Human Resources Administration
Department of Social Services

FAMILY INDEPENDENCE ADMINISTRATION

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POLICY DIRECTIVE #09-30-OPE

(This Policy Directive Replaces PD #09-27-OPE)

CASH ASSISTANCE PROGRAM ELIGIBILITY MAILER

Date: August 18, 2009	**Subtopic(s):** CA/FS Eligibility

AUDIENCE

The instructions in this policy directive are for Job Center staff and Income Clearance Program (ICP) staff. For all other staff, this policy directive is informational only.

REVISION TO THE PRIOR DIRECTIVE

This policy directive has been revised to accommodate NYCWAY format changes to the Six-Month Mailer Notice to Report to the Job Center (**M-327m**) form.

POLICY

Pursuant to state regulations, every six months the Human Resources Administration (HRA) must evaluate the continuing eligibility of all participants who receive Cash Assistance (CA) and Food Stamps (FS). HRA will be sending an eligibility questionnaire to participants instead of conducting a face-to-face interview to satisfy the eligibility evaluation. Failure to return the properly completed questionnaire, along with the necessary documentation, could adversely affect CA/FS eligibility.

BACKGROUND

Beginning the first week of July 2009, HRA Management Information Systems (MIS) sent participants the Important Notice Regarding Your Eligibility for Cash Assistance and Food Stamps (**M-327hh**) form. This form advises the participant that he/she will receive by mail the Mail-in Recertification/Eligibility Questionnaire (**M-327h**) in the following months. Beginning August 2009, the **M-327h** form will be sent to CA participants who are nearing the 6th month of their certification period. Form **M-327h** will indicate that it must be completed and returned to HRA by the return date on the notice. HIV/AIDS Services Administration (HASA) participants will be omitted from these mailings, and homeless and homebound participants will be phased in at a later date.

Revisions to the Form

Previously, the form asked if the household still needed CA.

Form **M-327h** mirrors the New York State Office of Temporary and Disability Assistance (OTDA) Mail-In Recert/Eligibility Questionnaire Form (**LDSS-4887**), and allows a participant to select which program areas (CA, MA [Medical Assistance], or FS) he/she would like to close or remain active in. In addition, the return address was added to the first paragraph of the form.

MIS responsibility

Form **M-327h** is mailed to CA/FS participants in the 5th month of the 12-month recertification period. The **M-327h** is sent with a business reply envelope that includes HRA's return address of, HRA/Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10213-0195. The participant must return Form **M-327h** to HRA by the 1st day of the following month (6th month). A vendor has been contracted to pickup the forms from the P.O. Box, and review them to determine the next course of action.

Vendor responsibility

The vendor's review will result in one of the following outcomes.

1. Completed **M-327h** Received – No Changes

   The vendor must send the form to the imaging vendor for scanning and indexing. If a completed voter registration form is included, the vendor must send the voter registration form to ICP. In addition, the Vendor will notify the Welfare Management System (WMS) systemically to update the case and produce a no change budget.

2. **M-327h** is not Received by the Deadline

   Closed cases can be identified by the unique Authorization Number **888893**.

   On the 15th of the month following the month the **M-327h** form was mailed, the vendor will send a file of all cases that failed to return the **M-327h** form (or the form was returned undeliverable) to WMS, to close the case with one of the following closing codes:

   - **G36** (Failure to Complete the TA [6 Month] Mail in Recertification For Cases on 12 Month Recertification Schedule), or
   - **G37** (Failure to Complete the TA [6 Month] Mail in Recertification For Cases on 12 Month Recertification Schedule).

   Use Closing Code **G36** when all adults on the case are aged or disabled.

   Note: Should the vendor receive a completed **M-327h** form between the 16th and the end of the month (the month following the month Form **M-327h** was mailed), the vendor will update the system and stop the closing in WMS.

   Automated Settle In Conference (SIC)

3. **M-327h** is Returned Undeliverable

   These cases will be treated like cases that failed to return the **M-327h** form. See outcome 2 on the previous page.

4. **M-327h** is Returned – Changes Required/Form is Incomplete

   If changes to the participant's case are required, or if information is missing such as a signature, the vendor must send form **M-327h** and accompanying documents to ICP for processing.

Participant returns documents but does not return **M-327h**

Note: If the participant returns the documents but does not include the **M-327h**, the Vendor must close the case using Closing code **G37**. The case is to be treated the same as in outcome two on the previous page, "**M-327h** is not Received by the Deadline.".

5. Participant Requests Case Closing

This information is sent to WMS by the vendor on the 1st day of the month following the month form **M-327h** was mailed.

When the participant requests to have the CA portion or the entire case closed, the closing request will be processed via an automated process. When the participant requests to have the MA or FS portion of the case closed (leaving the CA portion active), the closing request must be processed via a manual process.

