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 #20-07-ELI

(This Policy Bulletin Replaces PB #19-34-ELI)

HRA/FAF 2020 SUMMER CAMP PILOT PROGRAM

Date: February 28, 2020	**Subtopic(s):** Eligibility
Revised	**Revisions to the Original Policy Bulletin** This policy bulletin is being revised to update the age of eligible children and number of slots available for the Human Resources Administration (HRA)/Fresh Air Fund (FAF) 2020 Summer Camp pilot program. **Purpose** This policy bulletin informs Job Center staff about HRA/FAF 2020 Summer Camp program and is informational for all other staff. The HRA/FAF 2020 Summer Camp pilot program provides children who receive ongoing Cash Assistance (CA), and are between ages 8 through 15, an opportunity to participate in a HRA/FAF Sleepaway Camp or a Host Family program in Summer 2020. Working with FAF, HRA offers CA youth recipients: • Enhanced FAF application services and support; • Post-Sleepaway summer camp and post-Host Family celebration event(s); and • Subsequent non-summer weekend at an FAF campsite following the Sleepaway Summer camp or Host Family experience. This pilot program connects eligible participants to a sleepaway summer camp experience, offer inner-City children and youth an outdoor environment to grow and flourish, and develop an interest in nature and the outdoors that could last a lifetime.

Many of HRA's young CA participants never had an opportunity to experience life outside of New York City – what it feels like to be surrounded by nature. Through this opportunity, our young participants can become more self-reliant through developing their own self-esteem and -confidence, find a passion and accompanying future goal for adventure and exploration, and most importantly, better understand themselves outside of their regular environment. Like any other retreat or adventure, HRA hopes this program can inspire participating youth to take steps actualize their own life goals and ambitions, which in turn, would decrease their chances of being dependent on public benefits later on.

Revised

HRA expects the HRA/FAF program participants to reconnect to FAF and other available summer camp programs the following year. Families with children ages 8 through 15 must first apply to FAF, be accepted by FAF, and be eligible for a "Camp Fees" grant. 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.

Revised

The HRA/FAF pilot program is limited with only 475 slots available. HRA/FAF will publicize the availability of this Supplemental CA Grant. If the child's household is interested in applying for the grant, they must submit the 2020 Child Application HRA/FAF Pilot Program (completed, signed, dated and stamped by the child's Medical Doctor) to: 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**

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 needs to:

See **Attachment B**

See **Attachment C**

- 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 last and first names), sign and date the form; and
- Email the completed **W-137A** with the HRA/FAF Pilot Program Acceptance Letter to SummerCamp@hra.nyc.gov.

Note: This special submission process for the **W-137A** form is limited to the HRA/FAF Pilot program only. Any other requests on the **W-137A** or submitted to the email address above will be forwarded to the appropriate Job Center for processing.

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.

Once an approval request is received 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 review, 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	2020 Child Application – HRA/FAF Pilot Program
Attachment B	HRA/FAF Pilot Program Acceptance Letter
Attachment C	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

the *Fresh Air* fund

2020 Child Application

The Fresh Air Fund's safe and fun **summer sleepaway programs** are provided at **no charge** to NYC families.

Visit child.freshair.org to apply online.

Completing your application by April 30, 2020 may increase your child's chances of participation. We do accept applications until all spots are filled. Please submit the application as soon as possible.

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 08/10/20.

Friendly Towns

NEW Applicants

7-13

year old girls & boys

Returning children can reapply until age 18

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

Camp

8-13 year old girls

8-15 year old boys

Specialized Programs for Girls & Boys:

Career Awareness Program (CAP)/Camp Mariah (Currently in the 6th grade) (11-12 years old by 06/29/20)

Explorers Summer Learning Program (11-12 years old by 07/13/20)

11-12 years old

Returning applicants can reapply until age 15

Returning teens who will be 16 or 17 years old by 06/29/20 can apply to the Counselor-in-Training (CIT) program

Income

Families are eligible if:

1. Family receives Public Assistance (TANF/SNAP/Medicaid/ Section 8 Voucher).

OR

2. Child is currently in foster care.

OR

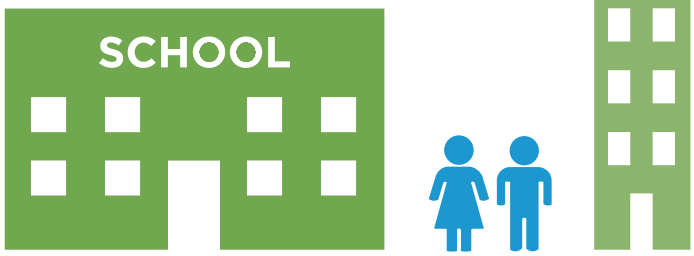
3. **Total Household Income:**

   Camp: Meets USDA income guidelines for free/reduced lunch.

   Friendly Towns: No more than $10,000 above the USDA income guidelines.

Address

Children must live in and go to school in one of NYC's 5 boroughs. Camp Junior applicants must live in the Bronx.



Medical Form

Option 1: DOE/DOH medical form and the "Authorized Medications" form

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

Friendly Towns Applicants:
Most recent physical exam must have happened **on or after 01/01/19**

Camp Applicants:
Most recent physical exam must have happened **on or after 06/01/2019**

Attachment A

Summer 2020 Program Summary

Friendly Towns

Every summer, thousands of New York City children visit with volunteer host families who live in rural, suburban, and small town communities along the East Coast and Southern Canada.

