The PA Poverty Level Test applies to all PA households except those residing temporarily in hotels/motels, homeless shelters, domestic violence shelters, AIDS housing and congregate care facilities.

REQUIRED ACTION

Before the earned income disregard can be applied, the following financial eligibility tests must be conducted:

- **Gross Income Test** – The semimonthly gross income is compared to 185% of the semimonthly standard of need for the household size. If the gross income exceeds 185% of the standard of need, the household is ineligible for cash assistance.

- **PA Poverty Guideline Test** – If the household's gross income does not exceed 185% of the standard of need, the semimonthly gross income is compared to the current year's semimonthly poverty guidelines limit for the household size (see chart found on page 3 of this directive). If the gross income exceeds the poverty guideline, the household is ineligible for cash assistance.

- **Net Income Test** – If the household's gross income does not exceed the PA poverty guideline limit for the household size, the Net Income Test is conducted. At this point the earned income disregard is applied as follows:

  - If the family or individual has an active PA case or is reapplying on a case that has been closed four months or less, a budget including the income disregard is calculated to determine the household's budget deficit, if any.

    Note: The earned income disregard is not granted for any period of time in which the earned income is not reported in a timely manner (within 10 days of receipt) or is concealed.

  - If the family or individual is applying for the first time or reapplying on a case that has been closed for more than four months, financial eligibility must be determined prior to the application of the earned income disregard. If, without the disregard, there is a budget deficit, the earned income disregard is then applied to determine the household's semimonthly grant.

When calculating a budget in WMS, ABEL automatically performs all three financial eligibility tests.

The Family Budget Computation (Form **W-648**) and the Budget Worksheet for Families with Income in Temporary Housing (Form **W-648D**) have been revised to reflect the 2004 Poverty Level guidelines (shown below) and the decrease in the income disregards. The Guide to Budgeting (**W-203K**) has also been revised to reflect the decrease in the earned income disregard. Location heads must ensure that all previous versions of the **W-648**, **W-648D** and the **W-203K** are recycled.

2004 PA Poverty Level Guidelines	
Size of Family Unit	Semimonthly Limit
1	$387.91
2	$520.41
3	$652.91
4	$785.41
5	$917.91
6	$1050.41
7	$1182.91
8	$1315.41
For each additional person add $132.50 semimonthly.	

As part of the implementation of the changes in the EID and PA Poverty Guidelines, the following will take place:

The Unique Authorization Number for this MRB is **99999343**

- On May 24, 2004, the 43% EID and revised PA Poverty Level Guidelines were made available for all budgets calculated with a budget "effective date" of 6/A/04 or later. Budgets calculated with a budget effective date prior to 6/A/04 will continue to use current amounts.

- A mass rebudget (MRB) of PA/FS cases took place the weekend of May 22–23, 2004 to effect these changes. The Office of Temporary and Disability Assistance (OTDA) has sent the appropriate CNS notices to all cases included in the mass rebudgeting.

- As part of the mass rebudgeting process, all stored budgets that were affected by these changes were rebudgeted. The "effective date" of these budgets is 6/A/04.

- As a result of the mass rebudgeting process, any budget stored more than 60 days before the mass rebudgeting with an effective date more than 30 days prior to the storage date was purged from the system.

Cases Excluded from Mass Rebudgeting	A list of cases excluded from the mass rebudgeting will be forwarded to the Regional Offices. The Regional Offices will forward the lists to the appropriate Centers for rebudgeting and monitor the lists for completion. Upon receipt of this list, the JOS/Workers must rebudget the case(s) and take all required actions based on standard procedures.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications	There are no POS implications.
Food Stamp Implications	As a result of this change, some PA/FS participants may receive a decrease in their cash assistance grant. This decrease is budgetable for FS purposes and may result in an increase in the household Food Stamp benefits.
Medicaid Implications	Since Medicaid did not revise the shelter allowance, the EID increased rather than decreased as it did for PA. All cases that lose PA eligibility due to increased income as a result of the lower EID for PA should be referred for a separate Medicaid determination. For PA cases closed due to the reduction of the EID, Workers must use closing code **E30**, Excess Income (no Transitional Medicaid). Use of this code will prompt the separate Medicaid determination required. Medicaid budgets with an effective "From Date" of June 1, 2004 or later will reflect the change in the EID from 51% to 53%. At recertification, cases with an effective "From Date" of June 1, 2004 or later will be rebudgeted using the EID of 53% and the Poverty Level Test based on the 2004 poverty level. Some cases may change from Medically Needy eligibility to Low Income Families (LIF) eligibility due to the increase in the EID. Cases rebudgeted after June 1, 2004, but with an effective "From Date" of June 1, 2004, will qualify retroactively for Transitional Medicaid Assistance (TMA) and the four-month child support extension if otherwise eligible.

LIMITED ENGLISH SPEAKING ABILITIES (LESA) IMPLICATIONS

For Limited English Speaking Ability (LESA) applicants/participants, make sure to obtain appropriate interpreter services in accordance with Policy Directive #02-43-OPE.

FAIR HEARING IMPLICATIONS

Avoidance/ Resolution

Applicants whose request for assistance is denied and participants whose benefits are reduced or discontinued are entitled to request a Fair Hearing. Remember to give individuals an opportunity for a conference/resolution on the issue(s).

Conferences

If an applicant/participant comes to the Job Center and requests a conference, the Receptionist must alert the Fair Hearing and Conference (FH&C) Unit that the participant is to be seen by a FH&C Supervisor I/Associate Job Opportunity Specialist (AJOS I). If the applicant/participant contacts the FH&C Supervisor I/Associate Job Opportunity Specialist (AJOS I) directly, the Worker/Job Opportunity Specialist (JOS) must tell the applicant/participant to go to the Receptionist to be referred to FH&C.

