FAMILY INDEPENDENCE ADMINISTRATION

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POLICY DIRECTIVE #08-43-ELI

(This Policy Directive Replaces PD #05-02-ELI)

EMERGENCY ASSISTANCE TO NEEDY FAMILIES WITH CHILDREN (EAF)

Date: November 18, 2008	**Subtopic(s):** Emergency Assistance

AUDIENCE

The instructions in this policy directive are for staff at Job Centers and are informational for all other staff.

REVISIONS TO THE PRIOR DIRECTIVE

This policy directive has been revised as follows:

- A paragraph has been added to page 3 of the Policy section, informing Workers that they must explore the use of Emergency Assistance to Needy Families with Children (EAF) before authorizing benefits under Emergency Safety Net Assistance (ESNA).
- A statement has been added to inform staff that households that are converted to Safety Net Assistance (SNA) or Safety Net Non Cash Assistance (SNNC) due to the 60-month time limit on Cash Assistance (CA) are still eligible to receive emergency assistance in the EAF category.
- The Required Action section has been revised to include instructions for processing EAF cases in the Paperless Office System (POS).

POLICY

EAF is a federally funded program dedicated to meeting the emergency needs of families with children. The emergency situation must be a result of a sudden occurrence or set of circumstances requiring immediate attention. Individuals claiming an emergency need must have a same-day interview.

BACKGROUND

To be categorically eligible for EAF, the household must contain either an individual with a medically verified pregnancy or a child under the age of 18 or age 18 and attending full-time secondary school or the equivalent level of vocational or technical training. In addition, the following criteria must be met:

Categorical Eligibility for EAF

- The child must be currently living with an adult related by blood, marriage or adoption;
- The child, parents or other eligible relatives must be without immediately accessible resources necessary for meeting their needs, and those needs cannot be met by an advance allowance;
- The child must be facing destitution or requiring emergency assistance to provide living arrangements for him/her in a home; and
- The emergency could not have been foreseen by the applicant and was not under his/her control.

  Note: Utility payments are not subject to the "sudden and unforeseen" EAF requirement.

Financial Eligibility for EAF

Financial eligibility for EAF is not based on financial eligibility for CA, but rather on actual income and resources available on the date of the application to meet the emergency need.

In order to be financially eligible for EAF, all applicants must meet the following requirement:

See Federal Poverty Level Guidelines form (**EXP-76D**)

- The gross available income of the applicant on the date of application must be at or below 200% of the Federal poverty level for that household size and the applicant must be without the resources to meet the emergency need (income, money on hand, bank accounts, etc.).

The gross available income standards do not apply to households receiving child protective, child preventative or any other child welfare services paid for under EAF. Such households must, however, include one member in receipt of CA or Supplemental Security Income (SSI) at the time of the EAF determination.

EAF cannot be granted in the following instances:

- When the emergency is the result of a refusal to accept employment or training for employment without good cause;
- When the emergency is the result of mismanagement of the CA grant; or
- When it replaces or duplicates assistance for which a person would otherwise be eligible were it not for an employment or other program sanction.

  Note: Emergency assistance cannot be requested to cover the share of an individual person in "sanction" status, and the amount of assistance for which the remaining household members are deemed eligible must be sufficient to overcome the household's emergency need.

The Determination of Eligibility for Emergency Assistance to Needy Families (EAF) form (**W-145TT**) is a tool used to determine EAF eligibility and has been programmed into POS.

EAF may be authorized more than once in a 12-month period, even if the subsequent emergency is unrelated to a previous one. EAF payments may be made to meet needs related to the emergency situation that occurred before the EAF program authorization and/or needs that continue after the EAF program authorization.

EAF is generally provided as a non-recoverable grant. However, shelter payments made in excess of the Agency maximum for the household size are recoverable. In addition, Non Cash Assistance (NCA) households ("One-Shot Deals") are required to sign the Utility Arrears Repayment Agreement form (**W-147X**), to be eligible for utility assistance granted under EAF.

Form **W-147X** includes an agreement that the household will repay the amount of the utility arrears grant in twelve monthly installments, each of which must be received on or before the first of each month. The first payment is due on or before the first day of the month after the grant is received. The Human Resources Administration (HRA) Division of Accounts Receivable and Billing will send a monthly bill with an addressed postage-free return envelope.

The household is responsible for mailing payments in the return envelope provided to:

Human Resources Administration
Division of Accounts Receivable and Billing
180 Water Street, 9th Floor
New York, NY 10038

If the household is receiving utility arrears assistance to restore service or to prevent termination of service, they will not be eligible for subsequent assistance unless all prior utility arrears payments have been fully repaid, or if the household is currently repaying such assistance in accordance with their repayment agreement (has not defaulted on the current repayment agreement and is not in arrears). If the household fails to repay the utility arrears assistance in accordance with the repayment agreement outlined in form **W-147X**, HRA will enforce the agreement by any method available to a creditor, including referring the matter to a collection agency, obtaining a judgment from a court, obtaining a lien on real property, or garnishing wages, in appropriate cases.

If the household later becomes eligible for recurring CA, any unpaid balance remaining under the repayment agreement will be suspended until the household is no longer receiving recurring CA. At that time, the unpaid balance will become due to HRA.

New Information

Households that are converted to SNA or SNNC due to the 60-month time limit on CA are still eligible to receive emergency assistance in the EAF category. The eligibility for and use of EAF for these applicants for emergency assistance must be explored before authorizing benefits under ESNA.

Note: See **Attachment A** for a list of all of the issuance codes that may be issued under EAF if all other EAF eligibility criteria are met.

REQUIRED ACTION

Applicants

If the applicant is applying for a one-time emergency assistance grant, the Worker must register the case by selecting the "**One Shot Deal**" check box in the Site Determination window and the EAF category in the Case Log-in window of the **POS Application Intake**. The Worker must make an EAF eligibility assessment and record the EAF decision in the **Eligibility Determination** of the **POS Application Interview**.

If the applicant is applying for ongoing CA, the Worker must register the application under the FA category or a Safety Net category, as appropriate, in the **POS Application Intake**. The finger imaging referral and same-day interview must also be completed in the **POS Application Interview** activity. The Worker must then assess the household's eligibility for payments under EAF.

New Information

When assessing eligibility for emergency payments under EAF, the Worker must complete form **W-145TT** in the POS Form Data Entry window to determine whether the applicant is eligible for an EAF grant.

EAF Assessment

Form **W-145TT** Data Entry Window:

Response to Question

Form W-145TT – Determination of Eligibility for Emergency Assistance to Needy Families (EAF)

Type of Emergency:

Cause of Emergency:

This Crisis Situation is Due to the Following Circumstance(s):

- ☐ Fire or Other Disaster
- ☐ Asked to leave shared apartment by relative or friend who is primary tenant
- ☐ Emergency medical expenses required all available resources to be diverted from rent
- ☐ Sudden loss of employment due to layoff or other reason not brought about by voluntary quit
- ☐ Landlord refused late or partial rent payment
- ☐ Utility shut-off/termination
- ☐ Eviction by landlord for reasons other than nonpayment of rent (specify):
- ☐ Eviction by landlord due to nonpayment as part of a complex set of problems, which constitutes an emergency for the family
- ☐ Victim of domestic violence (adult and/or child)
- ☐ Other (specify):

EAF Eligibility Determination Checklist: **Eligible for EAF?** ○ Yes ○ No

Is there at least one child under the age of 18, or age 18 and attending full-time secondary school, who is currently residing with an adult caretaker who is related by blood, marriage or adoption?	○ Yes	○ No
Is there a woman of any age with a medically verified pregnancy?	○ Yes	○ No
Does the family have resources to meet their needs or available income at or above 200% of the most recently published Federal poverty guidelines, as transmitted by the Office of Temporary and Disability Assistance, on the date of application for that family size?	○ Yes	○ No
Did the emergency arise because an employable child or relative refused without good cause to accept employment or participate in work activities or community activities?	○ Yes	○ No
Will the emergency grant being applied for duplicate or replace a Cash Assistance grant already made under **18 NYCRR § 352.2(a)(b)(c)? (Do not answer "Yes" if the duplication will replace lost or stolen Cash Assistance.)	○ Yes	○ No
Is payment needed to restore utility services or to prevent service interruption?	○ Yes	○ No
Is the emergency the result of a sudden occurrence or situation, unforeseen and beyond the individual's control?	○ Yes	○ No

OK Cancel

Once it is determined that the household meets the EAF category criteria on form **W-145TT**, the Worker must determine whether or not sufficient income and/or resources are available to meet the needs of the household.

Income

If it is determined that income is available, the Worker must confirm whether the available income is at or below 200% of the current Federal poverty level for that household. Refer to the Federal Poverty Level Guidelines form (**EXP-76D**) for the current Federal poverty level guidelines.