Host families apply and go through a rigorous screening process that includes an in-home interview and background check.

First time visits are one to two weeks. After the first summer, children may stay for a longer visit. Children need to be 7-13 years old to register for the first time.

2020 Trip Dates:

Departures are between **Tuesday 06/30** and **Friday 08/20**

Camp

Five of our sleepaway camps are located on Sharpe Reservation, a more than 2,000 acre property, in Fishkill, NY. Our sixth camp, Camp Junior in memory of Lesandro Junior Guzman-Feliz, is located at Harriman State Park.

During their outdoor summer adventures, campers develop the confidence to take on new challenges, explore nature, learn new skills and make new friends.

2020 Session Dates:

	Session	Start Date	End Date	# Days
Camps: ABC, Hayden-Marks, Hidden Valley, Junior, Tommy Camp ABC Leadership Program	1	Monday, June 29	Friday, July 10	12
	2	Monday, July 13	Friday, July 24	12
	3	Monday, July 27	Friday, August 7	12
	4	Monday, August 10	Friday, August 21	12
Career Awareness Program/ Camp Mariah	1	Monday, June 29	Wednesday, July 22	24
	2	Wednesday, July 29	Friday, August 21	24
Explorers Summer Learning Program	1	Monday, July 13	Friday, August 7	26

Important Application Dates

Returning Applicants

- **11/04/19** Time to **apply**!
- **11/18/19** **Application Review** Begins*
- **02/01/20** **Placement Begins****
- **03/15/20** **Confirmation Packets** are mailed
- **Camp**: 06/29/20 **Friendly Towns**: 06/30/20 **Summer Experiences Begin**

If applicable, interviews must be completed by* **03/16/20.

Returning families receive priority through **03/31/20.

New Applicants

- **01/01/20** Time to **apply**!
- **01/14/20** **Application Review** Begins***
- **04/01/20** **Placement Begins**
- **04/15/20** **Confirmation Packets** are mailed
- **Camp**: 06/29/20 **Friendly Towns**: 06/30/20 **Summer Experiences Begin**

****If applicable, interviews must be completed by* **05/22/20.**

Before You Start

Be sure to gather the following information and documents:

Information for **three (3)** Emergency Contacts – must be at least 18 years old and **cannot** be a parent or guardian.

Copy of front and back of health insurance card. (Not applicable if child is in foster care.)

Schedule your **child's doctor's appointment** as soon as possible.

Passport for **Canada trips** through Friendly Towns only

Attachment A

How to Submit your Completed Application & Documents

a) Online: **child.freshair.org**

This is the quickest way to submit your child's application.

b) By email: **apply@freshair.org**

c) By fax: **212-681-0158**

d) With a Community Partner: **www.FreshAir.org/find-an-agency** (to find an agency near you)

e) In person/ by mail:

The Fresh Air Fund
633 Third Avenue, 14th Fl
New York, NY 10017
Attn: Community Outreach
M – F 10 am - 6 pm

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

Remember:

Please keep a copy for your records.

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

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.

What to Expect: Application Procecessing & Registration

Select only **one** of the above submission options. We recommend completing online at **child.freshair.org**.

We will begin reviewing your child's application within **two weeks of receiving it**.

If the application is missing ***any*** part (**see Checklist on next page**), we will contact you up to five times to let you know what is missing and to help you complete the application. If we are not able to reach you, the application will become "**Inactive**."

You may "Re-activate" the application at any time and continue submitting documents until it is complete.

Once we have finished reviewing your application, we will call and email you with the Participation Decision (registered or declined).

If registered, you will receive details via written confirmation (mail, email and/or text). **Please do not assume that your child has been registered if you do not receive this confirmation.**

Important Information

1) Completing the application by **April 30** may improve your child's chances of being accepted for a Summer 2020 experience.

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

3) **Submitting an application does *not* guarantee placement.**

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

5) Whether you are applying for camp or a visit with a host family, telling us a lot about your child helps us make their experience better!

6) If in foster care, ensure that the application is signed by the person **legally authorized to make decisions** for the child and complete **Page FC1**. If you are not the child's legal guardian, we require legal proof of guardianship.

7) Our programs accommodate children with special needs/circumstances, but they are ***not*** specifically designed for all special needs. We will refer you to the American Camp Association if we are not able to accommodate your child in one of our programs.

Attachment A

Application Checklist

Your application is complete once ALL of the below forms and documents have been received.

Submitting the application by April 30, 2020 may improve your child's chance of being accepted for Summer 2020.