The FH&C Supervisor/AJOS I will listen to and evaluate the applicant's/participant's complaint regarding reduction/closing issue. After reviewing the case record and discussing the issue with the CMU Supervisor, the FH&C Supervisor/AJOS I will make a decision. The FH&C Supervisor AJOS I is responsible for ensuring that further appeal by the participant through a Fair Hearing request is properly controlled and that appropriate follow-up is taken in all phases of the Fair Hearing process.

Evidence Packets

All evidence packets must include verifying documentation, such as pay stubs, employer letter, the CNS notice and the WMS budget printouts. The CNS notice can be accessed via the WMS terminal.

REFERENCES

ABEL Transmittal No: PA 2004-3
04-ADM-03

ATTACHMENTS

Forms can now be accessed through Print on Demand at all Job Centers.

W-648 Family Budget Computation (Rev. 5/25/04)
W-648 (S) Family Budget Computation (Spanish) (Rev. 5/25/04)
W-648D Budget Worksheet for Families with Income in Temporary Housing (Rev. 5/25/04)
W-203K Guide to Budgeting (Rev. 5/25/04)

Sample State Client Notice System (CNS) Notice of Decision on Your Public Assistance, Food Stamps and Medical Assistance (English)
Sample State Client Notice System (CNS) Notice of Decision on Your Public Assistance, Food Stamps and Medical Assistance (Spanish)

The **CITY** of **NEW YORK**
Human Resources Administration
Family Independence Administration

Family Budget Computation

Job Center Number: _____

Case Name	Case No./Category	Suffix	Address

Other Eligible Payee(s)

Name	Category	Suffix

Section 1: Calculations of Income/Needs

(Be sure to use conversion chart for weekly and monthly amounts.)

Enter Semimonthly Amounts

Number in household _____

A. Income	Suffix ____	Suffix ____
1.Semimonthly Gross Earned Income	$	$
Unearned Income:		
2. Net S/M Income from Boarder/Lodger		
3. Worker's Compensation		
4. New York State Disability		
5. Unemployment Insurance Benefits		
6. Social Security Benefits		
7. Veterans Pension or Compensation		
8. Other (Specify): _____		
9. Total Unearned Income (lines 2 through 9)		
10. Total S/M Gross Income (line 1 plus line 9)		

B. Needs Semimonthly Needs	S/M Amounts to be Prorated	Suffix ____	Suffix ____
		$	$
11. Family Allowance			
12. Shelter (up to agency maximum)			
13. Energy Grant			
14. Fuel for Heating			
15. Pregnancy Allowance			
16. Other			
17. Total Needs			

Section 2: 185% Gross Income Limitation Calculation

	Suffix ____	Suffix ____
18. Multiply amount on line 17 by 1.85.		

19. Compare amount entered on line 10 with amount on line 18.
(a) If the amount entered on line 10 is equal to or greater than the amount on line 18, the household does not meet 185% Gross Income Limitation and is ineligible for public assistance – check ☑ ineligible. Do not complete Section 3 or reverse. Complete Form **W-122D** to determine Food Stamp eligibility.
(b) If the amount entered on line 10 is less than the amount entered on line 18, the household meets the 185% Gross Income Limitation – check ☑ eligible box. Complete Section 3 below. ☐ Ineligible ☐ Eligible

Section 3: Poverty Test

Shelter codes 06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, and 35 are exempt from the Poverty Test.
All other shelter codes require the Poverty Test.

	Suffix ____	Suffix ____
20. Enter total S/M gross income from line 10 above.		
21. Enter poverty guideline amount for family size from lookup chart.		

22. Compare amounts on line 20 and 21:
(a) If amount on line 20 is greater than the amount on line 21, then the household has failed the poverty test and is ineligible for PA.
(b) If amount on line 20 is less than the amount on line 21, the household has passed the poverty test and is eligible for PA.
Check one: ☐ Passed ☐ Failed

Shelter code: _____

If the household passed the poverty test, continue on reverse.

2004 Poverty Guidelines Lookup Chart	
Size of Family	**Semimonthly Limit**
1	$387.91
2	$520.41
3	$652.91
4	$785.41
5	$917.91
6	$1,050.41
7	$1,182.91
8	$1,315.41
For each additional person, add $132.50 semimonthly.	

Section 4A: Net Income Test

active PA cases and cases closed less than 4 months

Shelter codes 06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, and 35 are exempt from the Net Income Test. All other shelter codes require the Net Income Test.

		Suffix ____		Suffix ____
23. Semimonthly gross earned income (line 1)				
24. Standard deduction – $45 S/M				
25. Income applicable for 43% disregard (line 23 minus line 24)				
26. 43% earned income disregard (multiply amount on line 25 by 0.43)				
27. Total deductions (line 24 plus line 26)				
28. S/M net earned income (line 23 minus line 27)				
29. S/M unearned income (from line 9)				
30. Total income (line 28 plus 29)				
31. Total S/M needs (line 17 – round to the nearest 50¢)				
32. Budget deficit (line 31 minus line 30 – round down to the nearest 50¢)	PA Grant		PA Grant	
33. Budget surplus – If amount on line 30 is equal to or more than line 31, the participant has a budget surplus and is not eligible for PA.	+		+	

Section 4B: Net Income Test

new cases or cases closed for 4 months or more

Shelter codes 06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, and 35 are exempt from the Net Income Test. All other shelter codes require the Net Income Test.