If the applicant's available gross income on the date of application is above the 200% Federal poverty level guideline for the applicant's family size, the income is sufficient and assistance under EAF cannot be granted. If the available gross income is at or below 200% of the Federal poverty level guideline, the household meets the income criteria for EAF. If the household is ineligible for EAF for reasons not related to income, Workers should explore other types of assistance available.

Resources

The applicant's available resources must not exceed the Resource Limits. Refer to the CA and FS Resource Limits/Exemptions Desk Guide form (**W-204X**) for the current Resource Limits. A resource must be easily converted to available cash, even if it results in a penalty for liquidating the resource, such as in the case of stocks, bonds, etc.

The Agency must also explore the use of diversion payments to meet the needs of applicants who are now applying for recurring CA, if authorizing such a payment will divert the applying household from the need for ongoing assistance. When issuing diversion payments, apply EAF resource/income criteria, not the income standards for ESNA or recurring FA/SNA.

When the EAF grant is requested, the JOS/Worker must evaluate the emergency situation of the family; a 30-consecutive day authorization may be granted for those items that are necessary for the family. Non-emergency needs that extend beyond the 30-day period should subsequently be granted under a regular category of assistance.

Benefits that can be provided under the EAF category include, but are not limited to:

- Rent
- Fuel for heating
- Food
- Essential household furniture/equipment
- Utilities
- Expenses for new housing such as security, broker's fees, moving, and storage fees.
- Repairs to the individual's owned home
- Mass emergency payments for clothing, blankets, medical care, food, restaurant allowance, other essential items, miscellaneous services
- Replacement of lost or stolen cash

See **Attachment A** for a list of issuance codes that may be provided under EAF.

Shelter Arrears

All applications for households requesting a one-time Emergency payment must be referred to the Rental Assistance Unit (RAU) for evaluation.

Rent in excess of the maximum for the household size is subject to recovery (one-shot deals) or recoupment (ongoing CA).

If the household requesting a one-time Emergency payment is applying for assistance with shelter arrears or any other type of emergency other than utility arrears, a repayment agreement is not required under EAF rules. However, if the amount of the monthly arrears exceeds the Agency maximum for the household size, the excess shelter cost is subject to recovery (one-shot deals) or recoupment (households in receipt of ongoing assistance).

> **Note**: If a household requesting a one-time Emergency payment does not have adequate fuel for heating, the household must be evaluated by the Emergency Home Energy Assistance Program ("E" HEAP) before the Agency pays arrears.

If the household requesting a one-time Emergency payment is applying for assistance with utility arrears, a repayment agreement is required under EAF. The Worker must complete form **W-147X**.

Form **W-147X** must be prepared manually, then scanned and indexed into the electronic case record. The original form **W-147X** and a duplicate should be sent via interoffice mail by the close of business on Fridays to:

> Investigation, Revenue and Enforcement Administration
> Division of Claims & Collections
> 250 Church Street, 5th Floor
> New York, NY 10013
> Attn.: Director's Office

If the household applying for ongoing assistance is also eligible for an EAF grant, the Worker must record the EAF grant decision on the Data Entry Window of the Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) form (**W-145HH**) in the **POS Notice Data Entry** window.

The data entry window for form **W-145HH** must be completed to inform the applicant about the decision on his/her request for a benefit. The Supervisor must review the approval activity and print form **W-145HH**.

The Worker must also prepare a notice in the Client Notices System (CNS). If the applicant cannot be informed through a notice issued via CNS, the form data entry windows for the Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage (NYC), Part A form (**LDSS-4013A NYC**) and the Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage (NYC), Part B form (**LDSS-4013B NYC**), must be completed in the **POS Application Interview** to inform the applicant about the CA eligibility determination.

The Supervisor must review the **Approve Eligibility Decision** activity and print forms **LDSS-4013A NYC** and **LDSS-4013B NYC** if the manual forms are required.

If the grant will be issued prior to the final CA decision, the Worker must use the **Non-Food Emergency/Special Grant** activity to prepare the grant forms and notices.

One-shot Deals

Once the emergency need has been met and the emergency authorization period ends, the case status is changed from “single issue” to "closed” using closing code **Y95** (Case Closed After Being Accepted for Emergency Assistance [Manual Notice]).

Participants

See PD #05-28-SYS

If the household is in receipt of CA benefits and makes a request for a special grant or an additional allowance that can be issued under the EAF category, the Worker must record the participant’s request using the **POS Single Issue Grant Request Task List** to prepare a Request for Emergency Assistance or Additional Allowance (For Participants Only) form (**W-137A**) and assess the household’s eligibility for payments under EAF.

If the household is eligible for EAF, the Worker must enter code **F** (Current EAF Authorization on a FA, SNFP, SNCA, SNNC, or EAF Case) in the **Emergency Indicator** field in the **POS Turn-Around Document (TAD)** window and inform the applicant about the decision on their grant request using the Action Taken on Your Request for Emergency Assistance or Additional Allowance (For Participants Only) form (**W-137B**).

Once the emergency need has been met and the emergency authorization period ends, the Worker must enter code **P** (Prior Emergency Authorization [Enter This Code When the Emergency Authorization Period Ends]) in the **Emergency Indicator** in the **POS TAD** window.

See PB #07-19-ELI

Workers are reminded that EAF applicants must be finger-imaged and referred to the Bureau of Eligibility Verification (BEV).

PROGRAM IMPLICATIONS

Food Stamp Implications

The Worker must ask all individuals applying for emergency assistance only (One-Shot Deal), who are not in receipt of Food Stamps (FS) and who have not indicated on the application that they have a food emergency or wish to apply for FS benefits, whether they wish to apply for FS.

If the answer is “no,” the Worker must make a case entry that clearly indicates the individual was offered this option.

If the answer is “yes,” an application for FS must be filed. The Worker must also ensure that the household has been screened for expedited processing of the FS application and that the FS benefits are made available within the required time frame.

Medicaid Implications

There are no Medicaid implications.

LIMITED ENGLISH-SPEAKING ABILITY (LESA) 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 #08-20-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

A participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If a 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 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 participant.

If the participant has in fact presented good cause for the infraction or shown that the outstanding Notice of Intent needs to be withdrawn for other reasons, the FH&C AJOS/Supervisor I will settle in conference (SIC), enter detailed case notes in NYCWAY and forward all verifying documentation submitted by the applicant/participant to the appropriate JOS/Worker for corrective action to be taken. In addition, if the adverse case action still shows on the "Pending" (**08**) screen in WMS, the AJOS/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (**LDSS-3722**), change the **02** to an **01** if the case has been granted aid continuing (ATC), or prepare and submit a PA Recoupment Data Entry Form – WMS (**LDSS-3573**) to delete a recoupment. The AJOS/Supervisor I must complete a Conference Report (**M-186a**).

If the participant fails to show good cause for the infraction or if it is determined that the Agency's action(s) should stand, the AJOS/Supervisor I will explain to the applicant/participant why s/he cannot settle the issue(s) in conference (SIC). The AJOS/Supervisor I must complete an **M-186a**.

Evidence Packets

Should the 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.

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.

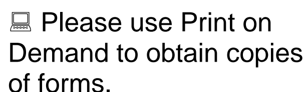
REFERENCES

GIS #07 TA/DC004
96 ADM-09
02 ADM 2
03 ADM 11
03 INF-35
04-INF-03
04-INF-21
TASB Chapter 2, Section C, page 2
18 NYCRR 372
SSL § 350-j

RELATED ITEMS

PD #05-28-SYS
PB #07-19-ELI

ATTACHMENTS


Please use Print on Demand to obtain copies of forms.

Attachment A	List of EAF-Eligible Issuance Codes
EXP-76D	2008 Federal Poverty Level Guidelines (Rev. 11/18/08)
W-137A	Request for Emergency Assistance or Additional Allowance (For Participants Only) (Rev. 11/18/08)
W-137A (S)	Request for Emergency Assistance or Additional Allowance (For Participants Only) (Spanish) (Rev. 11/18/08)
W-137B	Action Taken on Your Request for Emergency Assistance or Additional Allowance (For Participants Only) (Rev. 11/18/08)
W-137B (S)	Action Taken on Your Request for Emergency Assistance or Additional Allowance (For Participants Only) (Spanish) (Rev. 11/18/08)
W-145HH	Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Rev. 11/18/08)
W-145HH (S)	Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Spanish) (Rev. 11/18/08)
W-145TT	Determination of Eligibility for Emergency Assistance to Needy Families (EAF) (Rev. 11/18/08)
W-145TT(S)	Determination of Eligibility for Emergency Assistance to Needy Families (EAF) (Spanish) (Rev. 11/18/08)

W-147X	Utility Arrears Repayment Agreement (Rev. 11/18/08)
W-147X (S)	Utility Arrears Repayment Agreement (Spanish) (Rev. 11/18/08)

Attachment A

EAF-Eligible Issuance Codes*

- **07** Replacement of lost/stolen undelivered check
- **08** Replacement of cancelled check
- **10** Utility grant to prevent turn-off/restore services (Prior to CA)
- **14** Replacement of lost/stolen cash
- **16** Transportation to points outside of NYC – Waverly JC (Transportation Unit only)
- **18** Expenses connected with maintaining housing
- **19** Replacement of heating equipment, stove, or refrigerator
- **21** Storage fees
- **22** Moving fees
- **30** Rent payment is excess of maximum
- **31** Pre-CA rent arrears
- **38** Security Deposit private housing
- **39** Rent in advance to secure an apartment
- **40** Rent in advance to avoid eviction
- **42** Broker's and Finder's fees
- **44** Immediate needs grant
- **45** Disaster sustenance
- **46** Disaster
- **47** Disaster household furnishings and replacements
- **48** Disaster shelter – temporary housing
- **49** Disaster transportation to home of a friend/relative or to a shelter
- **50** Non-recoupable utility grant (no mismanagement)
- **58** Emergency childcare fees
- **60** Establishment of a home
- **99** Other

* Form **W-145TT** must be completed to determine EAF eligibility.

