist you in this process.

Attachment E

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Name: _____

Case Number: _____

Caseload: _____

Center: _____

Worker Telephone No.: _____

FH&C Telephone No.: _____

Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only)

Please fill out this form if you need emergency assistance, additional allowances, or to add a person to the case.

Remember:

(1) You may be asked for proof of what you tell us. If you have trouble obtaining proof, your Worker must help you.

(2) You may still need to see your Worker. If you do, you will be given an appointment.

SECTION I: EMERGENCY ASSISTANCE

The type of emergency assistance I am requesting is:

The reason I need emergency assistance is:

See next page ➡

(Worker: Scan and Index this completed form and give the signed original back to the participant.)

SECTION II: ADDITIONAL ALLOWANCES

I am requesting the following allowance(s) for special need(s):

- ☐ Back rent
- ☐ Repair of essential household items
- ☐ Back mortgage and/or taxes
- ☐ Pregnancy allowance
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  Brooklyn, NY 11201
  Telephone: (718) 473-8310
- ☐ Additional allowance for fuel
- ☐ Property repairs
- ☐ Replacement of clothing lost as a result of a disaster such as homelessness or fire
- ☒ Other:

CAMP FEES in amount of $400 payable to "Fresh Air Fund, Inc." for the HRA/FAF Summer Camp opportunity for:

_____
(Child's Last Name, First Name)

- ☐ **Expenses related to moving:**
  - ☐ Moving expenses
  - ☐ Security deposit/agreement
  - ☐ Broker's/finder's fee/voucher
  - ☐ Furniture and other household items
  - ☐ Storage of furniture and personal belongings

New Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

When did you move? _____ New rent: $ _____

Landlord's name: _____

Primary tenant's name: _____

Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

See next page ➡

SECTION III: WORK ACTIVITY-RELATED SUPPORTIVE SERVICES

I am requesting the following supportive services:

- ☐ Clothing for participants in job search activities who have **exceptional** circumstances, such as homelessness or a recent fire and lack of appropriate clothing
- ☐ Activity/engagement-related licensing, uniform or durable goods fee within approved limits, upon submission of documentation certifying the need for such items
- ☐ Child care allowance within approved limits, if needed
- ☐ Necessary public transportation
- ☐ Other work activity-related supportive services:

Necessary supportive services will be provided when you begin a work activity. If your needs change or if you are not receiving a needed service, you should apply for an additional allowance.

SECTION IV: ADD PERSON TO CASE

If you do not have all this information, you can still submit this form to your Worker.
I want to add the following person(s) to my cash assistance case:

- ☐ **New Baby**
- ☐ **Child entered home**
- ☐ **Child under 18 years of age** (whose immigrant status has changed since my last application/recertification)
- ☐ **Spouse/Adult living with me** who has not previously applied (this person must complete an application to receive assistance)
- ☐ **Spouse** who previously applied and was denied because of immigration status and his/her status has changed now
- ☐ **Myself/Adult payee to the case**
- ☐ **Other** _____
- ☐ **Other** _____

Name: _____ **Name:** _____

Date moved in/returned: _____ **Date moved in/returned:** _____

Date of Birth: _____ **Date of Birth:** _____

Social Security Number (if known): _____ **Social Security Number (if known):** _____

_____ _____ _____ ☐ AM ☐ PM
Participant's Signature Date of Request Time of Request

_____ _____
Worker's Name Date

Email completed form to SummerCamp@hra.nyc.gov

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____

Case Name: _____

Case Number: _____

Caseload: _____

Center: _____

Worker Telephone No.: _____

FH&C Telephone No.: _____

Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only)

Please fill out this form if you need emergency assistance, additional allowances, or to add a person to the case.

Remember:

(1) You may be asked for proof of what you tell us. If you have trouble obtaining proof, your Worker must help you.

(2) You may still need to see your Worker. If you do, you will be given an appointment.

SECTION I: EMERGENCY ASSISTANCE

The type of emergency assistance I am requesting is:

The reason I need emergency assistance is:

See next page ➡

(Worker: Scan and Index this completed form and give the signed original back to the participant.)