If you have questions, please contact the Community Outreach team at **1-800-367-0003.**

Friendly Towns

- ☐ Page 1: Parent/Guardian Information
- ☐ Page 2: Child Information
- ☐ Page 3: Summer Food Service Form
- ☐ Page 4: Health History
- ☐ Page 5: Additional Health History
- ☐ Page 6: Additional Health Information
- ☐ Page 9: Information for Friendly Towns
- ☐ Page 10: Program & Session Selection
- ☐ Page 11: Emergency Contacts
- ☐ Pages 12 & 13: Parental Consent & Release
- ☐ Medical Form & Immunization Record

Camp

- ☐ Page 1: Parent/Guardian Information
- ☐ Page 2: Child Information
- ☐ Page 3: Summer Food Service Form
- ☐ Page 4: Health History
- ☐ Page 5: Additional Health History
- ☐ Page 6: Additional Health Information
- ☐ Page 7: Meningococcal Meningitis Vaccination Form
- ☐ Page 8: Vision Van Form
- ☐ Page 10: Program & Session Selection
- ☐ Page 11: Emergency Contacts
- ☐ Page 12 & 13: Parent Consent & Release
- ☐ Medical Form & Immunization Record

Supplemental Documents (Required if applicable)

- ☐ Legal Guardianship Papers (Court-approved)
- ☐ Evaluation Form
  Dated after 01/02/20 & received by 04/30/20
- ☐ Special Dietery Plan
- ☐ Foster Care Information Page (FC1)
- ☐ Treatment Plan(s)
  Allergies/Asthma/Diabetes/Seizure Disorder
- ☐ Health Insurance Cards

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 A

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

Summer Food Service Program: Information for Parents

This insert relates to Page 3 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*
2	$31,284	$2,607	$ 608
3	$39,461	$3,289	$ 759
4	$47,638	$3,970	$ 917
5	$55,815	$4,652	$1,074
6	$63,992	$5,333	$1,231
For each additional family member, add:	*$ 8,177*	*$ 682*	*$ 158*

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, Tommy, and Camp Junior will serve breakfast at 8:00am, lunch at 12:30pm, and dinner at 6:00pm on the following dates:

Monday, June 29, 2020 - Friday, July 10, 2020
Monday, July 13, 2020 - Friday, July 24, 2020
Monday, July 27, 2020 - Friday, August 7, 2020
Monday, August 10, 2020 - Friday, August 21, 2020

Camp Mariah will serve breakfast at 8:00am, lunch at 12:30pm; and dinner at 6:00pm on the following dates:

Monday, June 29, 2020 - Friday, July 22, 2020
Wednesday, July 29, 2020 - Friday, August 21, 2020

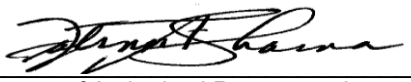
Please fill out the enclosed “Summer Food Service Program Form” (Page 3) and include it in your application.

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

11/01/2019

Date

Attachment A

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

Instructions for completing Page 3 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 A

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

Meningococcal Meningitis: Information for Camp Applicants Only (Page 7)

November 1, 2019

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: https://www.health.ny.gov;
- The Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines and
- The American College Health Association: www.acha.org.

Attachment A

PAGE 1 | **The Fresh Air Fund: Parent/Guardian Information** | **2020 CHILD APPLICATION**

_____ ___ _____ DOB ___ - ___ - 2 0 ___

Child's First Name **MI** **Last Name** MONTH DAY YEAR

Please do not cover barcode

Please provide information for the **CHILD's PRIMARY PARENT/GUARDIAN.**

This person will receive verbal and written application updates and communication from us.

Parent/Guardian 1 First Name: _____ **Last Name:** _____

Email Address: _____ **Preferred to be contacted by:** ☐ Email ☐ Primary Phone

Mailing Address: _____ **Apt #:** _____

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

Cell (: _____ **Home (:** _____ **Work (:** _____

Which number is your primary phone number? ☐ Cell ☐ Home ☐ Work

* **Relationship to child:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____ **☐ Currently living with child**

**** Please note**: If you are not the mother or father, you must provide a copy of court–approved guardianship papers.*

Please provide information for the **SECONDARY PARENT/GUARDIAN**.

☐ No secondary parent/guardian

Parent/Guardian 2 First Name: _____ **Last Name:** _____

Email Address: _____

Cell (: _____ **Home (:** _____ **Work (:** _____

* **Relationship to child:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____ **☐ Currently living with child**

☐ This person can receive verbal application updates

☐ This person can pick up child upon return from summer experience

Please tell us about your **HOUSEHOLD**.

1. **Preferred language to communicate with The Fresh Air Fund:**
   ☐ English ☐ Spanish ☐ Mandarin ☐ Other: _____
2. **Language(s) spoken at home:** *(check all that apply)*
   ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Creole ☐ Korean ☐ French ☐ Other: _____
3. **Is your child your regular interpreter?** ☐ Yes ☐ No
4. **Household type:** ☐ Single parent/guardian ☐ Two parents/guardians ☐ Other: _____ ☐ Prefer not to say
5. **Total number of ADULTS (18+) in household:** 1 2 3 4 5 Other: _____
6. **Total number of CHILDREN (up to age 17) in the household:** 1 2 3 4 5 6 7 8 Other: _____
7. **Is your family currently homeless or living in temporary shelter?** ☐ Yes ☐ No
   If yes, where are you living? ☐ In a shelter ☐ With family/friends ☐ Other:_____ ☐ Prefer not to say
8. **Is Parent/Guardian a former Fresh Air participant?** ☐ Yes ☐ No

If applying for the first time, how did you hear about us?