		Suffix ____		Suffix ____
34. S/M gross earned income (line 1)				
35. Standard deduction – $45 S/M				
36. Net earned income (line 34 minus 35)				
37. S/M unearned income (line 9)				
38. Total S/M needs (line 17 – round down to the nearest 50¢)				
39. Total income (line 36 plus 37)				
40. Subtotal budget deficit (line 38 minus line 39)				
41. Budget surplus – If amount on line 39 is equal to or more than line 38, participant has a budget surplus and is not eligible for PA. Do not continue.	+		+	
42. If participant has a budget deficit (line 40), apply 43% earned income disregard to the amount on line 36. Multiply the amount on line 36 by 0.43.				
43. Total deductions (line 35 plus line 42)				
44. S/M net income (line 34 minus line 43)				
45. Total S/M needs (line 38)				
46. Total income (line 37 plus line 44)				
47. Budget deficit (line 45 minus line 46)	PA Grant		PA Grant	

Section 5: Income for Food Stamp Calculation

48. Add together the budget deficits for each suffix (line 32 or line 47) and enter the total. This amount is also entered on line 4 of Form **W-122D/DD**. For alien cases with ineligible individuals for food stamps, enter only the prorated public assistance of eligible individuals on line 4 of Form **W-122D/DD**.	

Worker Signature _____ Date _____

Supervisor Signature _____ Date _____

The **CITY** of **NEW YORK**
Human Resources Administration
Family Independence Administration

Cómputo del Presupuesto Familiar

Número de Centro de Empleo: _____

Nombre del Caso	Número de Caso/Categoría	Sufijo	Dirección

Otro(s) Beneficiario(s) Elegible(s)

Nombre	

Sección 1: Cálculos de Ingreso/Necesidades

(Asegúrese de usar la tabla de conversión para cantidades semanales y mensuales.)

Anote las Cantidades Bimensuales

Número en el Hogar _____

A. Ingreso	Sufijo	____	Sufijo	____
1. Ingreso Bruto Salarial Bimensual	$		$	
Ingreso No Devengado:				
2. Ingreso Neto Bimensual por Huésped/Inquilino				
3. Compensación para Trabajadores				
4. Compensación por Incapacidad del Estado de Nueva York				
5. Beneficios de Seguro por Desempleo				
6. Beneficios del Seguro Social				
7. Pensión o Compensación de Veteranos				
8. Otro (Especifíque): _____				
9. Total de Ingreso No Salarial (2 a la 9)				
10. Total de Ingreso Bruto Salarial Bimensual (Sume la línea 1 a línea 9)				

B. Necesidades	Sumas Quincenales a Prorratear	Sufijo	____	Sufijo	____
Necesidades Bimensuales		$		$	
11. Asignación por Familia					
12. Refugio (hasta el máximo de la agencia)					
13. Concesión para Energia					
14. Combustible para Calefacción					
15. Asignación por Embarazo					
16. Otro					
17. Total de Necesidades					

Sección 2: Cálculo de la Limitación del 185% del Ingreso Bruto

	Sufijo ____		Sufijo ____	
18. Multiplique la cantidad en la línea 17 por 1.85				

19. Compare la cantidad en la línea 10 con la cantidad en la línea 18.
(a) Si la cantidad en la línea 10 equivale o supera la cantidad en la línea 18, el hogar no reúne la Limitación del 185% del Ingreso Bruto y no es elegible para asistencia pública – marque inaceptable. No complete la sección 3 o el reverso. Complete **W-122D** para determinar elegibilidad para cupones para alimentos.
(b) Si la cantidad en la línea 10 es menor que la cantidad en la línea 18, el hogar reúne la Limitación del 185% del Ingreso Bruto – marque la casilla aceptable. Complete la Sección 3 abajo.

☐ **Inaceptable** ☐ **Aceptable**

Sección 3: Prueba de Pobreza

Los códigos de refugio 06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, y 35 están exentos de la Prueba de Pobreza. Todos los demás códigos de refugio requieren la Prueba de Pobreza.

Código de Refugio: _____

	Sufijo ____		Sufijo ____	
20. Anote el total del ingreso bruto bimensual de la línea 10 arriba.				
21. Anote la cantidad de la guía de pobreza que corresponde al tamaño de la familia en la tabla de referencia.				

22. Compare las cantidades en la línea 20 y 21:
(a) Si la cantidad en la línea 20 es mayor que la cantidad en la guía de pobreza (línea 21) entonces el hogar no ha pasado la prueba y no es aceptable para Asistencia Pública.
(b) Si la cantidad en la línea 20 es menor que la línea 21, el hogar ha pasado la prueba de pobreza y es aceptable para Asistencia Pública.

Marque uno: ☐ Pasó ☐ No Pasó

Tabla de Referencia de las Guías de Pobreza del 2004

Tamaño de la Familia	**Límite Quincenal**
1	$387.91
2	$520.41
3	$652.91
4	$785.41
5	$917.91
6	$1,050.41
7	$1,182.91
8	$1,315.41
Añada $132.50 quincenalmente por cada persona adicional.	

Si el solicitante pasó la prueba de pobreza, continue al reverso.

Sección 4A: Prueba de Ingreso Neto

casos de Asistencia Pública activos y casos cerrados por menos de 4 meses

Los códigos de refugio 06, 13, 14, 15, 16, 17, 19, 27, 28, 29, 31, 33, 34, y 35 están exentos de la Prueba de Ingreso Neto.
Todos los demás códigos de refugio requieren la Prueba de Ingreso Neto.

