Human Resources Administration
Department of Social Services

FAMILY INDEPENDENCE ADMINISTRATION

Seth W. Diamond, Executive Deputy Commissioner

James K. Whelan, Deputy Commissioner
Policy, Procedures, and Training

Lisa C. Fitzpatrick, Assistant Deputy Commissioner
Office of Procedures

POLICY DIRECTIVE #08-19-ELI

(This Policy Directive Obsoletes PD #07-16-ELI)

CHANGE IN THE EARNED INCOME DISREGARD AND CASH ASSISTANCE POVERTY LEVEL INCOME TEST FOR 2008

Date:	**Subtopic(s):**
May 28, 2008	Cash Assistance Budgeting

AUDIENCE

This policy directive is for all Job Center staff and is informational for all other staff.

POLICY

Social Services Law (SSL) Section 131-a (8)(a)(iii) requires that annually on June 1, the CA EID be adjusted to reflect the changes in the most recently issued Poverty Level Guidelines of the United States Census Bureau.

The EID is applicable to all Family Assistance (FA) households and all Safety Net (SN) households that include at least one child who is applying for or receiving Safety Net Assistance (SNA) or Supplemental Security Income (SSI). Effective June 1, 2008, the EID will increase from 48 percent to 50 percent.

Additionally, the amounts used for the CA Poverty Level Guidelines will also change. The gross earned and unearned income of CA applicants and participants cannot exceed the 2008 Federal Poverty Level Guidelines as published in the Federal Register. This change impacts budgets with an effective date of 6/A/08 or later.

The CA Poverty Level Income Test applies to all CA households except those residing in temporary housing (e.g., hotels/motels, homeless shelters, domestic violence shelters, Acquired Immune Deficiency Syndrome (AIDS) housing and congregate care facilities.)

REQUIRED ACTION

Before the EID can be applied, the following financial eligibility tests must be conducted:

- **Gross Income Test** – The semimonthly gross income is compared to 185 percent of the semimonthly standard of need for the household size. If the gross income exceeds 185 percent of the standard of need, the household is ineligible for CA.
- **CA Poverty Level Income Test** – If the household's gross income does not exceed 185 percent of the standard of need, the semimonthly gross income is compared to the current year semimonthly poverty guidelines limit for the household size (see chart on page 3 of this directive). If the gross income exceeds the poverty guideline, the household is ineligible for CA.
- **Net Income Test** – If the household's gross income does not exceed the CA Poverty Level Guidelines limit for the household size, the Net Income Test is conducted. At that point the EID is applied as follows:

Applying the EID

- If the family or individual has an active CA 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 EID is not granted for any period of time in which the earned income is not reported 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 EID. If without the disregard there is a budget deficit, the EID is then applied to determine the household's semimonthly grant.

When calculating a budget in WMS, the Automated Budgeting and Eligibility Logic (ABEL) system automatically performs all three financial eligibility tests.

The **W-648** and **W-648D** have been revised to reflect the 2008 CA Poverty Level Guidelines (shown below) and the increase in the EID.

Chart represents 100% of Federal Poverty Level

2008 CA Poverty Level Guidelines	
Size of Family Unit	**Semimonthly Limit**
1	$433.34
2	$583.34
3	$733.34
4	$883.34
5	$1,033.34
6	$1,183.34
7	$1,333.34
8	$1,483.34
For each additional person add $150.00 semimonthly.	

The **W-203K** has also been revised to reflect the increase in the EID. Center Directors must ensure that all previous versions of the **W-203K**, **W-648**, and **W-648D** are removed from circulation and recycled.

As part of the implementation of the changes in the EID and CA Poverty Level Guidelines, the following took place:

The unique authorization number for this MRB is **99999343**.

A Mass Rebudgeting (MRB) of active CA/Food Stamp (FS) cases (e.g., in Active [AC] or Single Issue [SI] status) with earned income took place on the weekend of May 17–18, 2008. The Office of Temporary and Disability Assistance (OTDA) has sent appropriate notices to all cases included in the MRB (see **Attachment A** for an example of the Client Notice System [CNS] notice sent out by OTDA).

Note: Multisuffix cases are excluded from the MRB process.

- As part of the MRB process, all stored budgets, including FIA-3A budgets, affected by these changes have been rebudgeted. The effective date for these budgets is 6/A/08.
- On May 19, 2008, the 50 percent EID and revised CA Poverty Level Guidelines were made available for all budgets calculated with a budget effective date of 6/A/08, or later. Budgets calculated with a budget effective date prior to June 2008, will continue to use the current amounts.

PROGRAM IMPLICATIONS

Model Center Implications	There are no Model Office implications.
Paperless Office System (POS) Implications	There are no POS implications.
Food Stamp Implications	As a result of this change, some CA/FS participants may receive an increase in their CA grant. This increase is budgetable for FS purposes and may result in a decrease in the household's FS benefits.
Medicaid Implications	Cases that lose CA eligibility due to increased income should be referred for a separate Medicaid determination. For CA cases closed due to the increase of the EID, Workers must use closing code **E30**, Excess Income (No Transitional Medicaid). Use of this code will prompt a separate Medicaid determination.