Automated Closing Process

If the participant indicates on form **M-327h** that he/she wants to have the CA portion or the entire CA/FS case closed, the vendor will send a file to WMS to execute the action as follows:

- Close CA and FS – WMS will close the entire CA case using Closing Code **G87** (Client Request – Cash Assistance [CA]– Eligibility Mail Out), and process a separate determination for MA
- Close CA and MA only – WMS will close the entire CA case using Closing Code **EM4** (Client Request – Cash Assistance [CA] and Medicaid [MA] – Eligibility Mail Out), and process a separate FS determination
- Close CA only – WMS will close the entire CA case using Closing Code **EM5** (Client Request – Cash Assistance [CA] – Eligibility Mail Out), and process a separate determination for FS and MA
- Close CA, MA, and FS – WMS will close the entire CA case using Closing Code **EM7** (Client Request – Cash Assistance [CA], Medicaid [MA] and Food Stamps [FS] – Eligibility Mail Out). Separate determinations for FS and MA **will not** be processed on this closing

A Client Notice System (CNS) notice will be generated for the automated closings.

Manual Closing Process

If the participant indicates on form **M-327h** that he/she wants to keep the CA potion of the case active, but close the MA and/or FS portion of the case, the vendor will send the requests to ICP for processing.

REQUIRED ACTION	
ICP Responsibilities	Upon receipt of a case list requesting closure of either the FS or MA portion of the CA case, ICP will process the request as indicated below.
Participant requests to close FS and MA	• If the participant requests to close both the FS and MA portion of the case: ▪ calculate and save a new budget, closing the FS suffix, ▪ enter the Budget Number in Element **015** of the Turn-Around Document (TAD), ▪ enter **CL** in the **MA Status** field (Element **240**) and Closing Code **Y26** (Client Request – Medicaid (MA) and Food Stamps (FS) Eligibility Mail Out) in the **MA Reason** field (Element **241**), ▪ enter the MA **TO** date in Element **243** (the **TO** date is the last day of the month of the MA closing), ▪ enter **CL** in the **FS Status** field (Element **230**) and **Y26** in the **FS Reason** field (Element **231**), ▪ enter the **TO** date in Element **262** (the **TO** date is the date the FS action is being taken).
Participant requests to close FS only	• If the participant requests to close only the FS portion of the case: ▪ calculate and save a new budget closing the FS suffix, ▪ enter the Budget Number in Element **015** on the TAD, ▪ enter **CL** in Element **230** and FS Closing Code **Y24** (Client Request - Food Stamps (FS) – Eligibility Mail Out [Manual Closing]) in Element **231**, ▪ enter the **TO** date in Element **262**.

Participant requests to close MA only

- If the participant requests to close only the MA portion of the case:
  - enter **CL** in Element **240** and MA Closing Code **Y25** (Client Request - Medicaid (MA) – Eligibility Mail Out [Manual Closing]) in Element **241**,
  - enter the MA **TO** date in Element **243**.

The Notice of Intent to Change Benefits: Part A Public Assistance, Food Stamp Benefits and Medical Assistance Coverage and Services (Timely and Adequate) (**LDSS-4015 A**) form and the Notice of Intent to Change Benefits: Part B Public Assistance, Food Stamp Benefits and Medical Assistance Coverage and Services (Timely and Adequate) (**LDSS-4015 B**) form must be prepared and sent to the participant. The notice must be scanned and indexed into the electronic case record.

M-327h completed

For cases that require a change, or where form **M-327h** is incomplete, the vendor will send form **M-327h** and any supporting documents to ICP. ICP staff will:

- review form **M-327h** and the supporting documents.
- review WMS and the HRA OneViewer to determine if additional information is required, and/or if the change has already been implemented. If the change has not been made, proceed as follows:
  - If sufficient documentation was provided and the action can be taken, process the change in accordance with current procedure.
  - If the action cannot be taken because additional information is required, or a signature is missing, ICP will post Action Code **11SP** (Six Month Mailer Case Pending Call in) in New York City Work, Accountability and You (NYCWAY). The code will have a drop-down box allowing ICP to indicate that additional information is needed to verify:
    - Address Change
    - Case Composition Change
      - Add an Adult
      - Remove an Adult (Specify)
      - Add/Remove a Child
    - Income (Specify name)
    - Participant's Signature
    - Other (Specify)

Action Code **11SP** will trigger the posting of Action Code **11SC** (Six Month Mailer Job Center Call in Appointment), which generates the Six-month Mailer Notice to Return Documents or Report to the Job Center (**M-327m**) form. Form **M-327m** is batch mailed to the participant notifying him/her of the appointment at the Job Center (the appointment is 14 calendar days from the date of the **11SC** Action Code), and of the need to provide additional information beyond what was already provided with form **M-327h**. These cases will appear on the **SMCAL** Worklist.