☐ Ad ☐ Flyer ☐ Friend/Family ☐ Website ☐ Community Partner (name) _____

☐ School (name) _____ ☐ Other: _____

OFFICIAL USE ONLY **Date Received by FAF:** _____

Source: ☐ Email ☐ Fax ☐ Mail ☐ Phone ☐ Community Partner: _____

☐ FT Ambassador _____ **☐ School Event ☐ Summer in the Winter Party ☐ Street Outreach ☐ Walk-in**

☐ Other _____ **FAF STAFF INITIALS** _____

Attachment A

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

Please do not cover barcode

Please tell us about your **CHILD**. ***Note: Child must be 7 years old by 08/10/2020 to participate.***

Child First Name: _____ **M.I.** _____ **Last Name:** _____

Nickname: _____ **Date of Birth:** ___ – ___ – 2 0 ___ ___
MONTH DAY YEAR

Gender: ☐ Male ☐ Female ☐ Other: _____ **Age:** 6 7 8 9 10 11 12 13 14 15 16 17 18

Preferred Pronoun: ☐ She, her, hers ☐ He, him, his ☐ They, them, theirs

Race/Ethnicity: ☐ African American/Black ☐ African ☐ American Indian/Alaskan Native ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other: _____ ☐ Prefer not to say

Please tell us about your **CHILD's SCHOOL**.

School Name: _____ **School Borough:** _____ **2019-2020 Grade:** _____

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

Please tell us more about your **CHILD**.

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 ☐ Other
3. **Is your child in foster care?** ☐ **Yes** ☐ **No** *(If Yes, additional form required - Foster Care Info Page [FC1])*
4. **Does your child receive public assistance?** ☐ **Yes** ☐ **No** If yes, *check all that apply*
   ☐ Cash Assistance ☐ TANF ☐ SNAP ☐ Other: _____
   Please provide Cash Assistance Case Number: _____
   Please Provide SNAP Case Number: _____
5. **Please tell us your child's comfort level with communicating in English:**
   ☐ Only speaks English / Fluent in English
   ☐ English is second language but comfortable speaking to others in English
   ☐ Learning English / Speaks very little English - Native language: _____ (☐ In ELL / ENL classes in school)

Please tell us about the **SERVICES** your **CHILD** receives in or out of school. ***Please answer both questions.***

1. **Mark all SERVICE(S) your child receives:**
   (Must check at least one)
   - ☐ IEP (Individualized Education Plan) *(i.e. Special Needs Program/Classes, including SETTS)*
   - ☐ 1:1 Paraprofessional
   - ☐ Counseling/Therapy (in or out of school)
   - ☐ 504 Accommodations. Please explain below.
   - ☐ Other. Please explain below.
   - ☐ None

2. **Mark all service PROVIDER(S) your child sees:**
   (Must check at least one)
   - ☐ Psychiatrist
   - ☐ Psychologist
   - ☐ Social Worker
   - ☐ Other. Please explain below.
   - ☐ None

Please explain as indicated above. _____

If you marked any box above, please call 1-800-367-0003 to get The Fresh Air Fund's Evaluation Form.
This information helps in making the best programming decisions for your child and allows us meet their needs and offer a safe experience.

Attachment A

Must be completed by Parent/Legal Guardian (See **Page vi** for instructions)

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/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

Attachment A

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20___
MONTH DAY YEAR

Please do not cover barcode

Please tell us about your **CHILD's HEALTH HISTORY**.

	Has/does your child...	YES/SI	NO
1	Had a recent injury, illness or infectious disease?	☐	☐
2	Had a chronic or recurring illness/condition?	☐	☐
3	Have asthma?	☐	☐
4	Have allergies?	☐	☐
5	Ever been hospitalized?	☐	☐
6	Ever had surgery?	☐	☐
7	Had frequent headaches?	☐	☐
8	Ever had a head injury?	☐	☐
9	Ever been knocked unconscious?	☐	☐
10	Ever had frequent ear infections?	☐	☐
11	Ever been diagnosed with a heart murmur?	☐	☐
12	Ever had seizures/have a seizure disorder?	☐	☐
13	Had skin problems (e.g. itching, acne, eczema)?	☐	☐
14	Been treated for head lice in last six months?	☐	☐
15	Ever had problems with frequent diarrhea/constipation?	☐	☐
16	Ever had an eating disorder?	☐	☐
17	Wear glasses, contacts or protective eye wear?	☐	☐
18	**If female**, begun to menstruate?	☐	☐
	If not, does she know about the menstrual cycle?	☐	☐
19	Know how to swim? (If yes, no explanation needed)	☐	☐
20	Have a fear of being in the water?	☐	☐
21	Have a fear of being around animals?	☐	☐
22	Wet his/her bed?	☐	☐
	If yes, how often?	_____	
	If yes, is it a medical issue?	☐	☐
23	Have motion sickness?	☐	☐

Please explain all 'Yes' answers. Include the question number and the most recent occurrence./***Por favor explique todas las respuestas de 'Sí'.*** *Incluya el número de la pregunta y el caso más reciente.*

_____

_____

_____

_____

_____

_____

_____

_____

Attachment A

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__
MONTH DAY YEAR

Please do not cover barcode

Please tell us more about your **CHILD's HEALTH HISTORY**

1. Does your child have one of the following physical or medical conditions?

(Please check all that apply or "None")

- ☐ Cerebral Palsy
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hearing Impairment
- ☐ Hydrocephalus
- ☐ Visual Impairment
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ None
- ☐ Other *(please explain)* _____

2. Does your child have one of the following behavioral, cognitive, social or emotional conditions?

(Please check all that apply or "None")

- ☐ ADHD
- ☐ Adjustment Disorder
- ☐ Autism Spectrum Disorder
- ☐ Disruptive Mood Dysregulation Disorder
- ☐ Down Syndrome
- ☐ Emotional Disturbance
- ☐ Intellectual Disability
- ☐ Oppositional Defiant Disorder
- ☐ None
- ☐ Other *(please explain)* _____

3. Does your child currently have any other physical, mental, emotional, social health, developmental or psychological condition that will require medication, treatment or special restrictions or considerations during the program?