LIMITED ENGLISH SPEAKING ABILITY (LESA) AND HEARING-IMPAIRED IMPLICATIONS

For Limited English Speaking Ability (LESA) and hearing-impaired applicants/participants, make sure to obtain appropriate interpreter services in accordance with PD #08-18-OPE and PD #06-13-OPE.

FAIR HEARING IMPLICATIONS

Avoidance/ Resolution	Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up to date. Remember that applicants/participants must receive either adequate or timely and adequate notification of all actions taken on their case.
Conferences	An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If an applicant/participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. In Model Offices, the Receptionist at Main Reception will issue an FH&C ticket to the applicant/participant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.

The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the applicant/participant, review the case file and discuss the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker's Supervisor. The AJOS/Supervisor I will explain the reason for the Agency's action(s) to the applicant/participant.

Should the applicant/participant elect to continue his/her appeal by requesting a Fair Hearing or proceeding to a hearing already requested, the FH&C AJOS/Supervisor I is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Evidence Packets

All Evidence Packets must contain a detailed history (e.g., copies of POS "Case Comments" and/or NYCWAY "Case Notes" screens, History Sheet [**W-25**]), copies of relevant WMS screen printouts, notices sent and other documentation relevant to the action taken.

REFERENCES

18 NYCRR 352.20 (c) and (d)
SPP 2008-00050-00
SSL Section 131-a (8)(a)(iii)
TASB, Chapter 18, Page 319

ATTACHMENTS

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

Attachment A	Sample CNS Notice Sent By OTDA
W-203K	Guide to Budgeting (Rev. 5/28/08)
W-648	Cash Assistance Budget Computation (Rev. 5/28/08)
W-648 (S)	Cash Assistance Budget Computation (Spanish) (Rev. 5/28/08)
W-648D	Income Contribution Worksheet for Families in Temporary Housing (Rev. 5/28/08)
W-648D (S)	Income Contribution Worksheet for Families in Temporary Housing (Spanish) (Rev. 5/28/08)

Attachment A

XL0218 (09/97)

NOTICE NUMBER : Page: 1 *****

HRA (073)
94 FLATBUSH AVENUE 3RD FLOOR
BROOKLYN, NY 11217

NOTICE OF DECISION ON YOUR PUBLIC ASSISTANCE, FOOD STAMPS AND MEDICAL ASSISTANCE.

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS EN ESPANOL, POR FAVOR PONGASE EN CONTACTO CON SU TRABAJADOR(A).

NOTICE NUMBER:	DATE: April 27, 2008	CASE NUMBER:

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO. 718-330-9131

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	718-237-7202
OR Agency Conference	212-620-9893
Fair Hearing information and assistance	212-620-9893
Record Access	718-237-7202
Child/Teen Health Plan	888-692-8662

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, 2008, your public assistance benefits will be **CHANGED.** Your old benefit amount was $328.00; your new benefit amount is $374.00. 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 $374.00 will be distributed as follows:

	New Amount	Old Amount
o Restricted shelter payment:	$374.00	$328.00

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 less earned income against your public assistance needs. Each year the percentage of earned income that we must disregard is adjusted. The higher the earned income disregard, the smaller the amount

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 Department of Health and Human Services. The earned income disregard has been changed from 48% to 50%.

We do not count the first $90 of your gross earned income and 50% 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
CAROL	Salaries/Wages	$2,365.92
	Total Earned Income We Count.....	**$1,137.97**
	Total Unearned Income We Count...	**$0.00**
	Total We Count.....	**$1,137.97**

- 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 2 people in your Public Assistance case.
- There are 2 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 $1,100.00 for housing.
- According to our records, your type of housing is known as Unfurnished Apartment Or Room.
- We allow $283.00 for housing.
- Your heat is included in your rent.
- No one in your suffix is at least four months pregnant.

FOOD STAMPS

You will continue to get the **SAME AMOUNT** of food stamp benefits: $10.00.

Even though we figured your food stamp benefits again, it did not change the amount of food stamp benefits you get.

This decision is based on Regulations 18 NYCRR 387.8, 387.14 and 387.15.

- Your household has had a change in shelter costs.

  This decision is based on Regulation 18 NYCRR 387.12(f).

How we figured your Food Stamp 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.

- You will get $10.00 for the month of June, 2008.
- There are 2 people in your Food Stamp household.
- You pay $919.71 for housing.
- According to our records, your type of housing is known as Unfurnished Apartment Or Room.

CONTINUED ON THE NEXT PAGE ...

- Your heat is included in your rent. Either you have incurred air conditioning costs or we anticipate that you will receive a HEAP payment during this heating season for your current living situation. (You may need to apply for HEAP separately.) We allow the standard of $577.00.
- You have no allowable medical expenses.
- You have no individuals in your household that are enrolled in a Medicare approved Prescription Drug Discount Card program.
- No one in your household pays legally-obligated child support.
- We allow expenses for child care or dependent care while you are employed or seeking employment through job search, or are in training. You do not pay for child care or dependent care.
- We count the following monthly income:

Person with income	Type of Income	Monthly Amount
CAROL	Salaries/Wages	$2,365.92
	Public Assistance	$0.00
	Total Income:	**$2,365.92**
	Countable Income:	**$1,141.40**

MEDICAL ASSISTANCE

We will continue Medical Assistance coverage unchanged for:

Name	Client I.D. #
CAROL	**V**
JOHN	**U**

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 ...