	Sufijo ____		**Sufijo** ____	
23. Ingreso bruto salarial bimensual (línea 1)				
24. Deducción corriente – $45 bimensual				
25. Ingreso aplicable para el descuento del 43% (línea 23 menos línea 24)				
26. Descuento del 43% al ingreso salarial (multiplique la cantidad en la línea 25 por 0.43)				
27. Total de las deducciones (sume la línea 24 a la línea 26)				
28. Ingreso bruto salarial bimensual (línea 23 menos línea 27)				
29. Ingreso no salarial bimensual (línea 9)				
30. Ingreso total (Sume la línea 28 a la línea 29)				
31. Total bimensual de necesidades – (línea 17 – redondee a los 50¢ más cercanos)				
32. Déficit presupuestario (línea 31 menos línea 30 redondee hacia abajo a los 50¢ más cercanos)	Concesión AP		Concesión AP	
33. Exceso de presupuesto – Si la cantidad en la línea 30 equivale o supera la de la línea 31, el participante acumula un exceso de presupuesto, y por tanto, no es elegible para Asistencia Pública.	+		+	

Sección 4B: Prueba de Ingreso Neto

casos nuevos y casos cerrados por 4 meses o más

Los códigos de refugio 06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, y 35 están exentos de la Prueba de Ingreso Neto. Todos los demás códigos de refugio requieren la Prueba de Ingreso Neto.

	Sufijo ____		**Sufijo** ____	
34. Ingreso bruto devengado bimensual (línea 1)				
35. Deducción corriente – $45 bimensual				
36. Ingreso neto salarial (línea 34 menos 35)				
37. Ingreso no salarial quincenal (línea 9)				
38. Total de necesidades (línea 17) redondee hacia abajo a los 50¢ más cercanos)				
39. Total de ingreso (línea 36 + 37)				
40. Sub-total del deficit presupuestario (línea 38 menos línea 39)				
41. Exceso de presupuesto – Si la cantidad en la línea 39 equivale o supera a la línea 38, el participante acumula un exceso de presupuesto y por tanto no es elegible para Asistencia Pública. No continúe.	+		+	
42. Si el solicitante tiene un déficit presupuestario (línea 40), aplique el 43% del descuento del ingreso salarial a la cantidad en la línea 36. Multiplique la cantidad en la línea 36 por 0.43.				
43. Total de deducciones (línea 35 + línea 42)				
44. Ingreso neto bimensual (línea 34 menos línea 43)				
45. Total bimensual de necesidades (línea 38)				
46. Total de ingreso (línea 37 más línea 44)				
47. Déficit presupuestario (línea 45 menos línea 46)	Concesión AP		Concesión AP	

Sección 5: Cálculos de Ingreso para Cupones de Alimentos

48. Sume los déficits presupuestarios de cada sufijo (línea 32 o línea 47) y anote el total. Esta cantidad también se anota en la línea 4 del **Formulario W-122D/DD**. Para casos de extranjeros con personas inelegibles para cupones para alimentos, anote solamente la cantidad prorrateada de asistencia pública de las personas elegibles en la línea 4 del **Formulario W-122D/DD**.	

Trabajador: _____ **Fecha:** _____
Firma

Supervisor: _____ **Fecha:** _____
Firma

Form W-648D
Rev. 5/25/04

The **CITY** of **NEW YORK**
Human Resources Administration
Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____
Case Type: _____
Caseload: _____
Center: _____
Telephone Number: _____
Address: _____
_____

Budget Worksheet for Families with Income in Temporary Housing

	Enter Semimonthly Amounts Below
Needs	
1. Preadded Allowance	
2. Home Energy Allowance	
3. Restaurant Allowance	
4. Temporary Housing Allowance	
5. Carfare Allowance	
6. Other (specify): _____	
7. Total Needs (add lines 1–6)	
Net Income	
8. Semimonthly Gross Income	
9. Standard Work Deduction ($45 semimonthly)	
10. Income Applicable for 43% Disregard (line 8 minus line 9)	
11. Earned Income Disregard (line 10 x 0.43)	
12. Net Earned Income (line 10 minus line 11)	
13. Unearned Income	
14. Other (specify): _____	
15. Total Net Income (add lines 12, 13 and 14)	
Budget Deficit	
16. Total Needs (line 7)	
17. Total Net Income (line 15)	
18. Budget Deficit (line 7 minus line 15)	
Participant's Contribution	
19. Actual Shelter Cost	
20. Participant's Contribution Toward Shelter Cost (line 19 minus line 18)	$

Worker Signature _____ Date _____

Supervisor Signature _____ Date _____

Form W-203K
Rev. 5/25/04

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Guide to Budgeting

Schedule of Semimonthly Pre-Added Allowance (1/1/90)

PA Family Size	1	2	3	4	5	6	Each Additional Person
Amount	$ 56.00	$ 89.50	$ 119.00	$ 153.50	$ 189.50	$ 219.00	$ 30.00

Special Situations

1. Single persons residing in public shelters can receive a public assistance personal needs allowance of $22.50 s/m.
2. Homeless persons who refuse placement in a shelter can receive the pre-added, energy and restaurant allowance.
3. For family members joining household for limited periods (e.g., weekends) authorize $4.00 per day per person.
4. All participants who are billed for rent are entitled to a shelter allowance equal to the rent or the maximum shelter allowance for family size, whichever is less.
5. Persons with HIV/AIDS can receive a shelter allowance of up to $480 per month and up to $330 per month for each additional person on the case.