SAMPLE

EXP-76D
Rev. 11/18/08

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Federal Poverty Level Guidelines
(Effective April 1, 2008)

Size of Family	Federal Poverty Level		Emergency Assistance to Families (EAF) – 200% of Poverty Level		Emergency Safety Net Assistance (ESNA) – 125% of Poverty Level	
	Annual	Monthly (Rounded)	Annual	Monthly (Rounded)	Annual	Monthly (Rounded)
1	$10,400	$867	$20,800	$1,733	$13,000	$1,083
2	$14,000	$1,167	$28,000	$2,333	$17,500	$1,458
3	$17,600	$1,467	$35,200	$2,933	$22,000	$1,833
4	$21,200	$1,767	$42,400	$3,533	$26,500	$2,208
5	$24,800	$2,067	$49,600	$4,133	$31,000	$2,583
6	$28,400	$2,367	$56,800	$4,733	$35,500	$2,958
7	$32,000	$2,667	$64,000	$5,333	$40,000	$3,333
8	$35,600	$2,967	$71,200	$5,933	$44,500	$3,708
9	$39,200	$3,267	$78,400	$6,533	$49,000	$4,083
10	$42,800	$3,567	$85,600	$7,133	$53,500	$4,458
For each additional member:	$3,600	$300	$7,200	$600	$4,500	$375

SAMPLE

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Date: ____________________

Case Name: ____________________

Case Number: ____________________

Caseload: ____________________

Center: ____________________

Worker Telephone No.: ____________________

FH&C Telephone No.: ____________________

Request for Emergency Assistance or Additional Allowance
(For Participants Only)

Please fill out this form if you need emergency assistance or an additional allowance.

Remember:

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

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

SAMPLE

SECTION I: EMERGENCY ASSISTANCE

The type of EMERGENCY ASSISTANCE I am requesting is:

The reason I need emergency assistance is:

SECTION II: ADDITIONAL ALLOWANCES

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

- ☐ Back rent
- ☐ Repair of essential household items
- ☐ Back mortgage and/or taxes
- ☐ Pregnancy allowance
- ☐ Restaurant allowance because I cannot prepare meals where I am living
- ☐ Burial allowance – you or your duly authorized representative must apply for this allowance at: 151 Lawrence Street, 5th Floor Brooklyn, NY 11201
- ☐ Additional allowance for fuel
- ☐ Additional allowance to maintain or restore utility service
- ☐ Property repairs
- ☐ Replacement of clothing lost as a result of a disaster such as homelessness or fire
- ☐ Other:

Expenses related to moving:

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

New Address: ______________________________
Address (include apt. no.)

______________ ______ ________
City State Zip Code

When did you move? ____________ New rent: $____________

Landlord's name: ______________________________

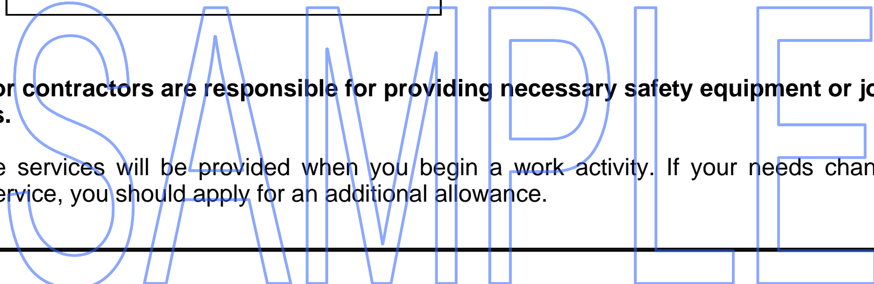
Primary tenant's name: ______________________________

Address: ______________________________
Address (include apt no.)

______________ ______ ________
City State Zip Code

SECTION III: WORK ACTIVITY – RELATED SUPPORTIVE SERVICES
I am requesting the following supportive services:

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



WEP agencies and/or contractors are responsible for providing necessary safety equipment or job-related clothing for their participants.

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

______________________________ ____________ ______________ ☐ AM ☐ PM
Participant's Signature Date of Request Time of Request

______________________________ ____________
Worker's Signature Date

Form W-137A (S) (page 1) (LDSS-3815) LLF
Rev. 11/18/08

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

Fecha: ______________________

Nombre del Caso: ______________________

Número del Caso: ______________________

Unidad de Casos: ______________________

Centro: ______________________

Núm. de Teléfono del Trabajador: ______________________

Núm. de Tel. del FH&C: ______________________

Petición para Asistencia de Emergencia o Asignación Adicional (Sólo para Participantes)

Favor de completar este formulario si necesita asistencia de emergencia o una asignación adicional.

Recuerde:

(1) Puede que se le pida prueba de los datos que nos proporcione. Si tiene problemas en obtener pruebas, su Trabajador tiene que ayudarle.

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

SAMPLE

SECCIÓN I: ASISTENCIA DE EMERGENCIA

El tipo de ASISTENCIA de EMERGENCIA que estoy solicitando es:

La razón por la cual necesito asistencia de emergencia es la siguiente:

SECCIÓN II: ASIGNACIONES ADICIONALES

Estoy solicitando la(s) siguiente(s) asignación(es) para necesidad(es) especial(es):

- ☐ Alquiler atrasado
- ☐ Reparación de artículos del hogar de primera necesidad
- ☐ Hipoteca y/o impuestos atrasados
- ☐ Asignación para embarazo
- ☐ Asignación para restaurante porque no puedo preparar comidas donde estoy viviendo
- ☐ Asignación para entierros – usted o su representante debidamente autorizado debe solicitar esta asignación en la siguiente dirección:
  151 Lawrence Street, 5to piso
  Brooklyn, NY 11201
- ☐ Asignación adicional para combustible
- ☐ Asignación adicional para mantener o restaurar servicios de electricidad y gas
- ☐ Reparaciones a la propiedad
- ☐ Reemplazo de ropa perdida a raíz de desastres tal como desamparo o incendio
- ☐ Otras asignaciones:

Gastos relacionados con la mudanza:

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

Nueva Dirección: ______________________________
(con núm. de apto.)

______________ ________ ____________
Ciudad Estado Código Postal

¿Cuándo se mudó? _________ Nuevo alquiler: $ _________

Nombre del casero: ______________________________

Nombre del inquilino principal: ______________________

Dirección: ______________________________
(con núm. de apto.)

______________ ________ ____________
Ciudad Estado Código Postal

SECCIÓN III: SERVICIOS DE APOYO RELACIONADOS CON ACTIVIDADES DE TRABAJO
Estoy solicitando los siguientes servicios de apoyo:

- ☐ Asignación de cuidado infantil dentro de los límites aprobados, de ser necesario
- ☐ Transporte público necesario
- ☐ Ropa para participantes que realicen actividades relacionadas a la búsqueda de trabajo, que se encuentren en situaciones **fuera de lo común**, tales como deshaucio o incendio reciente y no tener la vestimenta adecuada.
- ☐ Cuota de autorización, relacionada con actividad/participación, de uniformes o bienes duraderos dentro de los límites aprobados, a la hora de presentar la documentación que compruebe la necesidad de dichos artículos
- ☐ Otros servicios de apoyo relativos a actividades de trabajo:

SAMPLE

Las agencias de WEP y/o los contratistas tienen la responsabilidad de proporcionar a sus participantes la ropa o el equipo de seguridad necesarios para el trabajo.