CONTINUED ON THE NEXT PAGE ...

CONFERENCE AND FAIR HEARING SECTION

DO YOU THINK WE ARE WRONG?

If you think our decision was wrong, you can request a review of our decision. If we made a mistake, we will correct it. 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.

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 26, 2008**. This is the deadline even if you asked for a meeting (conference) with us.

If you want the State to review our decision about your medical assistance, you must ask for a fair hearing by **June 26, 2008**. This is the deadline even if you asked for a meeting (conference) with us.

If you want the State to review our decision about your food stamps, you must ask for a fair hearing by **July 26, 2008**. This is the deadline even if you asked for a meeting (conference) with us.

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

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.

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

(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: **66/073**
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 ...

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:

LEGAL AID SOCIETY - QUEENS NEIGHBORHOOD OFFICE, 120-46 QUEEENS BLVD, KEW GARDENS, NY 11415
Telephone: (718) 286-2450
LEGAL AID SOCIETY - QUEENS NEIGHBORHOOD OFFICE, 120-46 QUEEENS BLVD, KEW GARDENS, NY 11415
Telephone: (718) 286-2450

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. 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.

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

CONTINUED ON THE NEXT PAGE ...

IMPORTANT INFORMATION ABOUT
WHAT CHANGES YOU MUST REPORT FOR FOOD STAMPS

General Telephone No. for Questions or Help: (718) 237-7202

Most Food Stamp households with income will only have to report changes every six months, with one exception. You will either be asked to re-certify at this six-month checkpoint, or will be sent a mail report form for you to report changes. The one exception for households subject to six-month reporting is if your household's total gross monthly income is over 130% of the poverty level. Special reporting rules for Non-Six-Month Reporters, and for Able Bodied Adults Without Dependents (ABAWD's) are explained below (please see the reporting rules list at the end of this section to see if these rules apply to you).

At application or recertification, when changes occur between the Date of Interview and the date the Notice of Eligibility is issued, the household will have until 10 days following the end of the calendar month the Notice of Eligibility was issued to report any changes.

If your household's gross monthly income is more than **$1,484.00** (130% of the poverty level) you must report this monthly amount to your social services district by phone, in writing, or in person within 10 days after the end of the month. Gross income is the amount of income before taxes and other deductions are taken out, not the amount you receive when you cash your check. We must use the gross income in figuring your eligibility for food stamps.

Any other kind of income that you receive besides earnings must be added to your gross earned income to know if you are over 130% of the poverty level. Examples of other income that count include child support payments, Unemployment Insurance, temporary assistance payments, Workers Compensation or disability payments such as Social Security, SSI or private disability payments.

For example, if your only income is from earnings, you are paid weekly and your gross income is over **$371.00 a week,** or if you are paid biweekly and your gross income is over **$742.00 biweekly,** you must report this to us within 10 days after the end of the month. When you add up your earnings to see if you are over 130% of poverty, use your gross pay from the last four weeks of the month.

If you are an Able-Bodied Adult Without Dependents ("ABAWD"), you must tell us if your work hours go below 80 hours a month. You must tell us this within 10 days after the end of the month when your work hours fell below 80 hours.

Any other changes to your Food Stamp household including who lives with you, rent costs, and gross income changes under 130% of the poverty level do not need to be reported until your next recertification. You may still voluntarily report any change about your household and, if this change will increase your benefit level and you verify this change, we will increase your benefit.

If you only report once a year for recertification (12 month certification period), and do not receive Temporary Assistance, you will be required to report your changes on one mail report received 6 months into your certification period.

These reporting rules apply only to the Food Stamp Program. If you also receive Temporary Assistance (TA), you are still required to report changes for TA within 10 days of the change and at recertification.

If you have questions about this reporting requirement, or if your gross income exceeds the 130% poverty level printed above, you may call the number printed at the top of this letter. Otherwise you will be required to recertify at your next scheduled recertification date and can report any changes you have at that time.

Reporting Rules for Non-Six-Month Reporters, and for Able Bodied Adults Without Dependents (ABAWD's):

There are a few households who still have to report changes affecting their eligibility and food stamp benefits as the change occurs. You must report changes within ten days after the end of the month in which the change occurred, if your household:

1. Is without any income, or
2. Has no earned income, and all adults (individuals age 18 and older) are either disabled or over age 59, or

CONTINUED ON THE NEXT PAGE ...

3. Is on SSI or SSD and you live in a certified congregate care group home, or
4. Has a seasonal migrant farm-worker in the household, or
5. Is certified for 3 months or less, or
6. Is homeless (undomiciled - without shelter), or
7. If you are an Able-Bodied Adult Without Dependents ("ABAWD"): you must tell us if your work hours go below 80 hours a month. You must tell us this within 10 days after the end of the month when your work hours fell below 80 hours.

If you also receive Temporary Assistance (TA), you must report changes for TA within ten days after the change occurs.