Schedule 1

Maximum Semimonthly Shelter Allowance with Children* (effective 11/1/03)

PA Family Size	1	2	3	4	5	6	7 or more
S/M Amount	$138.50	$141.50	$200.00	$225.00	$250.50	$262.00	$273.00

* Includes pregnant women

Schedule 2

Maximum Semimonthly Shelter Allowance without Children

PA Family Size	1	2	3	4	5	6	7	8 or more
S/M Amount	$107.50	$125.00	$143.00	$156.00	$168.50	$174.50	$201.50	$210.50

Semimonthly Energy Grants

PA Family Size	1	2	3	4	5	6	Each additional person
S/M Amount	$12.55	$19.75	$26.50	$34.35	$42.35	$48.60	$6.25

Semimonthly Fuel for Heating: Other than Natural Gas (E)

PA Family Size	1	2	3	4	5	6	7	8 or more
S/M Amount	$35.00	$35.00	$35.00	$36.50	$38.50	$41.00	$44.00	$46.50

Semimonthly Fuel for Heating: Natural Gas (E)

PA Family Size	1	2	3	4	5	6	7	8 or more
S/M Amount	$28.00	$28.00	$28.00	$29.00	$30.50	$32.50	$34.50	$37.00

Expenses Incident to Employment

Item of Expense	Allowance
Standard Semimonthly Work Deduction	$45.00
Income Disregard	43% of net earned income

Expenses Incident to Approved Training

Carfare	public transportation expense

Schedule of Semimonthly Restaurant Allowance (Includes Sales Tax)

	Dinner	Lunch and Dinner	All Meals
Amount per Person	$14.50	$23.50	$32.00
Pregnant Women, Persons Under 18 Years of Age and Full-Time Students Who Will Graduate Before 19th Birthday	$32.50	$41.50	$50.00

Schedule of Emergency Assistance Grants for All Cases

Daily Rate

PA Family Size	Pre-Added and Energy Allowance	*Pre-Added, Energy and Restaurant Allowance
1	$ 4.50	$ 6.60
2	$ 7.50	$ 11.40
3	$ 9.55	$ 15.90
4	$ 12.35	$ 20.75
5	$ 15.10	$ 25.60
6	$ 17.60	$ 30.20
7	$ 20.00	$ 34.70
8	$ 22.35	$ 39.20
9	$ 24.75	$ 43.70
10	$ 27.15	$ 48.20
Each Additional Person	$ 2.40	$ 4.50

* Add $1.20 per day per individual, if entitled, to the additional $18.00 s/m.

XL0218 (03/97)

HRA 5TH FL CENTER
33-28 NORTHERN BLVD
LIC, NY 11101

NOTICE OF DECISION ON YOUR
PUBLIC ASSISTANCE AND
MEDICAL ASSISTANCE.

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA
NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:	DATE: April 25, 2004	CASE NUMBER:

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
051		00914		718-626-6727

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP 718-626-8372

OR Agency Conference 718-626-8491

Fair Hearing information and assistance 718-626-8491

Record Access 718-626-8491

Child/Teen Health Plan 212-630-1147

CASE NAME / AND ADDRESS

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

PUBLIC ASSISTANCE

Beginning June 1, 2004, your public assistance benefits will be CHANGED. Your old benefit amount was $519.00; your new benefit amount is $296.00. If the benefit amount is the same, you should compare the New Amount and Old Amount columns to see the change(s).

Your monthly public assistance benefit of $296.00 will be distributed as follows:

	New Amount	Old Amount
o Restricted shelter payment:	$296.00	$519.00

If you have any changes in your household such as increased rent or someone else moving in, tell your worker right away. A change in your household could mean a change in your benefit amount.

Please see the budget calculation section of this notice for an explanation of how we figured your benefit amount.

This decision is based on Regulation 18 NYCRR 352.29.

Your public assistance will be CHANGED because:

- o There has been a change in how your public assistance benefits are distributed.

  This decision is based on Regulation 18 NYCRR 381.3.

- o We are counting more earned income against your public assistance needs. Each year the percentage of earned income that we must disregard is adjusted. The lower the earned income disregard, the greater the amount

CONTINUED ON THE NEXT PAGE ...

XL218C (08/97)

of your earned income we count. We decide the amount of the new percentage based on changes to the most recently issued poverty guidelines issued by the United States Bureau of the Census. The earned income disregard has been changed from 51% to 43%.

We do not count the first $90 of your gross earned income and 43% of the remainder

This decision is based on Regulation 18 NYCRR 352.20(c).

How we figured your Public Assistance Benefits:

Check the information below and let us know if something is wrong. If there is a mistake, it could mean that this decision we made about your benefit is not correct.

- The way we figure your income and needs is shown below:

Person's Name	Type of Income	Monthly Amount
	Salaries/Wages	$2,875.33
	Total Earned Income We Count.....	$1,587.65
	Total Unearned Income We Count...	$0.00
	Total We Count.....	$1,587.65

- To figure your monthly income, we multiply your weekly income by 4 & 1/3, or your bi-weekly income by 2 & 1/6, or your semi-monthly income by 2, or use the monthly income amount which you provided.
- There are 3 people in your Public Assistance case.
- There are 2 children under 18 years old in your case.
- There are 3 people in your Public Assistance suffix.
- Your household includes a pregnant woman, or child under age 18, or an 18-year-old child attending full time secondary school.
- Your household pays $1,400.00 for housing.
- According to our records, your type of housing is known as Unfurnished Apartment Or Room.
- We allow $1,400.00 for housing.
- Your heat is included in your rent.
- No one in your suffix is at least four months pregnant.

FOOD STAMPS

You have not been getting food stamps in this case. If you want to see if you can get food stamps, you can apply at any time.

CONTINUED ON THE NEXT PAGE ...

XL218C (08/97)

MEDICAL ASSISTANCE

We will continue Medical Assistance coverage unchanged for:

Name

Client I.D. #

These persons will continue to be entitled to full services under the Medical Assistance Program.

This decision is based on Regulation 18 NYCRR 360-2.6.

CONTINUED ON THE NEXT PAGE ...

XL218C (02/97)

CONTINUED ON THE NEXT PAGE ...

XL218C (08/97)

CONFERENCE AND FAIR HEARING SECTION

DO YOU THINK WE ARE WRONG?

If you think our decision is wrong, you can request a review of our decision. We will correct our mistakes. You can do both of the following:

1. Ask for a meeting (conference) with one of our supervisors; and
2. Ask for a State fair hearing with a State hearing officer.