☐ Yes ☐ No If Yes, please explain: _____

4. Does your child have any activity exemptions, restrictions or limitations?

☐ Yes ☐ No If Yes, please explain: _____

Attachment A

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__
MONTH DAY YEAR

Please do not cover barcode

Please tell us about your **CHILD's HEALTH INSURANCE COVERAGE.**

Check one of the following / *Marque uno de los siguientes*:

☐ **Child has private health insurance (e.g. through my employer or the open market)**
El niño tiene seguro médico privado (por ejemplo, a través de mi empleador o el mercado abierto)

Policy includes dental coverage / *Póliza incluye cobertura dental* ☐ Yes/Sí/是 ☐ No/没有

☐ **Child has health insurance through NYS Medicaid**
El niño tiene seguro de salud a través de Medicaid del Estado de Nueva York.

If applicable, check provider and submit copy of insurance card with Medicaid card:
Si corresponde, consulte al proveedor y envíe una copia de la tarjeta de seguro con la tarjeta de Medicaid:

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

☐ **Child is in foster care** / *El niño está en cuidado de crianza*

☐ **Child does not have health insurance** / *El niño no tiene seguro de salud*

Would you like a referral to help you get health insurance? ☐ Yes/Sí/是 ☐ No/没有

A clear copy (front and back) of your child's health insurance card(s) is required/
Se requiere una copia clara (anverso y reverso) de la (s) tarjeta (s) de seguro de salud de su hijo

Please tell us more about your **CHILD's HEALTH INFORMATION**

1. **Does your child have any dietary restrictions (e.g. vegetarian, no pork, lactose intolerant, gluten-free)?** /
¿Su niño tiene alguna restricción dietética (ej. Vegetariano, no come cerdo, intolerante a lactosa, libre de gluten)?
☐ Yes/Sí Please explain / *por favor explique*: ☐ No red meat ☐ No poultry ☐ No pork ☐No seafood
☐ No ☐ No eggs ☐ No dairy product ☐ Other: _____

These dietary restrictions are due to: / *Estas restricciones dietéticas son debido a:*
☐ **Allergies/Medical Condition(s)** ☐ **Religious Beliefs** ☐ **Personal Preferences** ☐ **Other** _____
Alergias/Condiciones médicas *Creencias religiosas* *Preferencia personal* *Otro*

2. **Is your child currently taking any medication? / ¿Su niño esta actualmente tomando algún medicamento?**
☐ Yes/Sí Please explain / *por favor explique*: _____
☐ No

3. **Has an epi-pen been prescribed for your child?** */¿Su niño ha tenido una prescripción para una inyección de epinefrina?*
☐ Yes/Sí Please answer the questions below
☐ No

a. **Has the prescription been filled?** ☐ Yes/Sí
☐ No

b. **Has the epi-pen ever been used?** ☐ Yes/Sí Date/approximate date most recently used: ___ - ___ - ____
MONTH DAY YEAR
☐ No

c. **Does your child know how to inject him/herself?** */ ¿Su niño sabe como inyectarse?* ☐ Yes/Sí
☐ No

Please note / Por favor note: *If an epi-pen is prescribed, it is required during Fresh Air Fund trip. / Si su niño tiene una prescripción para una inyección de epinefrina (Epi-pen), es requerida durante su experiencia con el Fresh Air Fund.*

Child's First Name ___ MI ___ Last Name ___ DOB ___ - ___ - 2 0 ___
MONTH DAY YEAR

Please do not cover barcode

To be completed by Parent/Guardian.

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.

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.

Please provide all information.

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

Print Name: _____

Email Address: _____

Mailing Address: _____

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

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 2 0 ___
MONTH DAY YEAR

Please do not cover barcode

Please give your consent for your **CHILD to visit the VISION VAN at Camp.**

Your child is eligible to receive a **free eye examination and pair of glasses** during camp 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.

The state board of optometry may require a dilated fundus exam as part of an eye examination performed by a licensed optometrist. 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 which may make reading difficult.

☐ **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

By signing below, 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.

Signature of parent or legal guardian: _____ **Date:** _____/_____/_____

Please share some additional **HEALTH INFORMATION**.

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: _____

_____

_____

Child's First Name ___ MI Last Name DOB ___ - ___ - 20___ (MONTH - DAY - YEAR)

Please do not cover barcode

Please tell us more about your **CHILD**.

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: _____ ☐ No changes

Please complete the rest of this page if you are applying for the **Friendly Towns** program.