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- ☐ Back rent
- ☐ Repair of essential household items
- ☐ Back mortgage and/or taxes
- ☐ Pregnancy allowance
- ☐ Restaurant allowance because I cannot prepare meals where I am living
- ☐ Burial allowance – you or your duly authorized representative must apply for this allowance at the:
  Burial Claims Unit
  25 Chapel Street, Room 606
  Brooklyn, NY 11201
  Telephone: (718) 473-8310
- ☐ Additional allowance for fuel
- ☐ Property repairs
- ☐ Replacement of clothing lost as a result of a disaster such as homelessness or fire
- ☐ Other:

☐ **Expenses related to moving:**

- ☐ Moving expenses
- ☐ Security deposit/agreement
- ☐ Broker's/finder's fee/voucher
- ☐ Furniture and other household items
- ☐ Storage of furniture and personal belongings

New Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

When did you move? _____ New rent: $ _____

Landlord's name: _____

Primary tenant's name: _____

Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

See next page ➡

SECTION III: WORK ACTIVITY-RELATED SUPPORTIVE SERVICES

I am requesting the following supportive services:

- ☐ Clothing for participants in job search activities who have **exceptional** circumstances, such as homelessness or a recent fire and lack of appropriate clothing
- ☐ Activity/engagement-related licensing, uniform or durable goods fee within approved limits, upon submission of documentation certifying the need for such items
- ☐ Child care allowance within approved limits, if needed
- ☐ Necessary public transportation
- ☐ Other work activity-related supportive services:

Necessary supportive services will be provided when you begin a work activity. If your needs change or if you are not receiving a needed service, you should apply for an additional allowance.

SECTION IV: ADD PERSON TO CASE

If you do not have all this information, you can still submit this form to your Worker.
I want to add the following person(s) to my cash assistance case:

- ☐ **New Baby**
- ☐ **Child entered home**
- ☐ **Child under 18 years of age** (whose immigrant status has changed since my last application/recertification)
- ☐ **Spouse/Adult living with me** who has not previously applied (this person must complete an application to receive assistance)
- ☐ **Spouse** who previously applied and was denied because of immigration status and his/her status has changed now
- ☐ **Myself/Adult payee to the case**
- ☐ **Other** _____
- ☐ **Other** _____

Name: _____ **Name:** _____

Date moved in/returned: _____ **Date moved in/returned:** _____

Date of Birth: _____ **Date of Birth:** _____

Social Security Number (if known): _____ **Social Security Number (if known):** _____

_____ _____ _____ ☐ AM ☐ PM
Participant's Signature Date of Request Time of Request

_____ _____
Worker's Name Date

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Nombre del Caso: _____

Número del Caso: _____

Unidad de Casos: _____

Centro: _____

Núm. Telefónico del Trabajador: _____

Núm. Telefónico de FH&C: _____

Petición de Asistencia de Emergencia, Asignaciones Adicionales, o de Añadir a una Persona al Caso de Asistencia en Efectivo (Sólo para Participantes)

Favor de llenar este formulario si necesita asistencia de emergencia, asignaciones adicionales, o para añadir una persona al caso.

Recuerde:

(1) Puede que se le pida comprobante de los datos que usted nos proporcione. Si tiene problemas al obtener pruebas, su trabajador tiene que ayudarle.

(2) Puede que usted aún necesite reunirse con su Trabajador. En tal caso, se le programará una cita.

SECCIÓN I: ASISTENCIA DE EMERGENCIA

Solicito el siguiente tipo de asistencia de emergencia:

La razón por la cual necesito la asistencia de emergencia se reseña a continuación:

Vea la próxima página ➡

(Worker: Scan and Index this completed form and give the signed original back to the participant.)