CONFERENCE (Informal meeting with us)

If you think our decision was wrong or if you do not understand our decision, or need additional information about the reason for our decision, please call us to arrange a meeting. To do this, call the conference telephone number listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you have asked for a fair hearing.

If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See Keeping your Benefits the Same)

STATE FAIR HEARING

Deadline for Requesting a Fair Hearing

If you want the State to review our decision about your public assistance, you must ask for a fair hearing by **June 24, 2004**. This is the deadline even if you asked for a meeting (conference) with us.

Keeping your Benefits the Same

We will not change your public assistance if you ask for a fair hearing about the action we are taking on your public assistance by **May 5, 2004**.

If you lose the hearing you will have to pay back any public assistance which you got, but should not have gotten, while you were waiting for the decision.

If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you write or call for a fair hearing.

How to Request a Fair Hearing

You can ask for a fair hearing in writing, by telephone, by fax, electronically or in person.

WRITE: Complete the "tear-off" Request for a Fair Hearing at the bottom of this page and send it to the address on the bottom of the next page.

OR CALL: **(800) 342-3334**

When you call, please tell the worker the number of this notice which is **NO40SF6395.**

OR FAX: Send a copy of this notice to fax no. (518) 473-6735.

OR ONLINE: Complete the online request form at: http://www.otda.state.ny.us/oah/forms.asp

OR WALK-IN: Bring a copy of this notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, NY or 330 West 34th Street, New York City, NY.

(Read the next page for more of your Rights)

REQUEST FOR A FAIR HEARING

I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Name :
Address :

District/Office No:
Notice No. :
Case Number:
Telephone :

/_/ I do not want to "keep my benefits the same" until the Fair Hearing decision is issued.

ONLY USE THIS TEAR-OFF TO REQUEST A HEARING ABOUT THIS NOTICE.

CONTINUED ON THE NEXT PAGE ...

XL218B (09/97)

If you cannot reach the State electronically, by phone or fax, please write to request a fair hearing before the deadline for requesting a fair hearing.

What to Expect at a Fair Hearing

The State will send you a notice which 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. You can bring a lawyer, a relative or a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers which explain why we are wrong.

To help you explain at the hearing why you think our decision is wrong, you should bring any witnesses who can help you. You should also bring any papers you have such as: Pay stubs, Leases, Receipts, Bills, Doctor's Statements.

At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

LEGAL ASSISTANCE

If you think you need a lawyer to help you with this problem, you may be able to obtain a lawyer at no cost to you by contacting:

BROOKLYN LEGAL SERVICES CORPORATION, 105 COURT STREET, BROOKLYN, NY 11201
Telephone: (718) 237-5500
LEGAL AID SOCIETY, 186 MONTAGUE ST, BROOKLYN, NY 11201
Telephone: (718) 722-3100
BEDFORD-STUYVESANT COMMUNITY LEGAL SERVICES CORPORATION, 1360 FULTON STREET SUITE 301, BROOKLYN, NY 11216
Telephone: (718) 233-8400

For the names of other lawyers check your Yellow Pages under "LAWYERS".

ACCESS TO YOUR FILES 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, or FAX (718) 722-5018 or write to HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201. If you want copies of your documents from your case file, you should ask for them ahead of time. Usually, they will be sent to you within three working days of when you asked for them. If you make your request less than five working days before your hearing, your case file documents may be given to you at your hearing.

Send this "Request for a Fair Hearing" to:

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

XL0219 (09/97)

NUMERO DEL AVISO: Pagina: 1 *****

HRA 5TH FL CENTER
33-28 NORTHERN BLVD
LIC, NY 11101

NOTIFICACION SOBRE LA DECISION DE SU ASISTENCIA PUBLICA Y ASISTENCIA MEDICA.

ESTA NOTIFICACION EN ESPANOL NO LLEVA ACENTOS DEBIDO A QUE NUESTRO SISTEMA DE COMPUTADORAS NO OFRECE LA CAPACIDAD PARA INCORPORARLOS

NUMERO DEL AVISO:	FECHA:	NUMERO DE CASO:
	Abril 25, 2004	

OFICINA	UNIDAD	TRABAJADOR(A)	NOMBRE DEL TRABAJADOR(A) O DE LA UNIDAD	NO. DE TELEFONO
051		00914		718-626-6727

NUMEROS TELEFONICOS DE LA AGENCIA

NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA 718-626-8372

O Para Conferencia con la Agencia 718-626-8491

Información y asistencia sobre Vista Imparcial 718-626-8491

Acceso a archivos/récords 718-626-8491

Plan de Salud Infantil/Adolescente 212-630-1147

NOMBRE DEL CASO Y DIRECCION

SI USTED NO ESTA DE ACUERDO CON NINGUNA DE LAS DECISIONES EXPLICADAS EN ESTA NOTIFICACION, USTED TIENE EL DERECHO DE SOLICITAR UNA CONFERENCIA Y/O PEDIR AL ESTADO UNA VISTA IMPARCIAL. LEA LA SECCION SOBRE LA CONFERENCIA Y/O LA VISTA IMPARCIAL PARA AVERIGUAR COMO SOLICITAR UNA CONFERENCIA Y/O UNA VISTA IMPARCIAL.

ASISTENCIA PUBLICA

A partir del Junio 1, 2004, sus beneficios de asistencia publica seran **CAMBIADOS.** La cantidad de su viejo beneficio era $519.00; la cantidad de su nuevo beneficio es $296.00. Si la cantidad del beneficio no cambiado, tendras que comprar las columnas Cantidad Nueva y Cantidad Vieja para ver los cambios.