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

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

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

☐ Quiet ☐ Sad ☐ Shy ☐ Talkative ☐ Other _____

Please ask your child what they are interested in doing with their host family *(check all that apply):*

☐ Swimming & Water Activities
☐ Exploring Nature (Hiking / Fishing)
☐ Bike Riding
☐ Camping
☐ Cooking / Baking
☐ Arts & Crafts
☐ Sports (Basketball / Soccer)
☐ Watching TV / Movies
☐ Attending Community Events
☐ Picnicking / Going to Playgrounds / Playing Outdoors
☐ Reading

☐ Other *(Please Explain)* _____

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: _____

_____

_____

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

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

---

What are your child's favorite foods? _____

_____

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20___ (MONTH - DAY - YEAR)

Please do not cover barcode

Please indicate preferred program:

☐ Friendly Towns ☐ Camp ☐ Camp Junior ☐ ABC Leadership ☐ CAP ☐ Explorers ☐ CIT

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

Friendly Towns (Host Family Program)

My child is available to travel as follows:

Check all that apply. The dates below are time frames, not exact trip dates. Trips for first time participants are only 7-10 days.

Early July	☐	**June 29 - July 11**
Late July	☐	**July 12 - July 31**
Early August	☐	**August 1 - August 8**
Mid-Late August	☐	**August 9 - August 20**

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

(Check all that apply)

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

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? ___ - ___ - ___ (MONTH - DAY - YEAR)

****A copy of child's U.S. passport is required****

Returning Participants Only:

Does your child want to return to their Summer 2019 host family if they are available?

☐ Yes ☐ No

Summer Camp & Camp Junior

Summer Camp	Camp Junior
• Girls 8-13 and Boys 8-15	• Bronx residents only
• ABC Leadership: Must have attended Camp ABC, Hidden Valley or Camp Mariah and be invited to apply	• New: Girls & Boys 9-13
	• Returning: Girls & Boys 9-15

Using 1 - 4, please indicate session preferences:

1 for 1st Choice, 4 for 4th Choice

Session 1	☐	**June 29 - July 10** (12 days)
Session 2	☐	**July 13 - July 24** (12 days)
Session 3	☐	**July 27 - August 7** (12 days)
Session 4	☐	**August 10 - August 21** (12 days)

*** CITs must attend all 4 sessions**

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

☐ Yes ☐ No

Please Note:

Children must participate in the full session/trip and use transportation arranged by The Fresh Air Fund.

Sessions/trips are not allowed to start late or end early.

Career Awareness Program/Camp Mariah

New CAP applicants must be:

- 11 or 12 years old on the first day of the program (06/29)
- In the 6th grade when they apply
- Willing to commit to 3-year program including school year activities
- Interviewed by program staff

Returning CAP campers attend same session as Summer 2019.

New applicants, please indicate session preferences:

1 for 1st Choice, 2 for 2nd Choice

Session 1	☐	**June 29 - July 22** (24 days)
Session 2	☐	**July 29 - August 21** (24 days)

Explorers Summer Learning Program

Applicants must be:

- 11 or 12 years old on the first day of the program (07/13)
- In the 6th grade when they apply
- At Camp for the full 26-day session
- Interviewed by program staff

Session	☐	**July 13 - August 7** (26 days)

Child's First Name ___ MI ___ Last Name _____ DOB ___ - ___ - 20___ (MONTH - DAY - YEAR)

Please do not cover barcode

Please provide **EMERGENCY CONTACT** information.

Please provide information for **three (3) adults** we can contact if we are unable to reach you about this application or during your child's trip. Emergency Contacts **CANNOT** be the primary or secondary contacts listed on page 1 of this application, and must each have a unique phone number and email address. They **MUST BE 18 YEARS OR OLDER** and **BE AUTHORIZED TO PICK UP YOUR CHILD** if you are unable to do so on either the scheduled return date or if your child must return home early from their camp or their host family experience.

Emergency Contact 1

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

Relationship to child: ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Cousin ☐ Family Friend ☐ Other: _____

18 or older? ☐ Yes ☐ No

Cell (: _____ **Home (:** _____ **Work (:** _____

Email Address *(optional)*: _____

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

Emergency Contact 2

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

Relationship to child: ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Cousin ☐ Family Friend ☐ Other: _____

18 or older? ☐ Yes ☐ No

Cell (: _____ **Home (:** _____ **Work (:** _____

Email Address *(optional)*: _____

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

Emergency Contact 3

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

Relationship to child: ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Cousin ☐ Family Friend ☐ Other: _____

18 or older? ☐ Yes ☐ No

Cell (: _____ **Home (:** _____ **Work (:** _____

Email Address *(optional)*: _____

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

Child's First Name ___ MI ___ Last Name ___ DOB ___-___-20__ (MONTH DAY YEAR)

Please do not cover barcode

Please read, sign and date both **PARENTAL CONSENT & RELEASE FORMS** *(pages 12 and 13)*

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, Harriman State Park (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. My 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 Activities) 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 & Release Form on behalf of Child Parties and to bind them hereby.

Signature: _____ Date: _____/_____/_____

Print Name: _____

Title if child is in foster care: _____

Child's First Name ____ MI ____ Last Name ____ DOB ___-___-20__ (MONTH DAY YEAR)

Please do not cover barcode

Please read, sign and date both **PARENTAL CONSENT & RELEASE FORMS** *(pages 11 and 12).*

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, teachers, principals, 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 communicate directly with my child's primary physician to complete the application and medical forms, if necessary.
7. To provide the Host Family with a copy of my child's health insurance card while s/he is in the Friendly Towns Program.
8. 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.
9. 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.
10. 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.
11. To share my child's health record with duly licensed physicians, nurses, or qualified medical personnel of any hospital, urgent care facility, or clinic.
12. To share my child's health insurance information (medical and/or dental) with any provider of medical services to my child.
13. 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).
14. To receive billing and receipt information, and discharge papers once services are rendered by medical professional(s).