SECCIÓN II: ASIGNACIONES ADICIONALES

Solicito la(s) siguiente(s) asignación(es) para necesidad(es) especial(es):

- ☐ Alquiler atrasado
- ☐ Reparación de artículos de primera necesidad del hogar
- ☐ Hipoteca y/o impuestos atrasados
- ☐ Asignación para embarazo
- ☐ Asignación para restaurante porque no puedo preparar comidas en donde vivo
- ☐ Asignación para entierros – usted o su representante debidamente autorizado debe solicitar esta asignación en la:
  Burial Claims Unit
  25 Chapel Street, Sala 606
  Brooklyn, NY 11201
  Teléphono: (718) 473-8310
- ☐ Asignación adicional para combustible
- ☐ Reparaciones a la propiedad
- ☐ Reemplazo de ropa perdida debido a desastres tal como falta de albergue o incendio
- ☐ Otras asignaciones:

☐ **Gastos relacionados con la mudanza:**

- ☐ Gastos de mudanza
- ☐ Depósito/acuerdo de garantía
- ☐ Cuota/comprobante de agente
- ☐ Muebles y otros artículos del hogar
- ☐ Almacenamiento de muebles y artículos personales

Nueva Dirección: _____
(con número de apartamento)

_____ _____ _____
Ciudad Estado Código Postal

¿Cuándo se mudó? _____ Nuevo alquiler: $_____

Nombre del casero: _____

Nombre del inquilino principal: _____

Dirección: _____
(con número de apartamento)

_____ _____ _____
Ciudad Estado Código Postal

Vea la próxima página ➡

SECCIÓN III: SERVICIOS DE APOYO RELACIONADOS CON ACTIVIDADES DE TRABAJO

Solicito los siguientes servicios de apoyo:

- ☐ Ropa para participantes que realicen actividades relacionadas con la búsqueda de trabajo, que se encuentren en circunstancias **excepcionales**, tales como la carencia de techo o incendio reciente y falta de vestimenta adecuada.
- ☐ Cuota de autorización, relacionada con actividad/participación, de uniformes o bienes duraderos dentro de los límites aprobados, a la hora de presentar la documentación que compruebe la necesidad de dichos artículos.
- ☐ Asignación de cuidado infantil dentro de los límites aprobados, de ser necesario.
- ☐ Transporte público necesario
- ☐ Otros servicios de apoyo relacionados con actividades de trabajo:

Se brindarán los servicios necesarios al usted empezar una actividad de trabajo. Si se produce algún cambio en sus necesidades, o si usted no está recibiendo un servicio necesario, debería solicitar una asignación adicional.

SECCIÓN IV: AÑADA A UNA PERSONA AL CASO

Si usted no cuenta con toda esta información, aún puede presentar este formulario a su Trabajador.

Deseo añadir a la(s) siguientes persona(s) a mi caso de Asistencia en Efectivo:

- ☐ **Recién nacido**
- ☐ **Niño ingresado al hogar**
- ☐ **Niño menor de 18 años de edad (cuyo estado migratorio haya cambiado desde mi última solicitud/recertificación)**
- ☐ **Cónyuge/Adulto que viva conmigo** quien no haya presentado solicitud anteriormente (Para recibir asistencia dicha persona debe llenar una solicitud.)
- ☐ **Cónyuge** quien anteriormente haya presentado solicitud y haya sido rechazado por su estado migratorio, pero dicho estado ya ha cambiado.
- ☐ **Yo mismo(a)/Beneficiario adulto al caso**
- ☐ **Otra Persona** _____
- ☐ **Otra Persona** _____

Nombre: _____
Fecha de mudanza/regreso: _____
Fecha de Nacimiento: _____
Número de Seguridad Social (de saberlo): _____

Nombre: _____
Fecha de mudanza/regreso: _____
Fecha de Nacimiento: _____
Número de Seguridad Social (de saberlo): _____

_____ _____ _____ ☐ AM ☐ PM
Firma del Participante | Fecha de la Petición | Hora de la Petición

_____ _____
Nombre del trabajador | Fecha

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____
Center: _____
Caseload: _____
Worker Telephone No.: _____
FH&C Telephone No.: _____

Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only)

The Agency's decision(s) regarding your benefit program(s) is/are explained below, next to the checked box(es) ☒.

This Notice applies only to your request for an additional allowance to meet a special need, a change in grant, or an application for emergency assistance. If your request for additional assistance is denied, your ongoing Cash Assistance case will not be affected.

On _____ (Date), you requested ☐ Emergency Assistance ☐ Additional allowance for:

_____

☐ **Your request for _____ has been accepted. You will receive:**

- ☐ One payment in the amount of $ _____ .
  Period covered, if applicable: _____ .