- send form **M-327h** and supporting documents to the imaging vendor for scanning and indexing.

Job Center responsibility

When the participant reports to the Job Center for his/her appointment proceed as follows.

Model Center CSIC staff

In Model Centers, the Front Door Receptionist will refer the participant to the Customer Service Information Center (CSIC). The JOS/Worker in CSIC will:

- access NYCWAY and pull up the **SMCAL** Worklist to identify the participant, view the appointment (Action Code **11SC**), and determine what information is being requested (Action Code **11SP**).
- print form **M-327h** from the HRA OneViewer.

If an adult is being added to the household, the adult must complete and sign the Statewide Common Application (**LDSS-2921**).

  - If an Adult is being added to the case, give the participant an in-center referral to Applications. The adult must complete the application process before being added to the case.
  - If the participant has requested a change to:

    – add a minor child;
    – change an address;
    – remove an adult; or
    – update income,

    Obtain the necessary documents needed to verify the requested change.

  - If the participant's signature is missing from the **M-327h**, obtain the participant's signature on the form, and scan and index the form into the HRA OneViewer.

- initiate the appropriate POS activity to begin the required action, (for example, adding a child to the budget).
- suspend the case and send it to CSIC AJOS I.

The AJOS I will assign the case to the Processing Unit AJOS I. The Processing Unit AJOS I will assign the case to the Processing Unit JOS/Worker.

The JOS/Worker in the Processing Unit will:

- select the case in his/her queue to continue the activity and process the change per current procedure.
- post Action Code **11RS** (Participant Responded to Six Month Mailer Call in) in NYCWAY to indicate that the appointment was kept and to close down the **11SC**/**SR** code.
- for Brown v. Guiliani, requests such as adding a person to the budget, or requesting an additional allowance, POS will annotate the **W-111F**.
- for Brown cases processed outside of POS, the JOS/Worker must annotate the paper **W-111F**.
- prepare and send the **LDSS-4015 A** and **LDSS-4015 B**, and the Action Taken on Your Request for Emergency Assistance or Additional Allowance (For Participants Only) (**W-137B**) as needed, if the request is a Brown Request to indicate that the change was made.

Non Model Centers

In Non Model Centers, the Receptionist will refer the participant to the appropriate JOS/Worker. The JOS/Worker will:

- access NYCWAY and pull up the **SMCAL** Worklist to identify the participant, view the appointment (Action Code **11SC**), and determine what information is being requested (Action Code **11SP**).
- print form **M-327h** from the HRA OneViewer.
- obtain the necessary documents needed to verify the requested change. If an adult is being added to the case, the adult must complete the application process before being added to the case.
- If the participant's signature is missing from form **M-327h**, obtain the participant's signature on the form, and scan and index the form into the HRA OneViewer
- initiate the appropriate POS activity to begin the required action and process the change per current procedure.
- post Action Code **11RS** (Participant Responded to Six Month Mailer Call in) in NYCWAY to indicate the appointment was kept and to close the **11SC**/**SR**.
- prepare and send the **LDSS-4015 A** and the **LDSS-4015 B**, and the **W-137B** as needed, for Brown v. Giuliani requests.

There may be instances where the participant requests to reschedule his/her appointment. The JOS/Worker must:

Model/Non Model Centers for Rescheduling Appointments and Case Closing

- If the participant contacts the JOS/Worker to reschedule the appointment, enter Action Code **11SR** (Rescheduled Six Month Mailer Job Center Call in Code) with a new appointment date of four calendar days after the appointment date.

  If the participant fails to appear for the original or rescheduled appointment, NYCWAY will post Action Code **496M** (FTR/FTC 6-Month Mailer Appointment) and will initiate a **N17** (Failure to Complete Eligibility Process) closing in WMS.

N17 will be used until **V20** (Failure to Provide Verification) is programmed for an automated closing

Occasionally, a participant might come to the Job Center to return the **M-327h** instead of mailing it in the Business Reply envelope. If he/she comes to the Job Center to submit his/her completed **M-327h**, proceed as follows:

In Model Centers, the Front Door Receptionist should give the participant a ticket to CSIC.

MIS will provide Job Centers with a supply of Business Reply envelopes to mail form **M-327h** to the vendor.

- CSIC will take the completed forms and documentation, ensuring that form **M-327h** is signed and dated, and mail them to: Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10213-0195, using the self-addressed envelope provided by MIS.

In Non Model Centers, the Receptionist will take the completed form and documentation, ensuring that form **M-327h** is signed and dated, and mail them to Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10213-0195, using the business reply envelope provided by MIS.