C) I acknowledge that:

15. 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 10 of this application. I acknowledge that only those participants who are 16 years of age or older may sign themselves out upon arrival at the return site with prior written parental permission.
16. I have read, or have had explained to me, information about meningococcal meningitis disease and vaccination included in the application's information packet, and if I choose not to have my child vaccinated, I confirm that I understand the risks of not having my child vaccinated.
17. My child may use non-aerosol sunscreen and bug repellant 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.
18. In addition to calls from The Fresh Air Fund's staff and volunteers, information for application completion, participation confirmation, and other updates may be sent by email, text or automated phone calls.
19. 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.
20. 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.
21. 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.
22. Designated Fresh Air Fund staff may access my child's immunization record through the NYC Department of Health's Citywide Immunization Registry or the NYS Immunization Information System to expedite application completion if I do not submit it.

Signature: _____ Date: _____/_____/_____

Print Name: _____ Title if child is in foster care: _____

Attachment A

FC1 **The Fresh Air Fund: Foster Care Information** **2020 CHILD APPLICATION**

Child's First Name ___ MI ___ Last Name ___ DOB ___ - ___ - 20___
MONTH DAY YEAR

Must be Completed by Foster Care Agency

1. **This child has been in foster care since:** ____/____/____
MONTH DAY YEAR
2. **This child has been in the current foster home since:** ____/____/____
MONTH DAY YEAR
3. **Is this child's current home in one of the five boroughs?** ☐ Yes ☐ No If no, indicate city ____
4. **This child receives services from a:** *(check all that apply)*
   ☐ Counselor ☐ Social Worker ☐ Case Worker
   ☐ Psychiatrist ☐ Psychologist ☐ Guidance Counselor
   ☐ Other: ____ ☐ None

If you marked a provider above, call 1-800-367-0003 to obtain The Fresh Air Fund's Evaluation Form

With whom should FAF communicate for application completion? *(Choose one)* ☐ Case Worker ☐ Foster Parent ☐ Biological Parent

Agency Name: ____

Case Worker Name: ____
Work (: ____
Cell (: ____
Email: ____

Supervisor Name: ____
Work (: ____
Cell (: ____
Email: ____

Foster Parent Name: ____
Home (: ____ Work (: ____
Cell (: ____ Email: ____

Biological Parent Name *(If applicable)*: ____
Home (: ____ Work (: ____
Cell (: ____ Email: ____

The biological parent can:
Get information about the trip dates and location? **☐ Yes ☐ No**
Communicate with the child during the scheduled trip? **☐ Yes ☐ No**

IN CASE OF MEDICAL EMERGENCY, CONTACT:

Name: ____ Title: ____
Phone (: ____ Email: ____

Please list the individuals authorized to pick up this child (if different than those on Page 1):

	Contact name	Relationship	18 or older?	Phone number(s)
1			☐ Yes ☐ No	
2			☐ Yes ☐ No	

Must be Signed & Dated by Foster Care Agency

Signature: ____ **Date:** ___ - ___ - ____
MONTH DAY YEAR

Print Name: ____

Title: ____

Attachment A

Medical 1 | **The Fresh Air Fund: Medical Form** | **2020 CHILD APPLICATION**

Child's First Name _____ MI ___ Last Name _____ MONTH __ DAY __ YEAR ____

Please do not cover barcode

This form 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

Date of last asthma-related emergency room visit: MONTH __ DAY __ YEAR ____

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** ***(* Action Treatment Plan REQUIRED)***

Behavioral Information

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

☐ 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

Does this child currently take insulin? ☐ Yes ☐ No

If Yes, please attach Diabetes Treatment or Action 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. ☐ Other** _____

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 _____

Continued on next page. Doctor signature, stamp, and date re-

Attachment A

Medical 2 | **The Fresh Air Fund: Authorized Medications** | **2020 CHILD APPLICATION**

Child's First Name ____ MI ____ Last Name ____ MONTH ___ DAY ___ YEAR ___

Please do not cover barcode

Routine Medications

This form MUST be completed by a Doctor or qualified Medical Personnel.
Note: All listed medications will be required for check-in.

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 takes medications as indicated below

Medication name	Route	Dosage	Frequency	Diagnosis/Comments

Other Authorized Medications

The following medications are available in the camp infirmary/at hosts' homes and will be dispensed at the discretion of medical personnel or hosts, 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/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, psychological, 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:** ___ MONTH ___ DAY ___ YEAR

Date of Exam must be after June 1, 2019

Attachment B

the Fresh Air fund

because a summer can last a lifetime™

Date: _____

_____

_____

_____

Dear _____,

Congratulations! _____ is approved by The Fresh Air Fund for participation in the Summer 2020 HRA/FAF Pilot Program. The summer sleep-away experience details are provided below. You will receive a more detailed confirmation packet by email in the next 1-7 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 _____ this summer! Thank you for choosing The Fresh Air Fund for your child's Summer 2020 sleep-away experience!