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

______________________________ ______________ ______________ ☐ AM ☐ PM
Firma del Participante Fecha de la Petición Hora de la Petición

______________________________ ______________
Firma del Trabajador Fecha

Human Resources Administration
Department of Social Services
Family Independence Administration

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

Action Taken on Your Request for Emergency Assistance or Additional Allowance (For Participants Only)

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

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

On ______________________ (Date), you requested ☐ Emergency Assistance ☐ Additional Allowance for:

SAMPLE

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

☐ One payment in the amount of $ ______________ . Period covered, if applicable: ____________ .

Method of payment:

☐ Broker's or finder's fee/voucher
☐ Check to be picked up by you at your Job Center
☐ Check mailed to your home
☐ As an addition to your regular public grant, which can be obtained through the EBT system
☐ Security deposit agreement
☐ Direct vendor check

☐ Other action: ____

☐ You will receive a second notice informing you as to how your ongoing benefits will be affected.

☐ On ________________, you were referred to the Burial Claims Unit at 151 Lawrence Street, 5th Floor, Brooklyn, NY 11201, to apply for a burial allowance.

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

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

☐ Addition to Household § 352.30

☐ Additional Allowance for Fuel § 352.5

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

☐ Back Rent § 352.7(g)

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

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

☐ Furniture and Other Household Items § 352.7(a)

☐ Moving Expenses § 352.6(a)

☐ Payment to Maintain or Restore Utility Services § 352.5

☐ Pregnancy Allowance § 352.7(k)

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

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

☐ Repair of Essential Household Items § 352.7(b)

☐ Restaurant Allowance § 352.7(c)

☐ Semimonthly Fuel for Heating Allowance § 352.5(b)

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

☐ Work Activity Related Supportive Services § 385.4

☐ Other (specify): ________________________________

SAMPLE

________________________________ ________________
JOS/Worker's Signature Date

________________________________ ________________
Supervisor's Signature Date

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.**

Conference and Fair Hearing Information

CONFERENCE

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

STATE FAIR HEARING

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

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

(2) WRITE: Send a copy of the entire notice, with the "Fair Hearing Request" section completed, to:
Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201
(Please keep a copy for yourself.)

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

(4) IN PERSON: Bring a copy of the entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at either:
14 Boerum Place, Brooklyn or **330 West 34th Street, 3rd Floor, Manhattan**

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

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

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

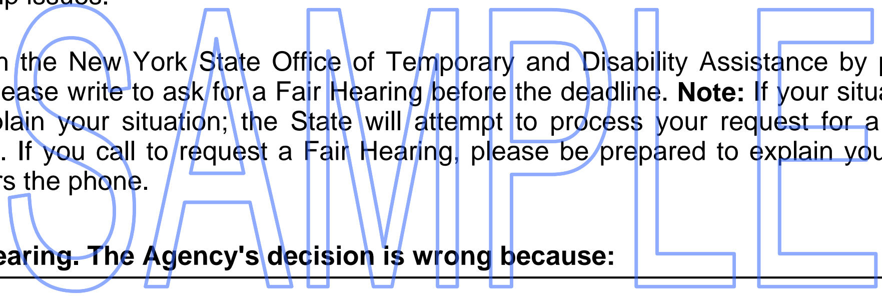
SAMPLE

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

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

FAIR HEARING REQUEST

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



If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, in person or online, please write to ask for a Fair Hearing before the deadline. **Note:** If your situation is extremely serious please explain your situation; the State will attempt to process your request for a Fair Hearing as quickly as possible. If you call to request a Fair Hearing, please be prepared to explain your situation to the person who answers the phone.

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

Print Name: ____________ ____ ____________
Name M.I. Last Name

Address: ______________________________

____

City: ____________ State: ______ Zip Code: ________

Signature: ______________________________ Date: ____________

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Fecha: ______________________

Númerodel Caso: ______________________

Nombre del Caso: ______________________

Centro: ______________________

Unidad de Casos: ______________________

Núm. de Teléfono
del Trabajador: ______________________

Núm. de Teléfono
de FH&C: ______________________

Medidas Tomadas con Respecto a su Petición de Asistencia de Emergencia o Una Asignación Adicional (Sólo para Participantes)

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

Este Aviso sólo trata de su petición de una asignación adicional para satisfacer una necesidad específica, un cambio en la concesión o una solicitud de asistencia de emergencia. Si su petición de asistencia adicional es rechazada, su caso actual de Asistencia en Efectivo no será afectado.

El ____________________ , usted solicitó ☐ Asistencia de Emergencia ☐ Asignación Adicional para:
(Fecha)

SAMPLE

☐ **Su solicitud de ____________________________ , ha sido aceptada. Usted recibirá:**

☐ Un pago por la cantidad de $ ___________. Período de cobertura, si corresponde: ____________________ .

Método de pago:

- ☐ Pago/comprobante de agente o intermediario
- ☐ Cheque que debe ser recogido por usted en su Centro de Trabajo
- ☐ Cheque enviado por correo a su hogar
- ☐ Un suplemento a su conncesión pública usual, que se puede obtener a través del sistema de EBT
- ☐ Acuerdo de depósito de garantía
- ☐ Cheque directo al contratista

☐ Otra medida: ____

☐ Usted recibirá un segundo aviso informándole de cómo serán afectados sus beneficios actuales.

☐ El ___________________, usted fue enviado a la Unidad de Reclamos de Sepultura (Burial Claims Unit) en el 151 Lawrence Street, 5to piso, Brooklyn, NY 1120,1 para solicitar una asignación de sepultura.

☐ **Su petición de ____ ha sido rechazada debido a que:**

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

☐ Asignación Adicional para Combustible § 352.5

☐ Agregar una Persona al Hogar § 352.30

☐ Pagos Atrasados de Hipoteca y/o Impuestos § 352.7(g)

☐ Alquiler Atrasado § 352.7(g)

☐ Pago/Comprobante de Agente o Intermediario de Bienes Raíces §352.6(a)

☐ Pérdida Catastrófica (reemplazo de ropa y muebles perdidos por un fuego, inundación u otro desastre) § 352.7(d)

☐ Muebles y Otros Artículos Domésticos § 352.7(a)

☐ Gastos de Mudanza § 352.6(a)

☐ Pagos para Mantener o Restaurar Servicios de Electricidad y Gas § 352.5

☐ Asignación para Embarazo §352.7(k)

☐ Reparaciones a la Propiedad § 352.4(d), § 352.6(e)

☐ Depósito de Garantía de Alquiler/Carta de Garantía § 352.6(a)

☐ Reparaciones de Artículos Domésticos Indispensables §352.7(b)

☐ Asignación para Restaurante § 352.7(c)

☐ Asignación Quincenal de Combustible para Calefacción § 352.5(b)

☐ Almacenamiento de Muebles y Pertenencias Personales § 352.6(f)

☐ Actividad de Trabajo Relacionada con Servicios de Apoyo § 385.4

☐ Otros (datos específicos): ____

_____________________________________ Firma del JOS/Trabajador

_____________________ Fecha

_____________________________________ Firma del Supervisor

_____________________ Fecha

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

SAMPLE

Información sobre Conferencias y Audiencias Imparciales

CONFERENCIA

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

AUDIENCIA IMPARCIAL ESTATAL

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

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

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

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

(4) EN PERSONA: Traiga una copia de todo el aviso, con la sección "Petición de Audiencia Imparcial" llenada, a la Oficina de Audiencias Administrativas, Oficina de Asistencia Temporaria y para Incapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a cualquiera de las siguientes direcciones:
14 Boerum Place, Brooklyn o **330 West 34th Street, 3rd floor, Manhattan**

SAMPLE

(5) POR INTERNET: Complete una solicitud de formulario electrónico conectándose a:
http://www.otda.state.ny.us/oah/forms.asp

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

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, podría obtener tal asistencia comunicándose con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede localizar la Sociedad de Ayuda Legal o grupo de abogacía más cercano buscando en las Páginas Amarillas (Yellow Pages) bajo "lawyers" (abogados).

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un facsímil, le proporcionaremos copias gratuitas de los documentos que se encuentran en su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por facsímil, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para pedir documentos o para averiguar como revisar su archivo, llámenos al **(718) 722-5012**, por facsímil 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 pedirlas con anticipación. Éstas se le enviarán dentro de un plazo adecuado antes de la fecha de la audiencia. Los documentos serán enviados por correo sólo si lo solicita específicamente.

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

PETICIÓN DE AUDIENCIA IMPARCIAL

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

Si no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporaria y para Incapacitados (New York State Office of Temporary and Disability Assistance) por teléfono, por fax, en persona o por Internet, favor de enviar por escrito su solicitud de Audiencia Imparcial antes de la fecha límite. **Nota:** Si su circunstancia es sumamente urgente, favor de explicarlo en detalle; el Estado hará todo esfuerzo de procesar su solicitud para una Audiencia Imparcial lo más pronto posible. Si usted llama para solicitar una Audiencia Imparcial, por favor esté preparado para explicar su situación a la persona que conteste el teléfono.