Once an Notice of Intent (NOI) is sent, an appointment to FH&C is automatically scheduled in Front Door Reception.

If the participant comes to the Job Center to submit his/her completed **M-327h** form after the Notice of Intent (NOI) has been issued, refer the participant to the Fair Hearing and Conference (FH&C) Unit, per current procedure.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications

The POS implications are discussed in this procedure.

Food Stamp Implications	As a result of a change in circumstances indicated on the form **M-327h**, some CA/FS participants may receive an increase/decrease in their CA grant. This increase/decrease may result in an increase/decrease in the household's FS benefits. When a CA case is closed due to a failure to return form **M-327h** and the closing code is **G36**, a separate determination for FS will be required. If the closing code is **G37**, a separate determination for FS will not be required.
Medicaid Implications	Cases that lose CA eligibility due to a failure to return form **M-327h** must be referred for a separate Medicaid determination.

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

For Limited English-Speaking Ability (LESA) and hearing-impaired participants, make sure to obtain appropriate interpreter services in accordance with PD #09-14-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 the participant 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 FH&C AJOS I/Supervisor I at anytime. 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 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 I/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 I/Supervisor I will explain the reason for the Agency's action(s) to the participant.

The closing of the CA/FS case is based on the participant's:

- failure to return form **M-327h** in a timely manner
- request to have all or a portion of the case closed

If the participant has a good cause reason for not returning form **M-327h**, FH&C should process a Settle In Conference (SIC) for the case. The participant must complete form **M-327h** in order to SIC the case.

In addition, if the adverse case action still shows on the "Pending" (**08**) screen in WMS, the AJOS I/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (**LDSS-3722**), change the **02** to **01** if the case has been granted Aid to Continue (ATC), or prepare and submit a CA Recoupment Data Entry Form (**LDSS-3573**) to delete a recoupment. The AJOS I/Supervisor I must complete a Conference Report (**M-186a**).

Evidence Packets

All Evidence Packets must contain a detailed history, copies of relevant WMS screen printouts, other documentation relevant to the action taken, and copies of NYCWAY "Case Notes" screens.

REFERENCES

18 NYCRR 351.21(a)
18 NYCRR 351.22(f)
18 NYCRR 360-2.6
18 NYCRR 387.17

RELATED ITEM

PD #09-15-ELI

ATTACHMENTS

Please use Print on Demand to obtain copies of forms.

M-327h	Mail-In Recertification/Eligibility Questionnaire (Rev. 7/9/09)
M-327h (S)	Mail-In Recertification/Eligibility Questionnaire (Spanish) (Rev. 7/9/09)
M-327hh	Important Notice Regarding Your Eligibility for Cash Assistance and Food Stamps (Rev. 7/9/09)
M-327hh (S)	Important Notice Regarding Your Eligibility for Cash Assistance and Food Stamps (Spanish) (Rev. 7/9/09)
M-327m	Six-Month Mailer Notice to Report to the Job Center (Rev. 8/18/09)
M-327m (S)	Six-Month Mailer Notice to Report to the Job Center (Spanish) (Rev. 8/18/09)

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Caseload: _____

Mail-in Recertification/Eligibility Questionnaire

To determine your continued eligibility for Temporary Assistance (TA) and Food Stamps (FS), you must answer every question, sign, date, and return this form in the enclosed postage-paid envelope to the **Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10013-9973** by: _____.
(Return Date)

- For TA, this form is considered a mail-in recertification form. For FS, this is an Eligibility Questionnaire.
- You must enclose copies of letters or documents that verify the changes you report.
- Failure to return the form or returning it without the required verification may result in the closing of your case or reduction of benefits.

1. Do you still need:
   Cash Assistance? ☐ Yes ☐ No Food Stamps? ☐ Yes ☐ No Medical Assistance? ☐ Yes ☐ No
   If No, your benefit will be stopped.

2. Did anyone **move into** or **out of** your household since the last time you reported the number of persons in your household (including births)? ☐ Yes ☐ No
   - If Yes, provide the information requested below.
   - If they want to apply for assistance an application must be filled.
   - If you are reporting a newborn enclose a copy of a birth certificate for verification.

Social Security Number	Name	Relationship to You	Moved In	Moved Out	Date

3. Other than Cash Assistance, did you, or anyone in your household, have a change in income? Has anyone begun receiving any new or increased income or lost income from any of the following sources since the last time you reported your income?
   If you check ☑ Yes, indicate the amount you receive and whether this amount is new, more, or less. If this amount has changed, enclose photocopies to verify your last four weeks of income, or other proof of how much you receive.