Sincerely,

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

---

Experience Details:

Child's Name: _____

Cash Assistance #: _____

FAF Program: _____

Scheduled Experience Dates: _____, 2020 – _____, 2020

633 Third Avenue FL14
New York, NY 10017

EXECUTIVE DIRECTOR Fatima Shama

t 800 367 0003
t 212 897 8900

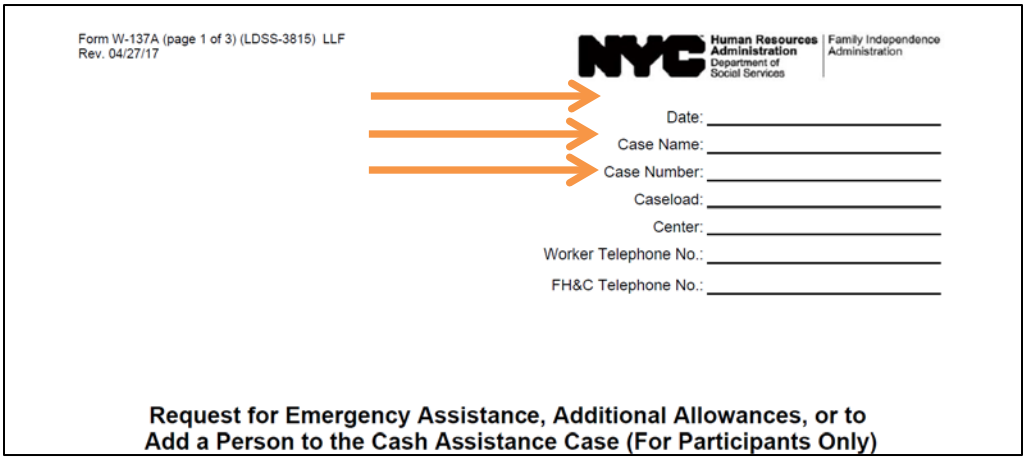
www.freshair.org

Find us on: twitter facebook linkedin instagram

Attachment C

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".



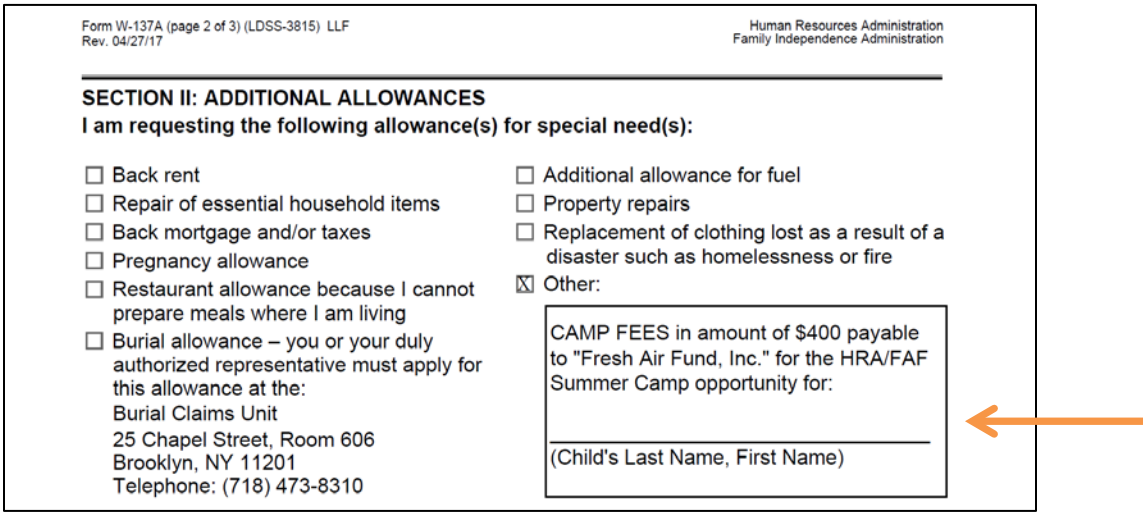
Form W-137A (page 1 of 3) (LDSS-3815) LLF
Rev. 04/27/17

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

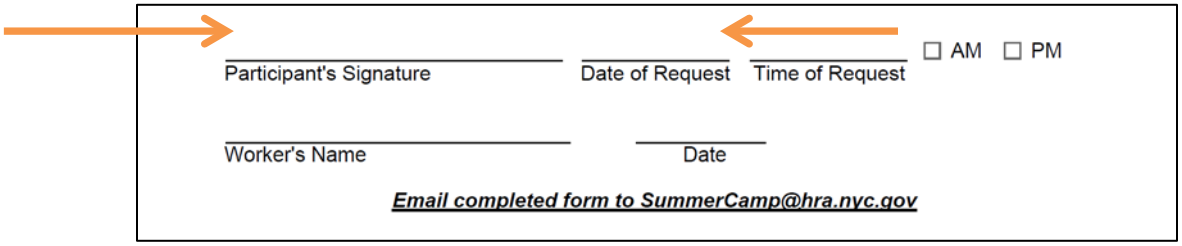
SECTION II: ADDITIONAL ALLOWANCES
I am requesting the following allowance(s) for special need(s):

- ☐ 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 of 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 C

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)

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
- ☐ 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)

- ☐ **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.)

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:

☐ **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: _____