Form W-203K
Rev. 5/28/08

NYC Human Resources Administration Department of Social Services
Family Independence Administration

Guide to Budgeting

(Effective June 1, 2008)

Schedule of Semimonthly Preadded Allowance (1/1/90)

CA 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 Cash Assistance personal needs allowance of $22.50 s/m.
2. Homeless persons who refuse placement in a shelter can receive the preadded, energy and restaurant allowance.
3. For family members joining the 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)

CA 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

CA 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

CA 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)

CA 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)

CA 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 Reduction	$45.00
Income Disregard	50% 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

CA Family Size	Preadded and Energy Allowance	*Preadded, 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 individual, if entitled, to the additional $18.00 s/m.

NYC Human Resources Administration Department of Social Services
Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____

Cash Assistance Budget Computation
(Effective June 1, 2008)

Other Eligible Payee(s)

First Name	M.I.	Last Name	Category	Suffix

Section 1: Calculation of Income/Needs

(Be sure to use conversion chart for weekly and monthly amounts.) Enter semimonthly (S/M) amounts.

Total number in household _____

A. Income		Suffix _____	Suffix _____
1.	Semimonthly gross earned income	$	$
Unearned Income:			
2.	Net S/M income from boarder/lodger	$	$
3.	Workers' Compensation	$	$
4.	New York State Disability	$	$
5.	Unemployment Insurance Benefits	$	$
6.	Social Security benefits	$	$
7.	Veterans' pension or compensation	$	$
8.	Child support/alimony income[TT] (subtract $25 from S/M amount)	$	$
9.	Other (specify):	$	$
10.	Total Unearned Income (add lines 2–9)	$	$
11.	Total S/M gross income (line 1 plus line 10)	$	$

[TT] Child support is counted only when determining initial eligibility for Cash Assistance. If determined eligible for Cash Assistance, child support is not budgetable but is assigned to the Agency through the Office of Child Support Enforcement.

Total number in household _____

B. Needs			Suffix _____	Suffix _____
	Semimonthly Needs	**S/M Amounts to Be Prorated**	**How many in the Suffix _____**	**How many in the Suffix _____**
12.	Family allowance		$	$
13.	Energy grant		$	$
14.	Fuel for heating		$	$
15.	Pregnancy allowance		$	$
16.	Other		$	$
17.	Basic allowance (add lines 12–16)		$	$
18.	Shelter allowance*		$	$
19.	Subtotal needs (add lines 17, 18)		$	$
20.	SSI prorated share		$	$
21.	Total needs (line 19 minus line 20)		$	$

*Up to Agency maximum unless in temporary housing with shelter codes **06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, 35**, **42** or **43**. For these shelter types, enter the actual cost of temporary housing.

Section 2: 185% Gross Income Limitation Calculation

		Suffix _____	Suffix _____
22.	Multiply amount on line 21 by 1.85	$	$
23.	Compare amount entered on line 11 with amount on line 22		
	(a) If the amount entered on line 11 is greater than the amount on line 22, the household does not meet the 185% Gross Income Limitation and is ineligible for Cash Assistance (CA) – check ☑ ineligible. Do not continue. Complete form **W-122D** to determine Food Stamp (FS) eligibility†	☐ Ineligible	☐ Ineligible
	(b) If the amount entered on line 11 is equal to or less than the amount entered on line 22, the household meets the 185% Gross Income Limitation – check ☑ eligible. Complete Section 3	☐ Eligible	☐ Eligible

†If one suffix fails the 185% test, recalculate the needs of the remaining suffix(es), excluding the ineligible suffix. Provide full allowances or an increased prorated share based on the number of remaining suffix(es).

Note: For households with income and residing in temporary shelters (shelter codes 06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, 35, 42 or 43): Prepare the Income Needs and Contribution Worksheet for Families in Temporary Housing (**W-684D**) to determine the household's needs and the amount of the income that must be contributed toward the cost of temporary housing. If there is no income in the household, continue to Section 4A or 4B as applicable.

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 _____
24.	Enter total S/M gross income from line 11	$	$
25.	Enter poverty guideline amount for family size from lookup chart	$	$
26.	Compare amounts on line 24 and 25:		
	(a) If amount on line 24 is greater than the amount on line 25, then the household has failed the poverty test and is ineligible for CA†	☐ Failed	☐ Failed
	(b) If amount on line 24 is less than or equal to the amount on line 25, the household has passed the poverty test and is eligible for CA	☐ Passed	☐ Passed

†If one suffix fails the poverty or net income test, recalculate the needs of the remaining suffix(es), excluding the ineligible suffix. Provide full allowances or an increased prorated share based on the number of remaining suffix(es).

If the household passed the poverty test, continue.

Shelter code: _____

2008 Poverty Guidelines Lookup Chart

Size of Family	Semimonthly Limit
1	$433.34
2	$583.34
3	$733.34
4	$883.34
5	$1,033.34
6	$1,183.34
7	$1,333.34
8	$1,483.34
For each additional person, add $150.00 semimonthly.	

