Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING

POLICY BULLETIN # 22-23-OPE

MANDATORY DISPUTE RESOLUTION (MDR) PROCESS IS NOW OBSOLETE

Date:	**Subtopic(s):**
April 11, 2022	Fair Hearings

The purpose of this Policy Bulletin is to inform Job Center and Fair Hearing and Conference staff that the Mandatory Dispute Resolution (MDR) process has been terminated.

Accordingly, all MDR policies (and associated forms) are now obsolete, including:

POLICY BULLETIN #12-82-OPE
POLICY BULLETIN #12-79-OPE
POLICY BULLETIN #05-95-OPE
POLICY DIRECTIVE #05-38-OPE

Center Directors must ensure that all current and previous versions of MDR forms and literature are properly disposed of.

Effective Immediately

Attachments:

M-186jj	Mandatory Dispute Resolution Appointment (Rev. 8/21/12) (*Obsolete*)
M-186jj (S)	Mandatory Dispute Resolution Appointment (Spanish) (Rev. 8/21/12) (*Obsolete*)
M-186rr	Mandatory Dispute Resolution Action Taken Form (Rev. 8/21/12) (*Obsolete*)
M-186rr (S)	Mandatory Dispute Resolution Action Taken Form (Spanish) (8/21/12) (*Obsolete*)
M-186tt	Mandatory Dispute Resolution No Action Taken Form (10/31/05) (*Obsolete*)
M-186tt (S)	Mandatory Dispute Resolution No Action Taken Form (Spanish) (10/31/05) (*Obsolete*)
W-204R	Mandatory Dispute Resolution (MDR) Summary (2/22/01) (*Obsolete*)

Form M-186jj LLF
Rev. 8/22/12

Human Resources Administration
Department of Social Services
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Fair Hearing Number: _____

Center: _____

Mandatory Dispute Resolution Appointment

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

OBSOLETE

New York State informs us that you have a Fair Hearing request, with the above Fair Hearing number.

This notice informs you that, prior to the Fair Hearing, you must attend a Mandatory Dispute Resolution (MDR) interview to discuss the issues relating to your cash assistance benefits that you intend to raise at the Fair Hearing.

You Must Report to Reception on:

Appointment Date: _____ Time: _____ Telephone: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

At the MDR Interview appointment, you will meet with a Supervisor to attempt to resolve the issues regarding your requested Fair Hearing. This will be your opportunity to discuss the issues regarding your cash assistance benefits. You will not be required to discuss any Medicaid or Supplemental Nutrition Assistance Program (SNAP) issues unless you choose to. At this appointment, you should present any evidence, testimony, and/or documentation that you intend to present at the Fair Hearing.

If you have been designated as a homebound appellant or are scheduled for a telephone hearing by the New York State Office of Temporary and Disability Assistance, Office of Administrative Hearings, we will contact you by telephone to attempt to resolve your issues.

If you are unable to keep the MDR appointment, you can reschedule it by calling _____. If you fail to keep the MDR appointment, the Hearing Officer will determine whether or not you had good cause for missing it. If he/she determines that you did not have good cause, this could affect your benefits. The Hearing Officer may consider your failure to appear at the MDR appointment in deciding whether to believe your testimony concerning the issue for which you requested the hearing. In determining whether good cause exists, the Hearing Officer must consider the facts, circumstances, and information submitted by you, including circumstances beyond your control.

Form M-186jj (S) LLF
Rev. 8/22/12

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

Fecha: _____

Número del caso: _____

Nombre del caso: _____

Número de audiencia imparcial: _____

Centro: _____

Cita Obligatoria para Resolución de Disputa

NOTA: A partir del 29 de agosto de 2012, toda referencia al Programa de Cupones para Alimentos en este aviso se denominará el Programa de Asistencia de Nutrición Suplementaria (SNAP, por sus siglas en inglés) y toda referencia a Cupones para Alimentos se denominará beneficios de SNAP.