SAMPLE

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

Nombre en Letras de Molde: ____________ ______ ________________ Núm. del Caso: __________

Nombre I. Apellido

Dirección: ______________________________

______________________________ Teléfono: __________

Ciudad: __________ Estado: ____ Código Postal: ______

Firma: ______________________________ Fecha: __________

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Date: ____________________

Case Number: ____________________

Case Name: ____________________

Caseload: ____________________

Worker Name: ____________________

Worker Phone: ____________________

FH&C Phone: ____________________

Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only)

The Agency's decision(s) regarding your application(s) is/are explained below next to the marked box(es) ☒.

Immediate Needs

This notice applies only to your request for assistance to meet an immediate need. If you have also applied for ongoing Cash Assistance, this notice does not affect application for ongoing Cash Assistance. You will also receive a notice advising you of this Agency's decision on your application for ongoing Cash Assistance when your eligibility has been determined.

If your application for ongoing Cash Assistance is denied for failure to comply with eligibility requirements, a second request for an immediate need/emergency grant for "no food" or items relating to health and safety, filed within three months of the original application denial, may also be denied unless you can document good cause for your original failure to comply.

On ____________________, you requested assistance to meet an immediate need of:

We are giving you this notice to tell you that your request for an immediate need grant was evaluated and the following decision was made:

☐ An emergency preinvestigation grant in the amount of $ ________ will be available to you on __________.
(Date)

☐ An emergency grant has been provided in the amount of $ __________ for ______________________.

☐ If this box is checked, you are responsible for repaying $ __________ as shown:

- ☐ This amount must be repaid to us in accordance with the agreement to repay which you signed on __________.
(Date)

- ☐ You must repay the amount shown above because the Human Resources Administration (HRA) shelter maximum of $__________ for your family size of _____ for each month of arrears that HRA agreed to pay.

SAMPLE

Immediate Needs (Continued)

☐ Assistance to meet an immediate need is denied because:

☐ when you applied for Cash Assistance on ________________ (within the last three months), you were issued:
(Date)

☐ an immediate need grant(s)

☐ a health and safety kit(s)

☐ Other: ________________

and subsequently, failed to comply with the eligibility requirements without good cause. The laws and regulations which allow us to do this are 18 NYCRR § 351.1, § 351.8, and § 352.7.

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

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

☐ Back Rent § 352.7(g)

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

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

☐ Furniture and Other Household Items § 352.7(a)

☐ Moving Expenses § 352.6(a)

☐ Payment to Maintain or Restore Utility Services § 352.5

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

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

☐ Repair of Essential Household Items § 352.7(b)

☐ Storage of Furniture and Personal Belongings § 352.7(b)

☐ Other (specify): ________________

☐ Other: ________________

SAMPLE

Medical Assistance

☐ If you need help with your medical bills, you must apply separately for Medical Assistance. If you want more information about eligibility for Medical Assistance, call the Worker's telephone number listed on **page 1**.

☐ Your Medical Assistance stays the same.

☐ Your application for Medical Assistance is being reviewed. We will send your decision within 30 days.

______________________________ ______________
Authorized by Date

SAMPLE

YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.

Conference and Fair Hearing Information

CONFERENCE

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

STATE FAIR HEARING

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

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

(2) WRITE: Send a copy of the entire notice, with the "Fair Hearing Request" section completed, to:
Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201
(Please keep a copy for yourself.)

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

(4) IN PERSON: Bring a copy of the entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at either:
14 Boerum Place, Brooklyn or **330 West 34th Street, 3rd Floor, Manhattan**

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

SAMPLE

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

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

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

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

FAIR HEARING REQUEST

Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within sixty (60) days from the date of the notice for Cash Assistance and/or medical issues.

Note: If your situation is extremely serious please explain your situation: the State will attempt to process your request for a Fair Hearing as quickly as possible. If you call to request a Fair Hearing, please be prepared to explain your situation to the person who answers the phone.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, in person or online, please write to ask for a Fair Hearing before the deadline.

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

Print Name: ______________________ ______________________ Case Number: ______________

Name M.I. Last Name

Address: ____

____ Telephone: ______________

City: ______________ State: ________ Zip Code: ______________

SAMPLE

Signature: ____ Date: ______________

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

Fecha: ____________________

Número del Caso: ____________________

Nombre del Caso: ____________________

Unidad de Casos: ____________________

Nombre del Trabajador: ____________________

Tel. del Trabajador: ____________________

Teléfono de FH&C: ____________________

Aviso de Decisión sobre la Asistencia para Cubrir una Necesidad Inmediata o Asignación Especial (Sólo para Solicitantes)

La(s) decisión(es) de la Agencia respecto a su(s) solicitud(es) se explica(n) más abajo junto a la(s) casilla(s) marcada(s) ☒.

Necesidades Inmediatas

Este aviso corresponde solamente a su solicitud de asistencia para cubrir una necesidad inmediata. Si usted también ha solicitado Asistencia en Efectivo continua, este aviso no afecta su solicitud de dicha asistencia. Usted también recibirá un aviso notificándole de la decisión de esta Agencia sobre su solicitud de Asistencia en Efectivo continua cuando se haya determinado su elegibilidad.

Si su solicitud de Asistencia en Efectivo actual es rechazada debido a incumplimiento de requisitos de elegibilidad, puede que también se rechace una segunda solicitud de concesión de emergencia/necesidad inmediata para artículos "no alimentarios" relacionados con la salud y la seguridad, si la misma es presentada menos de tres meses después de haber sido rechazada la primera solicitud, al menos que usted muestre pruebas válidas que justifiquen su incumplimiento respecto a los requisitos de la primera solicitud.

SAMPLE

El ____________________ , usted solicitó asistencia para cubrir una necesidad inmediata de:

Por medio del presente aviso le informamos de que hemos evaluado su solicitud respecto a una concesión para cubrir necesidades inmediatas. La decisión aparece a continuación:

☐ Una concesión de emergencia preinvestigación por la cantidad de $ __________ estará a su disposición en
________.
(Fecha)

☐ Se le ha otorgado una concesión de emergencia por la cantidad de $ __________ para ____________________.

☐ Si se marca esta casilla, usted es responsable por el reembolso de $ __________ como se indica:

- ☐ Esta cantidad se nos tiene que pagar conforme al acuerdo de reembolso que usted firmó el ______________.
(Fecha)
- ☐ Usted tiene que reembolsar la cantidad indicada más arriba porque el máximo de albergue de la Administración de Recursos Humanos (Human Resources Administration – HRA) de $______________ para su familia con __________ personas para cada mes de atraso que HRA acordó pagar.

Necesidades Inmediatas (Continuación)

☐ Asistencia para cubrir una necesidad inmediata se le ha rechazado debido a que:

☐ cuando solicitó Asistencia en Efectivo el _______________ (dentro de los últimos tres meses), usted recibió:
(Fecha)

☐ una concesión(es) para necesidades inmediatas

☐ un botiquín(es) de salud y seguridad

☐ Otro:

y posteriormente, no cumplió con los requisitos de elegibilidad sin motivo justificado. Las leyes y reglamentos que nos permiten hacer esto son 18 NYCRR § 351.1, § 351.8, y § 352.7.

La(s) ley(es) y/o regulación(es) que nos permite(n) obrar de tal forma es(son) 18 NYCRR (favor de ver los números de las secciones más abajo):

☐ Pagos Atrasados de Hipoteca y/o Impuestos § 352.7(g)

☐ Alquiler Atrasado § 352.7(g)

☐ Pago/Comprobante de Agente o Intermediario de Bienes Raíces §352.6(a)

☐ Pérdida Catastrófica (reemplazo de ropa y muebles perdidos por un fuego, inundación u otro desastre) § 352.7(d)

☐ Muebles y Otros Artículos Domésticos § 352.7(a)

☐ Gastos de Mudanza § 352.6(a)

☐ Pagos para Mantener o Restaurar Servicios de Electricidad y Gas § 352.5

☐ Reparaciones a la Propiedad § 352.4(d), § 352.6(e)

☐ Depósito de Garantía de Alquiler/Carta de Garantía § 352.6(a)

☐ Reparaciones de Artículos Domésticos Indispensables §352.7(b)

☐ Almacenamiento de Muebles y Pertenencias Personales § 352.6(f)

☐ Other (specify): ______________________________

☐ Otro:

SAMPLE

Asistencia Médica

☐ Si usted necesita ayuda para pagar sus facturas médicas, tiene que solicitar Asistencia Médica por separado. Si desea más información sobre elegibilidad para Asistencia Médica, llame al número de teléfono de su Trabajador en la **página 1**.

☐ Su Asistencia Médica permanecerá sin cambios.

☐ Se está evaluando su solicitud de Asistencia Médica. Le enviaremos su decisión dentro de 30 días.