Section 4A: Net Income Test

Active CA cases and cases closed less than four (4) months

		Suffix _____	Suffix _____
27.	S/M gross earned income (line 1)	$	$
28.	Standard deduction – $45 S/M (allow $45 S/M for each employed individual)	$	$
29.	Income applicable for 50% disregard (line 27 minus line 28)	$	$
30.	50% earned income disregard (multiply amount on line 29 by 0.50) Applicable for all FA households and any SNA household with at least one child or medically verified pregnant woman. All others enter zero (0)	$	$
31.	Total deductions (line 28 plus line 30)	$	$
32.	S/M net earned income (line 27 minus line 31)	$	$
33.	S/M unearned income (from line 10)	$	$
34.	Total S/M income (line 32 plus line 33)	$	$
35.	S/M needs subtotal (line 21)	$	$
36.	OCSE sanction: enter 25% needs reduction amount, if applicable (multiply amount on line 35 by 0.25)	$	$
37.	Total S/M needs (line 35 minus line 36)	$	$
38.	Budget deficit (line 37 minus line 34 – round down to the nearest 50¢) Enter amount if greater than zero (0). If equal to or less than zero (0) do not enter amount here, enter amount on line 39	–	–
39.	Budget surplus – if amount on line 34 is equal to or more than line 37, the household has **failed the net income test** and is **not eligible for CA**†	+	+
40.	Enter employment/substance abuse pro rata sanction amount, if applicable (prorated share of line 38)	$	$
41.	S/M budget deficit (line 38 minus line 40 – round down to the nearest 50¢)	CA Grant $	CA Grant $

†If one suffix fails the poverty or net income test, recalculate the needs of the remaining suffix(es), excluding the ineligible suffix. Provide full allowances or an increased prorated share based on the number of remaining suffix(es).

Section 4B: Net Income Test

New cases or cases closed for four (4) months or more

		Suffix _____	Suffix _____
42.	S/M gross earned income (line 1)	$	$
43.	S/M standard deduction – $45 S/M	$	$
44.	Net S/M earned income (line 42 minus line 43)	$	$
45.	Total S/M unearned income (line 10)	$	$
46.	Total S/M income (add lines 44 and 45)	$	$
47.	Total S/M needs (line 21 – round down to the nearest 50¢)	$	$
48.	OCSE sanction: Enter 25% needs reduction amount, if applicable (multiply amount on line 47 by 0.25)	$	$
49.	S/M needs (line 47 minus line 48)	$	$
50.	Subtotal budget deficit (line 49 minus line 46 – round down to nearest 50¢). If line 46 is equal to or more than line 49, enter zero (0)	–	–
51.	Budget surplus – **if line 50 is equal to zero (0), STOP; H/H is ineligible for CA.** If line 50 is greater than zero (0), continue†	+	+
52.	Income disregard (applicable for all FA households and any SNA household with at least one child or medically verified pregnant woman). Multiply the amount on line 44 by 0.50	$	$
53.	S/M net earned income (line 44 minus line 52)	$	$
54.	Total S/M needs (line 47)	$	$
55.	Total income (line 45 plus line 53)	$	$
56.	Budget deficit (line 54 minus line 55 – round down to the nearest 50¢)	CA Grant $	CA Grant $
57.	Enter employment/substance abuse pro rata sanction amount, if applicable (prorated share of line 56)	$	$
58.	S/M budget deficit (line 56 minus line 57 – round down to the nearest 50¢)	$	$

†If one suffix fails the net income test, recalculate the needs of the remaining suffix(es), excluding the ineligible suffix. Provide full allowances or an increased prorated share based on the number of remaining suffix(es).

Section 5: Income for Food Stamp Calculation

		Suffix _____	Suffix _____
59.	Add together the budget deficits for each suffix (line 38 or line 56) and enter the total. This amount is also entered on line 4 of form **W-122D/DD**. For alien cases with individuals ineligible for food stamps, enter only the prorated Cash Assistance of eligible individuals on line 4 of form **W-122D/DD**		

Authorization Period: From: _____ To: _____.

Authorized by

Date

Human Resources Administration
Department of Social Services
Family Independence Administration

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____

Cálculo del Presupuesto para Asistencia en Efectivo

(Vigente el 1ro de junio, 2008)

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

Nombre	I.	Apellido	Categoría	Sufijo

Sección 1: Cálculos de Ingreso/Necesidades

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

Número Total en el hogar _____

A. Ingreso		Sufijo _____	Sufijo _____
1.	Ingreso bruto salarial quincenales	$	$
Ingreso No Salarial:			
2.	Ingreso neto quincenal por huésped/inquilino	$	$
3.	Indemnización para Trabajadores	$	$
4.	Indemnización por Incapacidad del Estado de Nueva York	$	$
5.	Seguro de Desempleo	$	$
6.	Beneficios de Seguro Social	$	$
7.	Pensión o indemnización para veteranos	$	$
8.	Ingreso por mantenimiento niños/pensión alimenticia[TT] (deduzca $25 de la cantidad quincenal)	$	$
9.	Otro ingreso (detalle):	$	$
10.	Ingreso Total No Salarial (sume las líneas 2-9)	$	$
11.	Total de ingreso bruto salarial quincenal (sume las líneas 1 y 10)	$	$

[TT] El mantenimiento de niños se toma en cuenta sólo al determinar la elegibilidad inicial para asistencia en efectivo. Si se determina elegible para asistencia en efectivo, el matenimiento de niños no se incluye en el presupuesto. Sin embargo, se le asigna a la Agencia por medio de la Oficina de Aplicación del Mantenimiento de Niños (Office of Child Support Enforcement).