OBSOLETE

El estado de Nueva York nos ha informado sobre su petición para una audiencia imparcial, cuyo número aparece arriba.

Mediante el presente aviso le informamos que antes la audiencia imparcial, usted tiene que asistir a una entrevista obligatoria para resolución de disputa (MDR, por sus siglas en inglés) para tratar sobre los asuntos relativos a sus beneficios de asistencia en efectivo que desea plantear en la audiencia imparcial.

Debe presentarse en la recepción el:

Fecha de la cita: _____ Hora: _____ Teléfono: _____

Dirección: _____

_____

Ciudad: _____ Estado: ____ Código postal: _____

Durante la cita para la entrevista de MDR, usted se reunirá con un supervisor para tratar de solucionar los problemas relativos a la audiencia imparcial solicitada. Esta será su oportunidad de tratar los problemas relativos a sus beneficios de asistencia en efectivo. Sin embargo, no será necesario que se trate ningún asunto de Medicaid o de los beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP), a menos que así lo desee. Durante esta cita, usted debe presentar cualquier prueba, testimonio y/o documentos que usted tenga intención de presentar durante la audiencia imparcial.

Si usted ha sido designado como apelante confinado al hogar o si la Oficina de Asistencia Temporal para Incapacitados del Estado de Nueva York y la Oficina de Audiencias Administrativas (New York State Office of Temporary and Disability Assistance, Office of Administrative Hearings) le han programado una audiencia telefónica, entonces nosotros nos comunicaremos con usted por teléfono para tratar de resolver sus problemas.

Si usted no puede presentarse a la cita de MDR, la puede reprogramar llamando al _____.
Si no se presenta a su cita de MDR, el funcionario de audiencias determinará si usted tuvo motivo justificado para faltar a la cita de MDR. Si él/ella determina que usted no tuvo motivo justificado, esto podría afectar sus beneficios. El funcionario de audiencias podría tomar en consideración el hecho que usted haya faltado a la cita de MDR, al momento de decidir si su testimonio sobre los problemas por los cuales ha solicitado una audiencia es verídico. Para determinar si existe motivo justificado, el funcionario de audiencias tiene que considerar todos los hechos, circunstancias e información que usted presente, incluyendo circunstancias ajenas a su voluntad.

Form M-186RR LLF
Rev. 8/21/12

Human Resources Administration
Department of Social Services
Family Independence Administration

Date: _____

Case Number: _____

Appellant's Name: _____

Date of Fair Hearing: _____

Fair Hearing Number: _____

Mandatory Dispute Resolution Action Taken Form

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

I. Reason(s) for Requesting Fair Hearing (list all reasons appearing on **OAH-1891**)

Mandatory Dispute Resolution (MDR) issues: _____

_____

_____

Other issues (if any): _____

_____

_____

OBSOLETE

You are not required to discuss Medicaid, SNAP or employment sanction issues at MDR.

II. Action(s) Taken by City Agency

The City Agency has taken the following action(s):

☐ Benefits issued: _____

_____

_____

☐ Other action(s) to be taken by City Agency: _____

_____

If these actions were not taken by the date of the Fair Hearing, you should attend the Fair Hearing. You may contact your worker or the City Agency Supervisor listed below for an explanation.

III. Appellant's Fair Hearing Rights

- **I understand that the Fair Hearing I requested will be scheduled by the Sate, and I have a right to attend this Fair Hearing.**
- **I also understand that if there remains any issue in Part I of this form which is not resolved, or if I believe that any of the actions listed in Part II have not been taken, I may discuss these issues at the Fair Hearing.**
- **I understand that if the City Agency took all the actions listed in Part II, and these actions resolved all of my Fair Hearing issues, I may withdraw my request for a Fair Hearing as explained in the State Notice of Fair Hearing (OAH-457) that was or will be sent to me.**