______________________________ ______________

Autorizado por Fecha

SAMPLE

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

Información sobre Conferencias y Audiencias Imparciales

CONFERENCIA

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

AUDIENCIA IMPARCIAL ESTATAL

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

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

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

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

(4) EN PERSONA: Traiga una copia de todo el aviso, con la sección "Petición de Audiencia Imparcial" llenada, a la Oficina de Audiencias Administrativas, Oficina de Asistencia Temporaria y para Incapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a cualquiera de las siguientes direcciones:
14 Boerum Place, Brooklyn o **330 West 34th Street, 3rd floor, Manhattan**

(5) POR INTERNET: Complete una solicitud de formulario electrónico conectándose a:
http://www.otda.state.ny.us/oah/forms.asp

SAMPLE

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

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, podría obtener tal asistencia comunicándose con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede localizar la Sociedad de Ayuda Legal o grupo de abogacía más cercano buscando en las Páginas Amarillas (Yellow Pages) bajo "lawyers" (abogados).

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un facsímil, le proporcionaremos copias gratuitas de los documentos que se encuentran en su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por facsímil, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para pedir documentos o para averiguar como revisar su archivo, llámenos al **(718) 722-5012**, por facsímil 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 pedirlas con anticipación. Éstas se le enviarán dentro de un plazo adecuado antes de la fecha de la audiencia. Los documentos serán enviados por correo sólo si lo solicita específicamente.

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

PETICIÓN DE AUDIENCIA IMPARCIAL

Fecha Límite: Si usted desea que el Estado revise nuestra decisión, tiene que solicitar una Audiencia Imparcial dentro de sesenta (60) días a partir de la fecha de este aviso para asuntos de Asistencia en Efectivo y/o asistencia médica.

Nota: Si su situación resulta extremadamente grave favor de explicarla, el Estado intentara procesar su solicitud para una Audiencia Imparcial lo más pronto posible. Si nos llama para pedir una Audiencia Imparcial, favor de estar listo para explicar su situación a la persona que conteste el teléfono.

Si no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporaria y para Incapacitados (New York State Office of Temporary and Disability Assistance) por teléfono, por fax, en persona o por Internet, favor de enviar por escrito su solicitud de Audiencia Imparcial antes de la fecha límite.

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

SAMPLE

Nombre en Letras de Molde: ______________ ______ ______________________ Núm. del Caso: ____________

Nombre I. Apellido

Dirección: ____

____ Teléfono: ______________

Ciudad: ______________ Estado: ______ Código Postal: __________

Firma: ____ Fecha: ______________

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

Determination of Eligibility for Emergency Assistance to Needy Families (EAF)

Case Name:	Case Composition:
Case Number/Suffix:	
Caseload:	
Center:	
Type of Emergency:	
Cause of Emergency:	

As set forth in 18 NYCRR § 372.1 and 97 ADM-20, EAF may be authorized more than once in any 12 consecutive months as long as the eligibility criteria are met.

I. This Crisis Situation is Due to the Following Circumstance(s):

- ☐ Fire or other disaster
- ☐ Asked to leave shared apartment by relative or friend who is primary tenant
- ☐ Emergency medical expenses required all available recourses to be diverted from rent
- ☐ Sudden loss of employment due to layoff or other reason not brought about by voluntary quit
- ☐ Landlord refused late or partial rent payment
- ☐ Utility shutoff/termination
- ☐ Eviction by landlord for reasons other than nonpayment of rent (specify): ____________________
- ☐ Eviction by landlord due to nonpayment of rent as part of a complex set of problems, which constitutes an emergency for the family
- ☐ Victim of domestic violence (adult and or child)
- ☐ Other (specify): ____________________

SAMPLE

II. EAF Eligibility Determination Checklist:

In order to determine participant's eligibility for EAF, respond to each of the following items:

1. Is there at least one child under the age of 18, or age 18 and attending full-time secondary school, who is currently residing with an adult caretaker who is related by blood, marriage or adoption?* ☐ Yes ☐ No

* The term "caretaker who is related by blood, marriage or adoption" shall include the following:

(1) the child's father, mother, brother, sister, grandfather, great-grandfather, great-great-grandfather, grandmother, great-grandmother, great-great-grandmother, uncle, great-uncle, great-great-uncle, aunt, great-aunt, great-great aunt, of whole or half blood;

(2) the child's first cousin, nephew and niece, of whole or half blood;

(3) the child's stepfather, stepmother, stepbrother, stepsister, but no other step relative;

(4) in the case of a child who has been surrendered to an authorized agency or who has been adopted:

(i) any of the blood or step relatives included in the preceding paragraphs of this subdivision; and

(ii) the child's adoptive parents and:

(a) the other children of the adoptive parents and the children of such children;

(b) the parents, grandparents and great-grandparents of the adoptive parents;

(c) the brothers and sisters of the adoptive parents and the children of such brothers and sisters; and

(d) the aunts, uncles, great-aunts and great uncles of the adoptive parents.

(5) the spouse of any person described in the preceding paragraphs, even though the marriage may have been terminated by death, divorce or annulment; and

(6) in the case of a child born out of wedlock, any relative in the maternal line included in the preceding paragraphs of this subdivision and, if paternity has be adjudicated or acknowledged in writing, any relative in the maternal and paternal lines included in the preceding paragraphs.

2. Is there a woman of any age with a medically verified pregnancy? ☐ Yes ☐ No
If you checked "Yes" to either question 1 or 2 above, proceed. If not, the case is ineligible for EAF.

3. Does the family have resources to meet their needs or available income at or above 200% of the most recently published Federal poverty guidelines, as transmitted by the State Office of Temporary and Disability Assistance, on the date of application for the family size? (See **EXP-76D**) ☐ Yes ☐ No

4. Did the emergency arise because an employable child or relative refused without good cause to accept employment or participate in work activities or community services? ☐ Yes ☐ No

5. Will the emergency grant being applied for duplicate or replace a Cash Assistance grant already made under **18 NYCRR § 352.2(a)(b)(c)? (See **W-203K**) ☐ Yes ☐ No
(Do not answer "Yes" if the duplication will replace lost or stolen Cash Assistance.)

** Each social services district shall utilize the applicable schedules of monthly grants and allowances as found in subdivision (d) of Section 352.2 to provide for all items of need, exclusive of:

(1) shelter;
(2) fuel for heating;
(3) additional cost of meals for persons who are unable to prepare meals at home;
(4) purchase of necessary and essential furniture required for the establishment of a home;
(5) replacement of necessary and essential furniture for persons in need of Cash Assistance who have suffered the loss of such items as the result of fire, flood or other like catastrophe;
(6) essential repairs of heating equipment, cooking stoves and refrigerators;
(7) allowances for occupational training.

SAMPLE

If you checked "No" to questions 3,4, and 5, proceed.
If you checked "Yes" to any of questions 3,4, and 5, the applicant is ineligible for EAF.

6. Is the necessary payment a diversion payment or a utility emergency payment? ☐ Yes ☐ No
If you checked "Yes" to Number 6, **Stop** – EAF eligible.
If you checked "No" to Number 6, go to Number 7.

7. Is the emergency the result of a sudden occurrence or situation, unforeseen and beyond the individual's control? ☐ Yes ☐ No
If you checked "Yes" to Number 7, **Stop** – EAF eligible.
If you checked "No" to Number 7, ineligible for EAF.

III. Is This Case Eligible for EAF? ☐ Yes ☐ No

In accordance with 18 NYCRR § 372.4(d), services which can be determined as necessary to cope with the emergency situation include counseling, securing family shelter, if available, and any other services which meet needs attributable to the emergency situation.

JOS/Worker Signature	Date
Supervisor Signature	Date

IMPORTANT: If you have determined that this case is eligible for EAF, HAVE YOU:

- Completed all questions on this form?
- Signed and dated this form, and obtained your Supervisor's signature?
- Entered an "F" in 270 of POS TAD?

All POS case entries must be descriptive and indicate the nature of the emergency. Please ensure that all related materials are scanned and available on the HRA OneViewer. Complete the POS TAD and annotate EAF indicator.

(File copy in case record)

For CIS/OCP Use Only
EAF Indicator Data Entry

Case Name: ______________________

Case Number: 0 0 _ _ _ _ _ _ _ _ Suffix: _ _ _ _

Center: 0 _ _

Item 270: F

SAMPLE

OCP Control Clerk	Date	Control Clerk	Date
OCP CRT Operator	Date	Error	
		Resubmit Date	
		Control Clerk	Date

Human Resources Administration Department of Social Services | Family Independence Administration

Determinación de Elegibilidad para Asistencia de Emergencia a Familias Necesitadas (EAF)

Nombre del Caso:	Composición del Caso:
Número del Caso/Sufijo:	
Unidad de Casos:	
Centro:	
Tipo de Emergencia:	
Causa de la Emergencia:	

Como se estipula en 18 NYCRR § 372.1 y 97 ADM-20, EAF se puede autorizar más de una vez en cualesquier 12 meses consecutivos siempre se cumplan los criterios de elegibildad.