Número Total en el Hogar _____

B. Necesidades			Sufijo _____	Sufijo _____
	Necesidades Quincenales	**Cantidad Quincenal a Prorratear**	**Personas bajo este sufijo** _____	**Personas bajo este sufijo** _____
12.	Asignación por familia		$	$
13.	Concesión para energía		$	$
14.	Concesión para energía		$	$
15.	Asignación por embarazo		$	$
16.	Otra necesidad		$	$
17.	Asignación normal (sume desde la línea 12 a la 16)		$	$
18.	Asignación de vivienda*		$	$
19.	Subtotal de necesidades (sume las líneas 17 y 18)		$	$
20.	Porción del SSI prorateado		$	$
21.	Total de necesidades (línea 19 menos línea 20)		$	$

*Hasta el máximo permisible por la Agencia al menos que esté alojado(a) temporalmente en un refugio de acuerdo a los códigos de vivienda **06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, 35, 42 o 43.** Para estos tipos de refugios anote el costo real de alojamiento temporario.

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

		Sufijo _____	Sufijo _____
22.	Multiplique la cantidad en la línea 21 por 1.85.	$	$
23.	Compare la cantidades marcada en la línea 11 con la cantidad de la línea 22:	$	$
	(a) Si la cantidad en la línea 11 supera la cantidad en la línea 22, el hogar no califica según la Limitación del 185% del Ingreso Bruto y no es elegible para asistencia pública (public assistance – PA) – marque ☑ no elegible. No siga llenando el formulario. Complete el formulario **W-122D** para determinar si tiene derecho a cupones para alimentos (food stamps – FS)†	☐ No elegible	☐ No elegible
	(b) Si la cantidad en la línea 11 es menor que la cantidad en la línea 22, el hogar califica según la Limitación del 185% del Ingreso Bruto – marque ☑ la casilla elegible. Complete la Sección 3	☐ Elegible	☐ Elegible

†Si un sufijo no pasa la prueba de pobreza o de ingreso neto, vuelva a calcular las necesidades de los sufijos restantes, sin incluir aquellos que no sean elegibles. Proporcione una asignación completa o aumento de porción prorrateada de acuerdo al número de sufijo(s) que resten.

Nota: Para los hogares que reciban ingresos y residan en viviendas temporarias (códigos de vivienda 06, 13, 14, 15, 16, 19, 27, 28, 29, 31, 33, 34, 35, 42 o 43): Llene la Hoja de Cálculos de Necesidades y Contribuciones para Familias en Viviendas Temporarias (**W-648D**) para determinar las necesidades del hogar y la cantidad de los ingresos que se debe destinar al costo de la vivienda temporaria si no existe ningún ingreso en el hogar, continúe a la Sección 4A o 4B según le corresponda.

Sección 3: Prueba de Pobreza

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

		Sufijo _____	Sufijo_____
24.	Anote el total del ingreso quincenal que aparece en la línea 11	$	$
25.	Anote la cantidad según los niveles de pobreza y el número de miembros en el hogar que aparece en la tabla de referencia	$	$
26.	Compare las cantidades que aparecen en las líneas 24 y 25:		
	(a) Si la cantidad de la línea 24 supera a la cantidad en la línea 25, el ingreso del hogar está por encima del nivel de pobreza por lo cual no califica para Asistencia en Efectivo†	☐ No Elegible	☐ No Elegible
	(b) Si la cantidad de la línea 24 resulta menos o igual a la cantidad de la línea 25, el ingreso del hogar está por debajo del nivel de pobreza y por consiguiente califica para Asistencia en Efectivo	☐ Elegible	☐ Elegible

†Si un sufijo no pasa la prueba de pobreza o de ingreso neto, vuelva a calcular las necesidades de los sufijos restantes, sin incluir aquellos que no sean elegibles. Proporcione una asignación completa o aumento de porción prorrateada de acuerdo al número de sufijo(s) que resten.

Si el hogar está por debajo de los niveles de pobreza, prosiga.

Código de Refugio: _____

Niveles de Pobreza del 2008
Tabla de Referencia

Núm. de miembros en el hogar	Límite Quincenal
1	$433.34
2	$583.34
3	$733.34
4	$883.34
5	$1,033.34
6	$1,183.34
7	$1,333.34
8	$1,483.34
Para cada persona adicional, añada $150.00 quincenal.	