Applicant's Signature: _____ Date: _____

Print name: _____

Supervisor's Signature: _____ Date: _____

Print name: _____

Supervisor's Telephone Number: _____

Form M-186RR (S) LLF
Rev. 8/21/12

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

Fecha: _____

Número del Caso: _____

Nombre del Apelante: _____

Fecha de la Audiencia Imparcial: _____

Número de la Audiencia Imparcial: _____

Formulario de Medida Tomada en la Resolución Obligatoria de Disputa

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

I. Motivos de la Petición de Audiencia Imparcial(anote todos los motivos que figuren en **OAH-1891**)

Temas de la Resolución Obligatoria de Disputas (MDR- Mandatory Dispute Resolution):_____

_____

_____

Otros temas (de haberlos):_____

_____

_____

OBSOLETE

Usted no tiene la obligación de tratar los temas de Medicaid, SNAP o sanciones de empleo en la MDR.

II. Medida(s) Tomada(s) por la Agencia de la Ciudad

La Agencia de la Ciudad ha tomado la(s) siguiente(s) medida(s):

☐ Beneficios expedidos:_____

_____

_____

☐ Otra(s) medida(s) a ser tomadas por la Agencia de la Ciudad:_____

_____

Si estas medidas no se tomaron para la fecha de la Audiencia Imparcial, usted debe asistir a dicha Audiencia. Si desea una explicación, puede comunicarse con su Trabajador o con el Supervisor de la Agencia de la Ciudad indicado abajo.

III. Derechos del Apelante de la Audiencia Imparcial

- **Entiendo que la Audiencia Imparcial que he solicitado será programada por el Estado de Nueva York, y que tengo el derecho de asistir a esta Audiencia Imparcial.**
- **Entiendo además que si algún tema en la Parte I del presente formulario queda sin resolver, o si estimo que cualquiera de las mediadas indicadas en la Parte II no se ha tomado, puedo tratar dicho tema en la Audiencia Imparcial.**
- **Entiendo que si la Agencia de la Ciudad tomó todas las medidas indicadas en la Parte II, y dichas medidas resolvieron todos mis problemas relativos a mi Audiencia Imparcial, puedo retirar mi petición de una Audiencia Imparcial, tal como se indica en el Aviso del Estado de Nueva York de Audiencia Imparcial (State Notice of Fair Hearing - OAH- 457) que se me ha enviado ya, o que se me enviará posteriormente.**

Firma del Solicitante:_____ Fecha:_____

Nombre y Apellido en letra de molde:_____

Firma del Supervisor:_____ Fecha:_____

Nombre y Apellido en letra de molde:_____

Número de Teléfono del Supervisor:_____

Form M-186tt LLF
Rev. 10/31/05

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____
Fair Hearing Number: _____
Center: _____

Mandatory Dispute Resolution No Action Taken Form

The City Agency has explained its determination to me as follows:

OBSOLETE

- I understand that the Fair Hearing I requested will be scheduled by the State and I have a right to attend this Fair Hearing.
- I also understand that the State has sent or will send me a Notice of Fair Hearing (**OAH-457**), which advises me of my rights, including but not limited to my right to attend, adjourn or withdraw the Fair Hearing.

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

Appellant's Signature: _____ Date: _____

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

Agency Supervisor's Signature: _____ Date: _____

Agency Supervisor's Telephone Number: _____ Center Number: _____

Form M-186tt (S) LLF
10/31/05

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Número de la Audiencia Imparcial: _____

Centro: _____

Formulario de Resolución de Disputa Obligatoria sin Acción

La decisión que la Agencia de la Ciudad me ha explicado es la siguiente:

OBSOLETE

- Entiendo que la Audiencia Imparcial que solicité será programada por el Estado y que tengo derecho de asistir a la misma.
- Entiendo también que el Estado me ha enviado o me enviará un Aviso de Audiencia Imparcial (Notice of Fair Hearing [**OAH-457**]) , el cual detalla mis derechos incluyendo, entre otros, mi derecho de asistir, aplazar o anular la Audiencia Imparcial.