Source of Income		Amount	New	More	Less
A. Contributions	☐ Yes ☐ No	$_____			
B. Employment Please indicate the number of hours working per week_____.	☐ Yes ☐ No	$_____			
C. Unemployment Insurance Benefits (UIB)	☐ Yes ☐ No	$_____			
D. Supplemental Security Income (SSI)	☐ Yes ☐ No	$_____			
E. Social Security Income other than SSI	☐ Yes ☐ No	$_____			
F. Child Support (including court-ordered payments)	☐ Yes ☐ No	$_____			
G. Veteran's or other military benefits	☐ Yes ☐ No	$_____			
H. Other Income	☐ Yes ☐ No	$_____			

Case Number: _____

4. Have there been any changes in the following since you last reported to us?

A. Rent costs: ☐ Yes ☐ No
If Yes, Increase ☐ Decrease ☐ New amount $ _____ (Enclose proof of change)

B. Is someone pregnant or disabled? ☐ Yes ☐ No
If Yes, provide name (enclose medical proof): _____

C. Resources (e.g., motor vehicle, bank account, etc.): ☐ Yes ☐ No
If Yes, explain (enclose photocopy of bank statement, car title, etc.): _____

D. Child support you pay to someone outside your household: ☐ Yes ☐ No
If Yes, Increase ☐ Decrease ☐ New amount $ _____ (Enclose proof of court order)

E. Medical expenses paid by household member who is disabled or who is 60 years old or older: ☐ Yes ☐ No
If Yes, explain change: _____

F. Other changes: ☐ Yes ☐ No
If Yes, explain: _____

I swear (or) affirm that the information on this form is true and correct.

Name (please print): _____

Signature: _____ Date: _____

Signature of Husband/Wife or Authorized Representative: _____ Date: _____

WARNING: Federal and State law provides for penalties of fine, imprisonment or both if you do not tell the truth or if you conceal or fail to disclose facts regarding your continuing eligibility for assistance. Regulations require that you immediately notify this Agency of any changes in needs, income, resources, living arrangements or address.

Food Stamps

In order to determine if you can still get food stamps, you must complete this Eligibility Questionnaire and return it by the date on **page 1** of this form. If you do not complete and return the Eligibility Questionnaire by the due date, your food stamp benefits will be reduced or stopped. We will send you another notice if this happens. This decision is based on Regulation 18 NYCRR 387.17.

List of changes you must report for Food Stamps at this time:

- Changes in any **source of income** for anyone in your household.
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month.
- Changes in your household's total **unearned income from a public source** such as Social Security Benefits or Unemployment Insurance Benefits when it goes up or down by more than $50 a month.
- Changes in your household's total **unearned income from a private source** such as child support payments or private disability insurance when it goes up or down by more than $100 a month.
- Changes in the amount of court-ordered **child support you pay** to a child outside of your food stamp household.
- Changes in **who lives with you**.
- **If you move**, your new address and your new rent or mortgage costs, heat costs, and utility costs.
- **A new or different car**, or other vehicle.
- Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2,000 for a household without an elderly or permanently disabled household member or $3,000 for a household with an elderly or permanently disabled household member.
- If anyone in your food stamp household is an Able Bodied Adult Without Dependents (ABAWD), you must tell us if their work hours go below 80 hours a month within 10 days after the end of that month.

MEDICAL ASSISTANCE – You must immediately report any changes in your address, income, resources or household size to this agency. You will be notified if your Medical Assistance coverage changes.

Authorization for Reimbursement of Cash Assistance Benefits from SSI Retroactive Payment

I authorize the Commissioner of the Social Security Administration (SSA) to send to the local social services district the amount due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI, or (2) retroactive SSI benefits I may receive if my SSI benefits are terminated or suspended and are later reinstated.

I understand that the local social services district may take from my retroactive SSI payment the amount of cash assistance (except assistance paid wholly or partly with federal funds) that it paid to me during the period that begins (1) with the first day I became eligible for payment of SSI, or (2) the first day to which SSI benefits were reinstated after a period of suspension or termination and ends with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last cash assistance payment during the month that SSI payments resume).

After taking this money from my SSI check(s), the local social services district will pay me the balance; if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as cash assistance; I will be given an opportunity for a hearing.
I understand that:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.
- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement. It will not have any effect on cases that have been completely decided or if the SSA has already made an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I have mutually agreed to terminate the authorization.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon new SSI applications made after that date.

LIFELINE – For applicants/participants of TA and/or FS Benefits: The Office of Temporary and Disability Assistance may or may not release your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate.

If you do not want this information released, check this box ☐

You may contact your telephone service provider directly for enrollment in the discounted rate Lifeline Service. Medicaid-only applicants/participants must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

Able Bodied Adult Without Dependents (ABAWD) – If anyone in your food stamp household is an ABAWD, you must report when the individual's, who is an ABAWD, monthly participation in employment or other work activities falls below 80 hours.