Sección 4A: Prueba de Ingreso Neto

Casos Activos de Asistencia en Efectivo y cerrados por menos de cuatro (4) meses

		Sufijo _____	Sufijo _____
27.	Ingreso bruto salarial quincenal (línea 1)	$	$
28.	Deducción normal – $45 quincenal	$	$
29.	Ingreso que califica para descuento del 50% (línea 27 menos línea 28)	$	$
30.	Descuento del 50% al ingreso salarial (multiplique la cantidad en la línea 29 por 0.50) Le corresponde a todos los hogares en Asistencia Familiar (FA) y a todos los de Asistencia de la Red de Seguridad (SNA) con por lo menos un niño o mujer con embarazo clínicamente comprobado. Para todos los demás anote cero (0)	$	$
31.	Total de las deducciones (sume la línea 28 a la línea 30)	$	$
32.	Ingreso bruto salarial quincenal (línea 27 menos línea 31)	$	$
33.	Ingreso no salarial quincenal (línea 10)	$	$
34.	Ingreso total quincenal (sume la línea 32 a la línea 33)	$	$
35.	Subtotal quincenal de necesidades (línea 21)	$	$
36.	Sanción de OCSE: Anote la cantidad de la reducción del 25% de necesidades, si le corresponde (multiplique la cantidad de la línea 35 por 0.25)	$	$
37.	Total quincenal de necesidades (línea 35 menos línea 36)	$	$
38.	Déficit presupuestario (línea 37 menos la 34 – redondee reduciendo a los 50¢ más cercanos). Si la cantidad resulta mayor a cero (0), anótela. Si dicha cantidad resulta cero (0) o menos anótela en la línea 39 y no aquí	–	–
39.	Sobrante de presupuesto – Si la cantidad en la línea 34 equivale o supera la de la línea 37, el hogar **no pasó la prueba de ingreso neto , y por tanto, no es elegible para Asistencia en Efectivo**†	+	+
40.	Anote la cantidad prorrateada de la sanción de empleo/drogadicción, si le corresponde (cantidad de línea 38 prorateada)	$	$
41.	Deficit presupuestario quincenal (reste la línea 38 de la línea 40 – redondee la cifra a los 50¢ más cercanos)	Concesión CA $	Concesión CA $

†Si un sufijo no pasa la prueba de pobreza o de ingreso neto, vuelva a calcular las necesidades de los sufijos restantes, sin incluir aquellos que no sean elegibles. Proporcione una asignación completa o aumento de porción prorrateada de acuerdo al número de sufijo(s) que resten.

Sección 4B: Prueba de Ingreso Neto

Casos nuevos o cerrados por cuatro (4) meses o más

		Sufijo _____	**Sufijo** _____
42.	Ingreso bruto salarial quincenal (línea 1)	$	$
43.	Deducción normal quincenal – $45 quincenal	$	$
44.	Ingreso neto salarial quincenal (línea 42 menos línea 43)	$	$
45.	Total quincenal de ingresos no salariales (línea 10)	$	$
46.	Total quincenal de ingresos (sume la cantidad de las líneas 44 y 45)	$	$
47.	Total de necesidades quincenales (cantidad de la línea 21 – redondee a los 50¢ más cercanos)	$	$
48.	Sanción de OCSE: Anote la cantidad de la reducción del 25% de necesidades, si le corresponde (multiplique la cantidad de la línea 47 por 0.25)	$	$
49.	Necesidades quincenales (cantidad de la línea 47 menos la cantidad de la línea 48)	$	$
50.	Subtotal del déficit presupuestario (deduzca la línea 46 de la línea 49 – redondee la cifra a los 50¢ más cercanos). Si la cantidad de la línea 46 equivale o supera la cantidad de la línea 49, anote cero (0)	–	–
51.	Sobrante de presupuesto – **si la línea 50 es igual a cero (0**), **DETÉNGASE; el hogar no es elegible para Asistencia Efectivo**. Si la línea 50 resulta más de cero (0), prosiga†	+	+
52.	Descuento del ingreso (le corresponde a todos los hogares en Asistencia Familiar [FA] y cualquier hogar en Asistencia de la Red de Seguridad [SNA] donde resida un niño o mujer con embarazo clínicamente comprobado). Multiplique la cantidad de la línea 44 por 0.50	$	$
53.	Ingreso neto salarial quincenal (reste la línea 44 de la línea 52)	$	$
54.	Total de necesidades quincenales (línea 47)	$	$
55.	Ingreso total (línea 45 más línea 53)	$	$
56.	Déficit presupuestario (línea 54 menos línea 55 – redondee la cifra a los 50¢ más cercanos)	Concesión CA $	Concesión CA $
57.	Anote la cantidad prorrateada conforme a la sanción de empleo/abuso de sustancias, si le corresponde (cantidad de linea 56 prorateada)	$	$
58.	Deficit presupuestario quincenal (cantidad en línea 56 menos la cantidad de la línea 57 – redondee la cifra a los 50¢ más cercanos)	$	$

†Si un sufijo no pasa la prueba de pobreza o de ingreso neto, vuelva a calcular las necesidades de los sufijos restantes, sin incluir aquellos que no sean elegibles. Proporcione una asignación completa o aumento de porción prorrateada de acuerdo al número de sufijo(s) que resten.

Sección 5: Cálculos de Ingreso para Cupones para Alimentos

		Sufijo _____	Sufijo ____
59.	Sume los déficits presupuestarios de cada sufijo (línea 38 o línea 56) y anote el total. Esta cantidad también se anota en la línea 4 del formulario **W-122D/DD**. Para casos de con personas inelegibles para cupones para alimentos, anote en la línea 4 del formulario solamente la cantidad prorrateada de Asistencia en Efectivo de las personas elegibles **W-122D/DD**		

Período de Autorización: De: _____ A: _____.