Method of payment:

- ☐ Broker's or finder's fee/voucher
- ☐ Check to be picked up by you at your Job Center
- ☐ Check mailed to your home
- ☐ As an addition to your regular public grant, which can be obtained through the EBT system
- ☐ Security deposit agreement
- ☐ Direct vendor check
- ☐ Other action: _____
- ☐ You will receive a second notice informing you as to how your ongoing benefits will be affected.

See next page ➡

☐ On _____, you were referred to the Burial Claims Unit at 25 Chapel Street, Room 606, Brooklyn, NY 11201, (718) 473-8310, to apply for a burial allowance.

☐ **Your request for _____ has been denied because:**

The law(s) and/or regulation(s) that allow(s) us to do this is/are 18 NYCRR (please see the section numbers below):

☐ Addition to Household § 352.30

☐ Additional Allowance for Fuel § 352.5

☐ Back Mortgage and/or Taxes § 352.7 (g)

☐ Back Rent § 352.7 (g)

☐ Broker's or Finder's Fee/Voucher § 352.6(a)

☐ Catastrophic Loss (replacement of clothing and furniture lost in fire, flood or other disaster) § 352.7(d)

☐ Furniture and Other Household Items § 352.7(a)

☐ Moving Expenses § 352.6(a)

☐ Repair of Essential Household Items § 352.7(b)

☐ Pregnancy Allowance § 352.7(k)

☐ Property Repairs § 352.4(d), § 352.6(e)

☐ Rent Security Deposit/ Letter of Guarantee § 352.6(a)

☐ Work Activity Related Supportive Services § 385.4

☐ Restaurant Allowance § 352.7(c)

☐ Semimonthly Fuel for Heating Allowance § 352.5(b)

☐ Storage of Furniture and Personal Belongings § 352.6(f)

☐ Other (specify): _____

_____ _____
JOS/Worker's Name Date

_____ _____
Supervisor's Name Date

**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.**

See next page ➡

Conference and Fair Hearing Information

CONFERENCE

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

STATE FAIR HEARING

Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within sixty (60) days from the date of the notice for Cash Assistance, medical assistance, or social services issues; and you must ask within ninety (90) days for Supplemental Nutrition Assistance Program (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.

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

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

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

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

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

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

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

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

See next page 

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

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

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

AVAILABILITY OF POLICY MATERIALS: The Office of Temporary and Disability Assistance (OTDA) policy issuances and HRA policy issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. OTDA policy issuances and manuals are posted on the OTDA website at **http://www.otda.ny.gov/legal**. In addition, upon request to HRA, specific OTDA and HRA policy issuances and manuals are also available to explain how the agency reached its determination. To request policy issuances and manuals, call **(718) 722-5012**, or fax **(718) 722-5018**, or email **CRO@hra.nyc.gov** or write to **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, NY 11201**.

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

FAIR HEARING REQUEST

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

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

Address: _____

_____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Unidad de Casos: _____

Núm. de Teléfono del Trabajador: _____

Núm. de Teléfono de FH&C: _____

Medida Tomada con Respecto a su Petición de Asistencia de Emergencia, Asignaciones Adicionales, o Añadidura de una Persona al Caso de Asistencia en Efectivo (Sólo para Participantes)

La(s) decisión(es) de la Agencia con respecto a su(s) programa(s) de beneficio(s) se reseña(n) a continuación, junto a la(s) casilla(s) marcada(s) ☒.

El presente sólo corresponde a su solicitud de una asignación adicional para satisfacer determinada necesidad, un cambio en la concesión o una solicitud de asistencia de emergencia. En caso de denegarse su solicitud de asistencia adicional, no se verá afectado su caso de Asistencia en Efectivo continua.

El _____ (Fecha), usted solicitó ☐ Asistencia de Emergencia ☐ Asignación adicional para:

☐ **Se ha aceptado su solicitud de _____. Usted recibirá:**

☐ Un pago en la cantidad de $_____ .

Período de cobertura, si corresponde:_____ .