NOTE: The last part of this form is an application to register to vote. If you would like help filling out the voter registration application form, ask your Worker. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency. Return this form to the Agency whether it has been completed or not.

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

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"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ YES (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)

☐ NO because I choose not to register OR

☐ I am already registered at my current address OR

☐ I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____ ____/____/____

(Signature) (Date)

_____

(Please Print Name)

Qualifications for Registration

You Can Use This Form To:

- **register to vote in New York State;**
- **change your name and/or address, if there is a change since you last voted;**
- **enroll in a political party or change your enrollment.**

To Register You Must:

- **be a U.S. citizen;**
- **be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);**
- **be a resident of the County, or of the City of New York at least 30 days before an election;**
- **not be in jail or on parole for a felony conviction; and**
- **not claim the right to vote elsewhere.**

IMPORTANT!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

New York State Board of Elections, 40 Steuben Street, Albany, New York 12207-2109
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (01/07)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1 Are you a U. S. citizen? Yes ☐ No ☐ If you answered NO, do not complete this form.

2 Will you be 18 years old on or before election day? Yes ☐ No ☐ If you answered NO, do not complete this form unless you will be 18 by the end of the year.

For Board use only!

3 Last Name First Name Middle Initial Suffix

4 Address where you live (do not give P.O. address) Apt. No. City/Town/Village Zip Code County

5 Address where you get your mail (if different from above) P.O. Box, star route, etc. Post Office Zip Code

6 Date of Birth

7 Sex (circle) M F

8 Home Tel. Number (optional)

9 ID Number - Check the applicable box and provide your number

☐ New York DMV number __ __ __ __ __ __ __ __ __

If you do not have a New York DMV number, please provide:

☐ Last four digits of your Social Security Number __ __ __ __

☐ I do not have a New York Driver's license number or a Social Security Number

10 The last year you voted

Your Address was (give house number, street, and city)

In county/state

Under the Name (if different from your name now)

11 **Choose a party** -- Check one box only

☐ DEMOCRATIC PARTY
☐ REPUBLICAN PARTY
☐ INDEPENDENCE PARTY
☐ CONSERVATIVE PARTY
☐ WORKING FAMILIES PARTY
☐ OTHER (write in) _____
☐ I DO NOT WISH TO ENROLL IN A PARTY

Please note: In order to vote in a **primary election**, you must be enrolled in one of these parties. *See reverse

12 **AFFIDAVIT**: I swear or affirm that

- I am a citizen of the United States
- I will have lived in the county, city or village for at least 30 days before the election.
- I meet all requirements to register to vote in New York State.
- This is my signature or mark on the line below.
- The above information is true. I understand that if it is not true I can be convicted and fined up to $5,000 and/or jailed for up to four years.

→ _____

(Signature or Mark in Ink) (Date)

IDENTIFICATION REQUIREMENTS

Your identity must be verified prior to election day, so that you will not have to provide identification when you vote. Your identity can be verified through your DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, as requested in Box 9 of this application.

If your identity is not verified before election day, you will be asked to provide identification when you vote for the first time. Samples of the identification you may provide include a valid photo ID, a current utility bill, bank statement, government check or some other government document that shows your name and address.

TO COMPLETE THIS FORM:

Box 1: **Must be completed. If you answer NO, do not complete this form.**

Box 2**: Must be completed, however if you check NO, do not complete this form UNLESS you are a New York resident who will be 18 by the end of this year.**

Box 4**: Give your home address.**

Box 5**: Give your mailing address if it is different from your home address (post office box no., star route or rural route no., etc.).**

Box 8**: The completion of this box is optional.**

Box 9**: Must be completed. If you have a current New York driver's license, you must provide that number. If you do not have a current New York driver's license, you must provide the last four digits of your social security number.**

Box 10**: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".**

Box 11**: In order to vote in a party primary, you must be enrolled in one of New York's 5 constituted parties. Check one box only. (*Except the Independence Party, which permits non-enrolled voters to vote in their primary elections.)**

Box 12**: This application must be signed and dated in ink.**

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

Form M-327h (S) (LDSS-4887 SP) (page 1) LLF Rev. 7/9/09

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Unidad de Caso _____

Cuestionario de Recertificación/Elegibilidad Por Correo

Para determinar su elegibilidad Continua para Asistencia Temporaria (Temporary Assistance – TA) y Cupones para Alimentos (Food Stamps – FS), debe contestar todas las preguntas, firmar, fechar y devolver este formulario en el sobre prepagado adjunto a la **Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10013-9973** para el día_____
(Fecha de Regreso)

- Para el Programa de Asistencia Temporal, este formulario se considera un formulario de recertificación por correo. Para el programa de Cupones para Alimentos, se considera un cuestionario de Elegibilidad.
- Debe adjuntar copias de cartas o documentos que comprueben los cambios que usted reporte.
- Si usted no devuelve el formulario, o lo devuelve sin los comprobantes estipulados, es posible que cerremos su caso o reduzcamos la cantidad de beneficios que recibe.