Autorizado por

Fecha

NYC Human Resources Administration Department of Social Services
Family Independence Administration

Date: _____
Case Number: _____
Case Name: _____
Caseload: _____
Center: _____

Income Contribution Worksheet for Families in Temporary Housing

To be used in conjunction with form **W-648** or WMS CA budget calculation
(Effective June 1, 2008)

S/M Needs		**Enter Semimonthly Amounts Below**
1.	Preadded allowance	$
2.	Home energy allowance	$
3.	Restaurant allowance	$
4.	Temporary housing allowance	$
5.	Other (specify):	$
6.	Total needs (add lines 1-5)	
S/M Net Income		**Enter Semimonthly Amounts Below**
7.	Semimonthly (S/M) gross income	$
8.	Enter the S/M poverty level for household size	$
9.	Subtract line 8 from line 7 (If line 8 is more than line 7, enter zero [0])	$
10.	Enter the amount from line 7 or line 8, whichever is LESS	$
11.	Subtract a $45 S/M standard work deduction from line 10 for each employed individual and enter the result	$
12.	Earned income disregard (line 11 x 0.50) for each employed individual. Applicable for all FA households and any SN household with at least one child or a medically verified pregnant woman. All others enter zero (0)	$
13.	Line 11 minus line 12	$
14.	Net S/M earned income (add line 9 and line 13)	$
15.	S/M child support income (If $25 or more S/M, subtract $25 and enter balance. If less than $25, enter zero [0])	$
16.	Other S/M unearned income (specify):	$
17.	Total S/M net income (add lines 14, 15 and 16)	$

S/M Budget Deficit		**Enter Semimonthly Amounts Below**
18.	Total needs (line 6)	$
19.	Total S/M net income (line 17)	$
20.	Budget deficit (line 18 minus 19 – round down to nearest 0.50)	$
Participant's S/M Contribution		**Enter Semimonthly Amounts Below**
21.	Actual S/M shelter cost (line 4)	$
22.	Budget deficit (enter amount from line 20)	$
23.	Participant's S/M contribution toward shelter cost (line 21 minus line 22)	$

Authorization Period: From: _____ To: _____.

_____ _____

Authorized by Date

NYC Human Resources Administration Department of Social Services
Family Independence Administration

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Unidad de Casos: _____
Centro: _____

Hoja de Contribución de Ingresos para Familias Residentes en Viviendas Temporales

A usarse conjuntamente con un formulario W-648 (S) o con cálculo presupuestarios de WMS CA
(Vigente el 1ro de junio, 2008)

Necesidades Quincenales		**Indique Cantidades Quincenales Más Abajo**
1.	Asignación añadida por anticipado	$
2.	Asignación para energía del hogar	$
3.	Asignación para restaurantes	$
4.	Asignación para vivienda temporal	$
5.	Otras necesidades (favor de detallar):	$
6.	Suma de todas las necesidades (sume las líneas 1–5)	$
Ingreso Neto Quincenal		**Indique Cantidades Quincenales Más Abajo**
7.	Ingreso quincenal (Q) bruto	$
8.	Anote el nivel quincenal de pobreza correspondiente al número de miembros en el hogar	$
9.	Reste la línea 8 de la línea 7 (Si la línea 8 es más que la línea 7, anote cero [0])	$
10.	Marque la MENOR de las cantidades de las líneas 7 y 8	$
11.	Reste la deducción normal de trabajo ($45 Q) de la línea 10 por cada persona empleada y anote el resultado	$
12.	Descuento del ingreso salarial (línea 11 x 0.50) por cada persona empleada. De aplicación para todos los hogares de FA o de SN con al menos un niño(a) o embarazo clinicamente comprobado. De lo contrario anote cero (0)	$
13.	Línea 11 menos línea 12	$
14.	Ingreso salarial neto y quincenal (sume las cantidades de las líneas 9 y 13)	$
15.	Ingreso quincenal de mantenimiento de niños (De ser $25 o más quincenalmente, deduzca $25 y marque el saldo. Si menos de $25, marque cero [0])	$
16.	Ingresos Q no salariales adicionales (favor de detallar):	$
17.	Ingreso Q neto total (sume las líneas 14, 15 y 16)	$

Déficit del Presupuesto Quincenal		**Indique Cantidades Quincenales Más Abajo**
18.	Cantidad total de necesidades (línea 6)	$
19.	Ingreso Q neto total (línea 17)	$
20.	Déficit del presupuesto (línea 18 menos línea 19 – redondee hacia los 0.50 más cercanos)	$
Contribución Quincenal del Participante		**Indique Cantidades Quincenales Más Abajo**
21.	Costo Q actual de alojamiento (line 4)	$
22.	Déficit presupuestario (anote la cantidad de la línea 20)	$
23.	Contribución Q del participante destinada al alojamiento (línea 21 menos línea 22)	$

Período de Autorización: De: _____ A: _____.

Autorizado por _____ Fecha _____