I. Esta Situación Crítica se Deba a la(s) Siguiente(s) Circunstancia(s):

- ☐ Incendio u otro desastre
- ☐ Pariente o amigo inquilino principal le pidió que se vaya de apartamento compartido
- ☐ Debido a gastos de emergencia médica todos los recursos disponibles se retiraron del alquiler
- ☐ Pérdida súbita de empleo debido a despido involuntario u otra razón no ocasionada por renuncia voluntaria
- ☐ El casero rehusó pago de alquiler atrasado o parcial
- ☐ Desconexión/terminación de servicio de electricidad y/o gas
- ☐ Deshaucio por casero por razones aparte de impago de alquiler (especifique): ____________________
- ☐ Deshaucio por casero debido a impago de alquiler como parte de una serie de problemas complejos, que constituyen una emergencia para la familia
- ☐ Victíma de violencia doméstica (adulto y/o niños)
- ☐ Otra circunstancia (especifique): ____________________

SAMPLE

II. Lista de Control de Determinación de Elegibilidad para EAF:

A fin de determinar la elegibilidad del participante para EAF, conteste cada uno de los siguientes puntos:

1. Hay por lo menos un niño de 18 años de edad o menor que asista a la segundaria a tiempo completo, y que resida actualmente con un adulto que brinde cuidado y tenga lazos de sangre, matrimonio o adopción?* ☐ Sí ☐ No

* El término "que brinde cuidado y que tenga lazos de sangre, matrimonio o adopción" incluye lo siguiente:

(1) el padre del niño(a), la madre, el hermano(a), abuelo(a), bisabuelo(a), tatarabuelo(a), tío, tío(a) abuelo(a), tío(a) bisabuelo(a), medios o completos;

(2) el primo hermano(a) del niño, sobrino(a), medios o completos;

(3) el padrastro del niño, madrastra, hermanastro(a), pero ningún otro medio pariente;

(4) en el caso que un niño(a) ha sido entregado a una agencia autorizada o que ha sido adoptado:

(i) cualquier pariente o medio pariente incluido en los párrafos anteriores de esta subdivisión; y
(ii) los padres adoptivos y:

(a) los otros hijos de los padres adoptivos y los hijos de dichos hijos;

(b) los padres, abuelos y bsiabuelos de los padres adoptivos;

(c) los hermanos(as) de los padres adoptivos y los hijos de dichos hermanos(as); y

(d) los tíos(as), tío abuelos(as) y tío abuelos(as) de los padres adoptivos;

(5) el cónyuge de cualquier persona indicada en los párrafos anteriores, a pesar de que el matrimonio se haya terminado debido a la muerte, el divorcio, o anulación; y

(6) en el caso de un niño nacido fuera del matrimonio, cualquier pariente materno incluido en los párrafos anteriores de esta subdivisión y, en caso de que la paternidad haya sido adjudicada o reconocida por escrito, cualquier pariente materno y paterno incluido en los párrafos anteriores.

2. ¿Hay alguna mujer embarazada de cualquier edad con comprobante médico? ☐ Sí ☐ No
Si marcó "Sí" a la pregunta 1 o 2 más arriba, continúe. De no ser así, el caso es inelegible para EAF.

3. ¿Tiene la familia recursos para cubrir sus necesidades o ingreso disponible al 200% o más de las pautas Federales de pobreza más recientemente publicadas, como se transmitió por la Oficina del Estado de Asistencia Temporal y Asistencia para Incapacitados (State Office of Temporary and Disability Assistance), en la fecha de la solicitud para el tamaño de la familia? (Vea **EXP-76D**) ☐ Sí ☐ No

4. ¿Ocurrió la emergenica a raíz de que un niño(a) o pariente empleable rehusara sin causa justificada aceptar empleo o participar en actividades de trabajo o servicios comunitarios? ☐ Sí ☐ No

5. ¿Repitirá o reemplazará la concesión de emergencia solicitada una concesión de Asistencia en Efectivo ya otoragada conforme a **18 NYCRR § 352.2(a)(b)(c)? (Vea **W-203K**) ☐ Sí ☐ No

(No conteste "Sí" si la repetición reeplazará Asistencia en Efectivo perdida o robada.)
** Cada distrito de servicios sociales usará los calendarios de concesiones y asignaciones mensuales que correspondan conforme a la subdivisión (d) de la Sección 352.2 para cubrir todas las necesidades, sin incluir:

(i) el albergue;
(ii) el combustible para calefacción;
(iii) el costo adicional de comidas para las personas que no puedan preparar comidas en le hogar;
(iv) la compra de muebles esenciales para establecer un hogar;
(v) el reemplazo de muebles esenciales para las personas que necesiten Asistencia en Efectivo que han sufrido la pérdida de tales artículos a raíz de un incendio, inundación u otra catástrofe similar;
(vi) los arreglos esenciales del equipo de calefacción, hornos y neveras;
(vii) las asignaciones para capacitación vocacional.

Si marcó "No" a las preguntas 3,4, y 5, continúe.
Si marcó "Sí" a cualquier de las preguntas 3, 4, y 5, el solicitante es inelegible para EAF.

6. ¿Es le pago necesario un pago de reasignación o un pago de emergencia para servicios de electricidad y/o gas o servicios? ☐ Sí ☐ No

Si marcó "Sí" al Número 6, **Pare** – es elegible para EAF.
Si marcó "No" al Número 6, continúe al Número 7.

7. ¿Es la emergencia el resultado de un suceso súbito, una situación imprevista y agena a la voluntad de la persona? ☐ Sí ☐ No

Si marcó "Sí" al Número 7, **Pare** – es elegible paraEAF.
Si marcó "No" al Número 7, es inelegible para EAF.

III. ¿Es el Caso Elegible para EAF? ☐ Sí ☐ No

Conforme a 18 NYCRR § 372.4(d), entre los servicios que se pueden determinar necesarios para lidiar con una emergencia se incluyen, la obtención de albergue familiar, si disponible, y cualesquier otros servicios que satisfagan las necesidades ocasionadas por la emergencia.

Firma del JOS/Trabajador	Fecha
Firma del Supervisor	Fecha

SAMPLE

IMPORTANTE: Si usted ha determinado que este caso es elegible para EAF, ¿HA:

- Llenado todas las preguntas de este formulario?
- Firmado y fechado este formulario, y obtenido la firma de su Supervisor?
- Anotado "F" en 270 de POS TAD?

Todas las anotaciones de casos de POS tienen que ser detalladas e indicar la naturaleza de la emergencia. Favor de asegurarse de que todos los materiales relacionados se escaneén y estén disponibles en el visionador (OneViewer)de HRA. Llene el POS TAD y incluya notas al indicador de EAF.

(Archive copia con el expediente del caso)

For CIS/OCP Use Only
EAF Indicator Data Entry

Case Name: ____________________

Case Number: | 0 | 0 | | | | | | | | | Suffix: | | | | |

Center: | 0 | | |

Item 270: | F |

SAMPLE

OCP Control Clerk	Date	Control Clerk	Date
OCP CRT Operator	Date	Error	
		Resubmit Date	
		Control Clerk	Date

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

Date: ____________________

Case Name: ____________________

Category: ____________________

Utility Arrears Repayment Agreement

(Eligibility Worksheet and Agreement)

SAMPLE

I. Applicant's Information

A. Applicant's Name: ____________________

Address: ____________________

____

City: ____________________ State: __________ Zip: __________

Case Number: ____________________ Utility arrears owed: $__________

Category: ☐ ESN ☐ EAF

B. Is applicant the customer of record? ☐ Yes. Proceed. ☐ No. The customer of record must come in to apply.

C. Household size (Include all persons residing in the applicant's house or apartment and their Social Security numbers):

(1) Name	(2) Relationship	(3) Social Security Number	(4) Type/Verification	(5) Semimonthly Gross
			Total	**$**

D. Is the customer of record in receipt of CA or SSI (or additional State payments) on the date of application?

☐ Yes, Repayment Agreement **not** required (regardless of category of assistance under which the arrears are paid).

☐ No, proceed to E.

E. Household's gross monthly income on the date of application is $__________________.
(Include all earned and unearned income for all persons residing in the house or apartment)

For employed persons, include the name, address and telephone number of the employer(s) beside the person's name.