1. Aún necesita:
   ¿Asistencia en Efectivo? ☐ Sí ☐ No ¿Cupones para Alimentos:? ☐ Sí ☐ No ¿Asistencia Medica? ☐ Sí ☐ No
   Si su respuesta es No, sus beneficios se terminarán

2. ¿Se han **mudado** de su hogar miembros del grupo familiar desde la última vez que usted reportó el número de integrantes de su hogar (incluyendo los recién nacidos)? ☐ Sí ☐ No
   - Si contestó que Sí, proporcione los siguientes datos.
   - Si desean solicitar asistencia deben llenar una solicitud.
   - Si está reportando a un recién nacido, favor de adjuntar como comprobante una copia de la partida de nacimiento.

Número de Seguro Social	Nombre	Parentesco con Usted	Se Mudó al Hogar	Se Mudó del Hogar	Fecha

3. Aparte de lo que recibe en Asistencia en Efectivo, ¿Usted o alguien en su hogar ha experimentado una modificación de ingreso? ¿Ha comenzado a recibir algún nuevo o mayor ingreso o perdido ingreso de cualquiera de las siguientes fuentes desde la última vez que usted reportó su ingreso?

   Si usted marcó ☑ Sí, indique la cantidad que recibe y si esta nueva cantidad representa una pérdida, un aumento, o una nueva fuente de ingresos. Si esa cantidad ha cambiado, favor de adjuntar copias para comprobar las últimas cuatro semanas de ingreso, u otro comprobante de cuánto usted recibe.

Fuente de Ingreso		Cantidad	Nueva	Aumento	Reducción
A. Contribuciones	☐ Sí ☐ No	$_____			
B. Empleo: Favor de indicar el número de horas que trabaja por semana _____.	☐ Sí ☐ No	$_____			
C. Beneficios de Seguro de Desempleo (UIB)	☐ Sí ☐ No	$_____			
D. Seguridad de Ingreso Suplementario (SSI)	☐ Sí ☐ No	$_____			
E. Ingreso de Seguro Social que no sea de SSI	☐ Sí ☐ No	$_____			
F. Manutención de niños (incluyendo pagos dictados por el tribunal)	☐ Sí ☐ No	$_____			
G. Beneficios de veteranos u otros beneficios a militares	☐ Sí ☐ No	$_____			
H. Otros ingresos	☐ Sí ☐ No	$_____			

Número de Caso: _____

4. ¿Se han dado cambios en las siguientes situaciones desde la última vez que usted nos reportó?

A. Costo de alquiler: ☐ Sí ☐ No
Si respondió Sí, Aumento ☐ Reducción ☐ Nueva cantidad $_____ (Adjunte comprobante del cambio).

B. Hay una persona embarazada o incapacitada: ☐ Sí ☐ No
Si respondió Sí, Proporcione el nombre (adjunte comprobante médico):_____

C. Recursos (p. ej.: auto, cuenta bancaria, etc.) ☐ Sí ☐ No
Si respondió Sí, favor de dar una explicación_____.
(Adjunte copia de comprobante de cuenta bancaria, auto, título del auto etc.)

D. Pagos de manutención para niños que usted le hace a alguien que no es parte de su hogar: ☐ Sí ☐ No
Si respondió Sí, Aumento ☐ Reducción ☐ Nueva cantidad $_____ (Adjunte comprobante de orden judicial)

E. Gastos médicos pagados por un miembro del hogar que está incapacitado o tiene 60 años de edad o más: ☐ Sí ☐ No
Si respondió Sí, favor de dar una explicación por el cambio:_____

F. Otros cambios: ☐ Sí ☐ No
Si respondió Sí, favor de dar una explicación:_____

Yo juro (o) afirmo que los datos que he proporcionado en este formulario son verdaderos y exactos

Nombre (Letra de Molde): _____

Firma: _____ Fecha: _____

Firma del Esposo(a) o Representante Autorizado:_____ Fecha: _____

ADVERTENCIA: Las leyes federales y estatales disponen sanciones en la forma de multas, encarcelamiento o ambos, si usted no declara la verdad o si oculta o no revela datos pertinentes respecto a su elegibilidad continua para asistencia. El reglamento estipula que usted notifique inmediatamente a esta agencia sobre todo cambio en sus necesidades, ingresos, recursos, situación de vivienda o domicilio.