Método de pago:

☐ Pago/comprobante de agente o intermediario

☐ Cheque a ser recogido por usted en su Centro de Trabajo

☐ Cheque enviado por correo a su hogar

☐ Un suplemento a su concesión pública normal, obtenible mediante el sistema de EBT

☐ Acuerdo de depósito de garantía

☐ Cheque directo al contratista

☐ Otra medida:_____

☐ Usted recibirá un segundo aviso que le informará de cómo se verán afectados sus beneficios continuos.

Vea la próxima página ➡

☐ El_____, se le ha enviado a la Unidad de Reclamos de Sepultura en 25 Chapel Street, Sala 606, Brooklyn, NY 11201, (718) 473-8310, para solicitar una asignación de sepultura.

☐ **Se ha denegado su petición de_____ debido a que:**

La(s) ley(es) y/o regla(s) que nos permite(n) hacer esto es/son 18 NYCRR (favor de ver el número de sección a continuación):

☐ Añadidura de una Persona al Hogar § 352.30	☐ Asignación Adicional para Combustible § 352.5	☐ Pagos Atrasados de Hipoteca y/o Impuestos § 352.7(g)	☐ Alquiler Atrasado § 352.7(g)
☐ Pago/Comprobante de Agente o Intermediario § 352.6(a)	☐ Pérdida Catastrófica (reemplazo de ropa y muebles perdidos en incendio, inundación u otro desastre) § 352.7(d)	☐ Muebles y Otros Artículos Domésticos § 352.7(a)	☐ Gastos de Mudanza § 352.6(a)
☐ Reparaciones de Artículos Domésticos Indispensables § 352.7(b)	☐ Asignación para Embarazo § 352.7(k)	☐ Reparaciones a la Propiedad § 352.4(d), § 352.6(e)	☐ Depósito de Garantía de Alquiler/Carta de Garantía § 352.6(a)
☐ Servicios de Apoyo Relacionados con Actividad de Trabajo § 385.4	☐ Asignación para Restaurante § 352.7(c)	☐ Asignación Quincenal de Combustible para Calefacción § 352.5(b)	☐ Almacenamiento de Muebles y Pertenencias Personales § 352.6(f)

☐ Otro caso (en concreto):_____

_____ _____
Nombre del JOS/Trabajador Fecha

_____ _____
Nombre del Supervisor Fecha

**USTED TIENE EL DERECHO DE APELAR ESTA DECISIÓN.
ASEGÚRESE DE LEER LA SECCIÓN DE INFORMACIÓN DE CONFERENCIAS Y AUDIENCIAS IMPARCIALES DE ESTE AVISO SOBRE CÓMO APELAR ESTA DECISIÓN.**

Vea la próxima página ➡

Información sobre Conferencias y Audiencias Imparciales

CONFERENCIA

Si usted considera que nuestra decisión ha sido errónea, o si no la entiende, por favor llámenos para programar una conferencia (reunión informal con nosotros). Para ello, llame al número de teléfono de la unidad de Audiencias Imparciales y Conferencias (FH&C) en la **página 1** de este aviso, o escríbanos a la dirección en la **página 1** de este aviso. A veces éste resulta el modo más rápido de solucionar algún problema que tenga. Le recomendamos que así lo haga, aun si ha solicitado una Audiencia Imparcial. En el caso de solicitar una conferencia, usted seguirá teniendo derecho a una Audiencia Imparcial.

AUDIENCIA IMPARCIAL ESTATAL

Fecha Límite: Si usted desea que el Estado revise nuestra decisión, tiene que solicitar una Audiencia Imparcial dentro de sesenta (60) días a partir de la fecha de este aviso para asuntos de Asistencia en Efectivo, asistencia médica, o de servicios sociales; y tiene que presentar solicitud dentro de noventa (90) días para asuntos del Programa de Asistencia de Nutrición Suplementaria (SNAP).

Si usted no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporaria y para Discapacitados por teléfono, por fax, en persona o por Internet, favor de solicitar por escrito una Audiencia Imparcial antes de la fecha límite.

Cómo Solicitar una Audiencia Imparcial: Si usted considera que la(s) decisión(es) que estamos tomando es/son errónea(s), puede solicitar una Audiencia Imparcial Estatal por teléfono, por escrito, por fax, en persona o por Internet.

(1) POR TELÉFONO: Llame al **(800) 342-3334**. (Favor de tener este aviso a la mano al llamar.)