Su beneficio mensual de asistencia publica de $296.00 se distribuira de la siguiente manera:

	New Amount	Old Amount
o Pago restringido de vivienda:	$296.00	$519.00

Si hay algun cambio en su hogar, tal como el aumento del alquiler o el traslado a su hogar de otra persona, informele a su trabajador(a) inmediatamente. Un cambio en su hogar podria significar un cambio en la cantidad de su beneficio.

Por favor vea la seccion del calculo del presupuesto de esta notificacion para una explicacion de como calculamos su cantidad de beneficios.

Esta decision esta basada en la Regulacion 18 NYCRR 352.29.

Su asistencia publica sera **CAMBIADA** debido a que:

- Ha habido un cambio en la manera en la que sus beneficios de asistencia publica se distribuyen.

  Esta decision esta basada en la Regulacion 18 NYCRR 381.3.

- Estamos tomando en cuenta una cantidad mayor de ingresos ganados al calcular sus necesidades con relacion al programa de asistencia publica.

CONTINUADO EN LA PROXIMA PAGINA ...

Cada ano, el porcentaje del ingreso ganado que nosotros no debemos tomar en cuenta se ajusta. Mientras mas bajo sea el ingreso ganado que se excluye, mayor es la cantidad del ingreso ganado que se toma en cuenta. Se calcula en nuevo porcentaje en base a los cambios recientes a las pautas sobre pobreza emitidas por la Oficina del Censo de EEUU. El porcentaje del ingreso ganado que se excluye ha cambiado del 51 por ciento al 43 por ciento.

Nosotros no contamos los primeros $90 de su ingreso bruto ganado y el 43% del resto.

Esta decision esta basada en la Regulacion 18 NYCRR 352.20(c).

Como calculamos sus Beneficios de Asistencia Publica:

Fijese en la informacion de abajo y notifiquenos si algo esta incorrecto. Si hay un error, este podria significar que la decision que tomamos acerca de su beneficio no es correcta.

- La manera en que calculamos su ingreso y necesidades se muestran abajo:

Nombre de la Persona	Tipo de Ingreso	Cantidad Mensual
	Salarios/Sueldos	$2,875.33
	Ingreso Total Ganado Que Contamos.....	**$1,587.65**
	Ingreso Total No Ganado Que Contamos...	**$0.00**
	Total Que Nosotros Contamos.....	**$1,587.65**

- Para calcular su ingreso mensual, nosotros multiplicamos su ingreso semanal por 4 & 1/3, o su ingreso quincenal por 2 & 1/6, o su ingreso bimensual por 2, o utilizamos la cantidad del ingreso mensual que usted proveyo.
- Existen 3 personas en su caso de Asistencia Publica.
- Existen 2 ninos menores de 18 anos de edad en su caso.
- Existen 3 personas en su sufijo de Asistencia Publica.
- Su hogar incluye una mujer embarazada o un(a) nino(a) menor de 18 anos de edad o un(a) nino(a) que asiste a tiempo completo la escuela secundaria.
- Su hogar paga $1,400.00 para la vivienda.
- De acuerdo a nuestros records, su tipo de vivienda tambien es conocido como Apartamento O Cuarto Sin Muebles.
- Nosotros permitimos $1,400.00 para gastos de vivienda.
- Los costos de su calefaccion estan incluidos en su renta/alquiler.
- Nadie en su sufijo tiene cuatro meses de embarazo.

CUPONES DE ALIMENTOS

Usted no ha estado recibiendo cupones de alimentos en este caso. Si usted desea averiguar si puede recibir cupones de alimentos, usted puede solicitar en cualquier momento.

CONTINUADO EN LA PROXIMA PAGINA ...

ASISTENCIA MEDICA

Nosotros continuaremos la cobertura de la Asistencia Medica sin cambio alguno para:

Nombre	No. del I.D. del Cliente

Estas personas continuaran teniendo el derecho a obtener servicios completos bajo el Progradma de Asistencia Medica.

Esta decision esta basada en la Regulacion 18 NYCRR 360-2.6.

CONTINUADO EN LA PROXIMA PAGINA ...

CONTINUADO EN LA PROXIMA PAGINA ...

SECCION PARA LA CONFERENCIA Y LA VISTA IMPARCIAL

CREE USTED QUE NOS HEMOS EQUIVOCADO?

Si usted cree que nuestra decision es incorrecta, puede solicitar una revision de nuestra decision. Nosotros corregiremos nuestros errores. Puede apelar de las dos maneras siguientes:

1. Solicitando una reunion (conferencia) con uno de nuestros supervisores; y
2. Solicitando una audiencia imparcial estatal con un funcionario estatal de audiencias.

CONFERENCIA (reunion informal con nosotros)

Si usted cree que nuestra decision fue equivocada o si no comprende nuestra decision, o si necesita mas informacion sobre la razon de nuestra decision, sirvase llamarnos y solicitar una reunion. Para hacer esto, llame al numero de telefono para conferencias indicado al comienzo de la pagina 1 de este aviso o escribanos a la direccion impresa al comienzo de la pagina 1 de este aviso. En ciertas ocasiones, esta es la manera mas rapida de resolver problemas. Le recomendamos hacer esto incluso si ha solicitado una vista imparcial.

Si usted solo solicita una reunion con nosotros, no mantendremos iguales sus beneficios durante su apelacion. Sus beneficios solo seguiran siendo los mismos si solicita una vista imparcial estatal. (Vea Como mantener sus beneficios iguales.)

VISTAS IMPARCIALES ESTATALES

Fecha limite para solicitar una vista imparcial

Si desea que el Estado revise nuestra decision sobre su asistencia publica, usted debe solicitar una vista imparcial antes de **Junio 24, 2004**. Esta es la fecha limite incluso si usted ha solicitado una reunion (conferencia) con nosotros.