Employer's Name: ____________________________________ Telephone: ________________________

Address: ____

____________________ _______ ______________
City State Zip Code

F. Semimonthly Cash Assistance needs for household size
(Include all persons residing in applicant's house or apartment)**:**

1. Basic Allowance (Schedule SA-2a) $________________
2. Home Energy Allowance (Schedule SA-2b) $________________
3. Supplemental Home Energy Allowance (Schedule SA-2c) $________________
4. Shelter Allowance as paid, not to exceed maximum amount in Department regulation 352.3(a) $________________
5. Heating Allowance if the applicant is the tenant and customer of record for the residential heating bill (Schedules SA-6a, SA-6b or SA-6c) $________________
6. If applicable, the additional cost of meals for persons unable to prepare meals at home (Schedule SA-5) $________________

Total of Semimonthly Need $________________ X 2 = $________________
Total Monthly Need

SAMPLE

G. Is "E" (gross monthly income) greater than "F" (Temporary Assistance) monthly standard of need?

☐ Yes, Repayment Agreement is required, **proceed to Part II.**   ☐ No, Repayment Agreement is **not** required.

II. Repayment Agreement

I understand that as a condition of eligibility for receiving utility arrears assistance, I agree to repay the Human Resources Administration the following amount: $ ____________________ utility arrears assistance to restore service or to prevent termination.

I agree to repay this amount within twelve (12) months. I will repay the assistance, in full, in installments of

$____________________ per ____________________(month, bi-weekly, etc.).

Each installment must be received by the Human Resources Administration on or before the_________________ of each __________________. The first installment is due on or before ________________ (enter date).

The payments must be sent to: Human Resources Administration
Division of Accounts Receivable and Billing
180 Water Street
9th Floor
New York, New York 10038

I understand that I will not be eligible for subsequent utility arrears assistance to restore service or prevent termination unless I have fully repaid any prior utility arrears payments that were subject to repayment; or I am repaying this assistance in accordance with the terms of any Repayment Agreement(s); or my household's income is below the temporary assistance standard of need for my household size as of the date of application for such subsequent assistance. I also understand that if I fail to repay this assistance within the twelve (12) month period, the Human Resources Administration will enforce this Repayment Agreement by any method available to a creditor. This includes, but is not limited to, referring the matter to a collection agency, obtaining a judgment from a court, obtaining a lien on real property or garnishing wages in appropriate cases.

I understand that the Human Resources Administration also has the right to require that I sign a lien on my real property for receiving a utility arrears payment authorized under emergency Safety Net Assistance or Emergency Assistance to Families. If a lien is taken, that portion which represents this arrears payment will be reduced by payments made under this agreement.

If I later become eligible for recurring temporary assistance, any unpaid balance of this arrears payment will be suspended until I am no longer receiving recurring temporary assistance. At that time, the unpaid balance will become due to the Human Resources Administration under the terms of this agreement.

I understand that by signing this form, I agree to all of the above conditions.

SAMPLE

Signature of Applicant ______________________ Date ________

Signature of Applicant ______________________ Date ________

Signature of Spouse ______________________ Date ________

Representative Signature ______________________ Date ________

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

Fecha: ______________________

Nombre del Caso: ______________________

Categoria: ______________________

Acuerdo de Reembolso de Pagos Atrasados de Gas, Electricidad o Combustible

(Hoja de Cálculos de Elegibilidad y Acuerdo)

I. Datos Personales del Solicitante

A. Nombre del Solicitante: ______________________

Dirección: ______________________

____

Ciudad: ______________ Estado: ________ Código Postal: ______________

Número del Caso: ______________ Cantidad de pagos atrasados debidos a la compañía de electricidad, gas o combustible $______________

Categoría: ☐ ESN ☐ EAF

SAMPLE

B. ¿ES el solicitante el cliente que tenemos en nuestros archivos? ☐ Sí. Continúe ☐ No. El cliente en nuestros archivos tiene que acudir en persona para poder presentar solicitud.

C. Tamaño del Hogar (Incluya a todas las personas que residen en la casa o apartamento del solicitante y su (s) número(s) de Seguro Social).

(1) Nombre	(2) Relación	(3) Número de Seguro Social	(4) Tipo/Verificación	(5) Bruto Quincenal
			Total	$

D. ¿Recibe el cliente que aparece en nuestros archivos Asistencia en Efectivo y/o SSI (u otros pagos adicionales del estado) en la fecha de solicitud?

☐ Sí, el Acuerdo de Reembolso **no** es mandatorio (sin importar la categoría de asistencia según la cual se paga el reembolso).

☐ No, continúe a la parte E

E. El ingreso bruto mensual del hogar en la fecha de la solicitud es $ ____________________. (Incluya todo ingreso salarial e ingreso no salarial para todas las personas que residen en el hogar o apartamento)

Para las personas empleadas, favor incuya el nombre, la dirección y número de teléfono del empleador junto al nombre de la persona.

Nombre del Empleador: ______________________________________ Teléfono: ___________________

Dirección: ____

Ciudad: ___________________________________ Estado ______ Código Postal: __________________

F. Nivel de Necesidad de Asistencia en Efectivo para el tamaño del hogar $____________________ (incluya a todas las personas que viven en la casa o apartamento del solicitante):

1. Asignación Básica (Schedule SA-2a) $______________________
2. Asignación de Energía para el Hogar (Schedule SA-2b) $______________________
3. Asignación Suplemental de Energía para el Hogar (Schedule SA-2c) $______________________
4. Asignación actual de Alquiler pagado (a no exceder de la máxima cantidad en el Reglamento del Departamento 352.3(a). $______________________
5. Asignación de Calefacción si el solicitante es el inquilino y el cliente del expediente para la factura de calefacción del hogar (Schedules SA-6a, SA-6b or SA- 6c). $______________________
6. Si corresponde, la cantidad adicional de comidas para personas que no pueden preparar comidas en casa (Schedule SA-5) $______________________

Total de la necesidad quincenal $__________________ X 2 = $____________________
Necesidad Mensual Total

SAMPLE

G. ¿Es "E" (ingreso bruto mensual) superior al Nivel mensual de necesidad de "F" (Asistencia Temporal)?

☐ Sí. Se requiere el Acuerdo de Reembolso, **continúe en la página II.**

☐ No, **no** se requiere el Acuerdo de Reembolso.

II. Acuerdo de Reembolso

Entiendo que como condición de elegibilidad para recibir asistencia de pagos atrasados de electricidad, gas o combustible, yo acepto pagar a la Administración de Recursos Humanos la siguiente cantidad de: $_______________ para restaurar servicio o para prevenir la terminación.

Acepto pagar esta cantidad dentro de doce (12) meses. Reembolsaré la asistencia, por completo, a plazos mensuales de $ _______________ al ______________________________ (mes, quincena, etc.)

Cada pago debe ser recibido por la Administración de Recursos Humanos antes del ______________________________ de cada ______________________________. El primer pago ha de pagarse antes del ______________________________
(Fecha)

Los pagos deben enviarse a: Human Resources Administration
Division of Accounts Receivable and Billing
180 Water Street, 9th Floor
New York, New York 10038

Entiendo que no seré elegible para asistencia adicional de atrasos de electricidad, gas o combustible para restablecer o evitar la terminación, a menos que yo haya reembolsado por completo cualquier pago de atraso anterior que debía reembolsarse; o estoy reembolsando esta asistencia conforme a las condiciones de cualquier Acuerdo(s) de Reembolso; o el ingreso de mi hogar es inferior a la norma de asistencia temporal de necesidad para el tamaño de mi hogar a partir de la fecha de solicitud de dicha asistencia adicional. Entiendo además que si no reembolso como debido esta asistencia dentro del plazo de doce (12) meses, la Administración de Recursos Humanos hará valer este Acuerdo de Reembolso por cualquier método del cual disponga el acreedor. Esto incluye, pero no se limita a, la remisión del asunto a una agencia de cobro, la obtención de una orden judicial, la obtención de una retención de la propiedad inmueble o el embargo del sueldo, de ser apropiado.

Entiendo que la Administración de Recursos Humanos tiene además el derecho de estipular que yo firme una retención de mi propiedad inmueble para recibir un pago de atrasos de electricidad, gas o combustible tal como lo dispone la Asistencia de Red de Seguridad (Safety Net Assistance) o la Asistencia de Emergencia a las Familias (Emergency Assistance to Families). Si se efectúa la retención, la porción que representa este pago de atrasos se reducirá por pagos hechos conforme a este acuerdo.

Si luego soy elegible para Asistencia en Efectivo recurrente, cualquier saldo no pagado de estos atrasos será suspendido hasta que yo no esté recibiendo asistencia temporal recurrente. Entonces, deberé el saldo no pagado al/a la Administración de Recursos Humanos conforme a las condiciones de este acuerdo.

Entiendo que al firmar este formulario accedo a todas las condiciones antemencionadas.

SAMPLE

Firma del Solicitante ______________________ Fecha ______________

Firma del Solicitante ______________________ Fecha ______________

Firma del Cónyuge ______________________ Fecha ______________

Firma del Representante ______________________ Fecha ______________