Nombre en Letras de Molde: _____ _____ _____
Nombre I. Apellido

Firma del Apelante: _____ **Fecha:** _____

Nombre en Letras de Molde: _____ _____ _____
Nombre I. Apellido

Firma del Supervisor de la Agencia: _____ **Fecha:** _____

Número de Teléfono del Supervisor de la Agencia: _____ **Núm. del Centro:** _____

Form W-204R
Rev. 02/22/01

Human Resources Administration
Family Independence Administration

Mandatory Dispute Resolution (MDR) Summary

Part I - Appellant Information

Last Name	First Name	M.I.
Case Number	**Fair Hearing Number**	**Caseload**

Appointment Date: _____

Time: _____

Part II - Case Record Review

Fair Hearing Issue(s):

List documents in Case Record which support Agency action: *(Please be Specific)*

Indicate steps to be taken to Resolve the Issues: *(Please be Specific)*

OBSOLETE

Part III: Appellant Interview

Was the Appellant Interview Completed?

- ☐ Interview Completed
- ☐ Interview Not Completed

If Interview Was Not Completed, Appellant:

- ☐ Reschedule Appointment: _____ (New Appointment Date)
- ☐ Did Not Appear/Without Good Cause (Explain Below):
- ☐ Did Not Appear/With Good Cause (Explain Below):

New Appointment Date: _____

Explain: _____

- ☐ Appellant signed M-186rr
- ☐ Issues resolved - Agency Action Taken
- ☐ Appellant Complied/Center pulled NOI
- ☐ Appellant signed M-186tt
- ☐ Appellant stated s/he understood Agency Explanation
- ☐ Appellant stated s/he does not understand Agency Explanation

Specify Documents: _____

If Appellant provides or identifies additional documents are the documents sufficient to resolve issue(s)?

- ☐ Yes - Resolve Issue(s)
- ☐ No - Proceed to Hearing

Signature of Unit Supervisor: _____ Date: _____

COPY 1 - CASE RECORD

Form W-204R
Rev. 02/22/01

Human Resources Administration
Family Independence Administration

Mandatory Dispute Resolution (MDR) Summary

Part I - Appellant Information

Last Name	First Name	M.I.
Case Number	**Fair Hearing Number**	**Caseload**

Appointment Date: _____

Time: _____

Part II - Case Record Review

Fair Hearing Issue(s):

List documents in Case Record which support Agency action: *(Please be Specific)*

Indicate steps to be taken to Resolve the Issues: *(Please be Specific)*

OBSOLETE

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New Appointment Date: _____

Explain: _____

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- ☐ Appellant stated s/he does not understand Agency Explanation

Specify Documents: _____

If Appellant provides or identifies additional documents are the documents sufficient to resolve issue(s)?

- ☐ Yes - Resolve Issue(s)
- ☐ No - Proceed to Hearing

Signature of Unit Supervisor: _____ Date: _____

COPY 2 - FH&C

Mandatory Dispute Resolution (MDR) Summary

Part I - Appellant Information

Last Name	First Name	M.I.
Case Number	**Fair Hearing Number**	**Caseload**

Appointment Date: _____

Time: _____

Part II - Case Record Review

Fair Hearing Issue(s):

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Indicate steps to be taken to Resolve the Issues: *(Please be Specific)*

OBSOLETE

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- ☐ Did Not Appear/With Good Cause (Explain Below):

New Appointment Date: _____

Explain: _____

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Specify Documents: _____

If Appellant provides or identifies additional documents are the documents sufficient to resolve issue(s)?

- ☐ Yes - Resolve Issue(s)
- ☐ No - Proceed to Hearing

Signature of Unit Supervisor: _____ Date: _____

Mandatory Dispute Resolution (MDR) Summary

Part I - Appellant Information

Last Name	First Name	M.I.
Case Number	**Fair Hearing Number**	**Caseload**

Appointment Date: _____

Time: _____

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New Appointment Date: _____

Explain: _____

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Signature of Unit Supervisor: _____ Date: _____