Como mantener sus beneficios iguales

Si usted solicita una vista imparcial hasta el **Mayo 5, 2004** sobre la medida que estamos tomando respecto de sus beneficios de asistencia publica, no cambiaremos tales beneficios.

Si la decision de la vista es en su contra, usted debera devolver los beneficios de asistencia publica recibidos y que no debia haber recibido, mientras esperaba la decision de la vista.

Si usted no desea que sus beneficios permanezcan iguales hasta que se emita la decision, debe informar al Estado cuando usted escriba o llame por telefono para solicitar una vista imparcial.

Como solicitar una vista imparcial

Usted puede solicitar una audiencia imparcial por escrito, por telefono, por facsimil, por electronico o visitando en persona.

ESCRIBA: Complete la seccion que se puede arrancar de la Solicitud para una Audiencia Imparcial en la parte de abajo de esta pagina y enviela a la direccion que aparece en la parte de abajo de la proxima pagina.

O LLAME AL: **(800) 342-3334**

Cuando llame, por favor comunique al empleado(a) el numero de esta notificacion, el cual es

(Lea la siguiente pagina para mas informacion acerca de sus derechos)

SOLICITUD PARA UNA VISTA IMPARCIAL

Yo deseo una vista imparcial. Yo no estoy de acuerdo con la accion de la agencia. (Puede ser util explicar la razon por la que usted esta en desacuerdo abajo, pero usted no tiene que incluir una explicacion por escrito.)

_____

_____

_____

Nombre :
Direccion:

No. de Distrito/Oficina:
No. de Notificacion:
No. de Caso :
Telefono :

/_/ **Yo no deseo "mantener mis beneficios iguales" hasta que la decision de la Vista Imparcial se emita.**

SOLO UTILICE LA PARTE QUE PUEDE SEPARARSE DE ESTA PAGINA (DEBAJO DE LOS PUNTOS) PARA SOLICITAR UNA VISTA ACERCA DE ESTA NOTIFICACION.

CONTINUADO EN LA PROXIMA PAGINA ...

O **POR FACSIMIL:** Envie una copia de esta notificacion al numero de facsimil (518) 473-6735.

O Envie su peticion llenando el formulario electronico en: **http://www.otda.state.ny.us/oah/forms.asp**

O **VISITANDO EN PERSONA:** Traiga una copia de esta notificacion al Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York al 14 Boerum Place, Brooklyn, NY or 330 West 34th Street, New York City, NY.

Si no puede comunicarse con el Estado por electronico, por telefono o por facsimil, por favor escriba una carta solicitando una audiencia imparcial antes de la fecha limite para solicitar una audiencia imparcial.

Que esperar en una vista imparcial

El Estado le enviara un aviso informandole cuando y donde se hara la vista imparcial.

En la vista, usted tendra oportunidad de explicar por que piensa que nuestra decision es equivocada. Usted puede traer un abogado, un familiar o amistad o alguien mas que pueda ayudarle a explicar esto. Si usted no puede venir personalmente, puede enviar a alguien para que le represente. Si en lugar suyo, usted envia a la vista una persona que no es abogado, debe enviar con esta persona una carta demostrando al funcionario de vistas que usted desea que tal persona le represente en la vista.

En la vista, usted y su abogado o cualquier otro representante suyo tendran la oportunidad de explicar por que nos hemos equivocado y de entregar al funcionario de vistas documentos escritos que demuestren por que estamos equivocados.

Usted puede traer a la vista cualquier testigo que pueda ayudarle a explicar por que piensa que nuestra decision es equivocada. Tambien debe traer documentos tales como: Recibos de pago, Contratos de arrendamiento, Recibos, Facturas, Declaraciones de sus medicos.

En la vista, usted y su abogado u otros representantes suyos pueden interrogar a los testigos que nosotros presentemos o que usted traiga como ayuda para su caso.

ASISTENCIA LEGAL

Si usted cree que necesita la ayuda de un abogado para resolver este problema, puede obtener un abogado sin costo alguno de su parte, comunicandose con:

BROOKLYN LEGAL SERVICES CORPORATION, 105 COURT STREET, BROOKLYN, NY 11201
Telefono: (718) 237-5500
LEGAL AID SOCIETY, 166 MONTAGUE ST, BROOKLYN, NY 11201
Telefono: (718) 722-3100
BEDFORD-STUYVESANT COMMUNITY LEGAL SERVICES CORPORATION, 1360 FULTON STREET SUITE 301, BROOKLYN, NY 11216
Telefono: (718) 233-6400

Para averiguar los nombres de otros abogados, puede ver las Paginas Amarillas de la Guia de telefonica bajo el titulo "LAWYERS".

ACCESO A SUS ARCHIVOS Y COPIAS DE DOCUMENTOS

Como asistencia en preparacion para la audiencia, usted tiene el derecho a inspeccionar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un fax, le proporcionaremos copias gratuitas de los documentos que se encuentran en su archivo, los mismos que se entregaran al funcionario de audiencias durante la audiencia imparcial. Ademas, si usted nos

Envie esta "Solicitud para una Vista Imparcial" a:

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

CONTINUADO EN LA PROXIMA PAGINA ...

llama, nos escribe o nos manda su peticion por facsimil, le enviaremos copias gratuitas de documentos especificos contenidos en su archivo y los cuales usted considere necesarios al prepararse para la audiencia imparcial. Para solicitar documentos o para averiguar como revisar su archivo, llamenos al (718) 722-5012, o por facsimil 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 anticipacion. Generalmente, estas se le enviaran dentro de tres dias laborales contados a partir de la fecha en que las solicita. Si solicita las copias menos de cinco dias laborales antes de la fecha en que se celebrara su audiencia, se le podrian entregar el dia de la audiencia.