(2) POR ESCRITO: Envíe una copia (y guarde una copia para sí) de todo este aviso, con la sección "Petición de Audiencia Imparcial" llenada, a:
Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201

(3) FAX: Faxee una copia de todo este aviso, con la sección "Petición de Audiencia Imparcial" llenada, al número: **(518) 473-6735**.

(4) EN PERSONA: Traiga una copia de todo este aviso, con la sección "Petición de Audiencia Imparcial" llenada, a la Oficina de Audiencias Administrativas, Oficina de Asistencia Temporaria y para Discapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a la siguiente dirección:
14 Boerum Place, Brooklyn, NY 11201.

(5) POR INTERNET: Llene un formulario de petición electrónica en:
http://www.otda.state.ny.us/oah/forms.asp

Qué Puede Esperar de La Audiencia Imparcial: El Estado le enviará una notificación que le informará de cuándo y dónde se llevará a cabo la Audiencia Imparcial. En la audiencia, usted tendrá la oportunidad de explicar la razón por la que considera que nuestra decisión es errónea. Para ayudarle a presentar su caso, usted puede traer a la audiencia a un abogado y/o testigos como familiares o amigos, y/o entregarle al Funcionario de la Audiencia cualquier documento escrito relacionado con su caso tal como: talones de paga, contratos de arrendamiento, recibos, cuentas y/o declaraciones médicas, etc. Si no puede acudir a la audiencia, puede enviar a alguien que le represente. Si tal representante no es abogado, usted debe proporcionarle una carta para que el Funcionario de la Audiencia sepa que usted desea que esa persona le represente. Durante la audiencia, usted, su abogado o su representante también pueden interrogar a los testigos por parte nuestra o suya, para aclarar el caso.

Vea la próxima página ➡

Si usted padece una discapacidad, y no puede trasladarse, puede comparecer mediante un representante, o un amigo, pariente o abogado. Si su representante no es abogado, ni es empleado de abogado, su representante debe traerle al funcionario de audiencias una carta escrita y firmada.

ASISTENCIA LEGAL: Si usted necesita asistencia legal gratuita, puede obtener tal asistencia al comunicarse con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede ubicar la Sociedad de Ayuda Legal o grupo de abogacía más cercana al buscar en las Páginas Amarillas (Yellow Pages) bajo "lawyers" (abogados).

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un fax, le proporcionaremos copias gratuitas de los documentos de su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por fax, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo, llámenos al **(718) 722-5012**, por fax al **(718) 722-5018** o escriba a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201**. Si desea copias de documentos contenidos en su archivo, debe solicitarlas con anticipación. Éstas se le proveerán dentro de un plazo adecuado antes de la fecha de la audiencia. Se le enviarán por correo los documentos sólo si lo solicita específicamente.

DISPONIBILIDAD DE MATERIALES DE POLÍTICA

Las expediciones y manuales de la política de la Oficina de Asistencia Temporaria y para Discapacitados (OTDA) y las expediciones de la política y manuales de la HRA están disponibles para usted y su representante para determinar si se debe solicitar Audiencia Imparcial y prepararse para la misma. Las expediciones y manuales de la política de OTDA se publican en el sitio web de la OTDA en **http://www.otda.ny.gov/legal**. Además, previa solicitud a la HRA, hay disponibles expediciones y manuales que explican cómo la agencia llegó a su determinación. Para solicitar expediciones y manuales de políticas, llame al **(718) 722-5012**, o envíe un fax al **(718) 722-5018**, o envíe correo electrónico a **CRO@hra.nyc.gov**, o escriba a **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, NY 11201**.

INFORMACIÓN: Si usted desea más información sobre su caso, cómo solicitar una Audiencia Imparcial, cómo revisar su archivo o cómo obtener copias adicionales de documentos, llame o escríbanos al número telefónico y/o dirección que aparecen en la **página 1** de este aviso.

PETICIÓN DE AUDIENCIA IMPARCIAL

☐ **Deseo una Audiencia Imparcial. La decisión de la Agencia es errónea porque:**

En Letras de Molde: _____ (Nombre) _____ (I.) _____ (Apellido) Núm. del Caso: _____

Dirección: _____

_____ Teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____