Cupones para Alimentos

Para que podamos determinar si usted puede continuar recibiendo Cupones para Alimentos, debe llenar este Cuestionario de Elegibilidad y regresarlo para la fecha que aparece en la **primera página** de este formulario. Si no llena y regresa el Cuestionario de Elegibilidad para la fecha indicada, sus beneficios de cupones se reducirán o se suspenderán. En tal caso, le enviaremos otro aviso. Esta decisión se basa en 18 NYCRR 387.17.

Lista de cambios, relativos al programa de Cupones para Alimentos, que debe reportar en este momento:

- Cambios en **fuente de ingresos** de algún miembro del hogar.
- Cambios en el total de **ingresos salariales** del hogar cuando este total aumenta o disminuye por más de $100 al mes.
- Cambios en el total de **ingresos no salariales del hogar provenientes de fondos públicos**, tales como beneficios de Seguro Social o beneficios del Seguro de Desempleo (UIB), cuando este total aumenta o disminuye por más de $50 al mes.
- Cambios en el total de ingresos no trabajados del hogar, provenientes de fondos privados, tales como pagos de Manutención de Niños o pagos del seguro privado por incapacidad, cuando este total aumenta o disminuye por más de $100 al mes.
- Cambios en los **pagos por orden judicial para Manutención de Niños** a un niño de su hogar de Cupones para Alimentos.
- Cambios en **quienes viven con usted.**
- **Si se muda**, su nuevo domicilio, o los nuevos montos de alquiler o hipoteca; gastos de calefacción y servicios de electricidad y/o gas.
- **Un automóvil nuevo o distinto**, u otro vehículo
- Aumento en lo que el hogar tiene en **dinero en efectivo, acciones, bonos, dinero en el banco** o en una institución de ahorros cuando el total del dinero en efectivo y ahorros de todos los miembros del hogar sobrepasa los $2,000 y, en el hogar no hay una persona de edad mayor o con una incapacidad permanente; o $3,000 cuando en el hogar hay una persona de edad mayor o con una incapacidad permanente.
- Si algún integrante de su hogar beneficiario de Cupones para Alimentos es un Adulto Apto para Trabajar sin Dependientes (“ABAWD”), usted DEBE informarnos si esa persona trabajó menos de 80 horas al mes dentro de los 10 días de finalizado dicho mes.

ASISTENCIA MÉDICA – Usted debe notificar inmediatamente a esta agencia de todo cambio de domicilio, ingresos, recursos o el número de integrantes de su hogar. Se le notificará si habrá cambios en la cobertura de Asistencia Médica.

Autorización de Reembolso de Beneficios de Asistencia de Dinero en Efectivo de los Pagos Retroactivos de SSI

Autorizo al comisionado de la Administración del Seguro Social (SSA) para que envíe al distrito local de servicios sociales la cantidad que se me adeuda al momento de mi primer pago de (1) pago retroactivo de Seguridad de Ingreso Suplementario que pueda recibir al presentar una solicitud de SSI, o (2) beneficios retroactivos que pueda recibir si mis beneficios de SSI cesan o se suspenden y más tarde se restituyen.

Comprendo que el distrito local de servicios sociales podría descontar de mi pago de SSI la cantidad de asistencia en efectivo (excepto la asistencia pagada total o parcialmente con fondos federales) que se me pagó durante el período que comienza con el primer día que tuve derecho a los beneficios de SSI, o el primer día en que los beneficios fueron restituidos después de un período de suspensión o cancelación y que termina con el mes en el que los pagos del SSI comenzaron (o el mes siguiente si el distrito local de servicios sociales no puede detener el envío de mi último pago de asistencia en efectivo durante el mes en que los pagos del SSI comenzaron).

Después de deducir este dinero de mi(s) cheque(s) de SSI, el distrito local de servicios sociales me pagará el balance, si existiera alguno, a más tardar dentro de los 10 días laborables a partir de la fecha en que reciba mi pago de SSI. También, estoy al tanto de que si el distrito deduce más dinero del que yo creo me fue pagado por asistencia en efectivo, se me dará la oportunidad de refutarlo por medio de una audiencia. Comprendo que:

- la Administración del Seguro Social puede considerar la fecha en que presento esta autorización firmada ante la oficina local de servicios sociales como la fecha inicial en la que comienzo a satisfacer los requisitos para recibir beneficios del SSI, si someto una solicitud de beneficios de SSI dentro de los próximos 60 días.
- esta autorización tendrá efecto con relación a toda solicitud de SSI o apelación que actualmente esté pendiente ante la oficina de la Administración de Seguro Social tocante a mi persona y a toda solicitud de SSI que yo presente, o apelación que reclame con respecto al período que concluye transcurrido un año de la fecha de mi firma en este acuerdo. Lo anterior no afectará los casos sobre los cuales ya se tomó una resolución definitiva, o si la Administración de Seguro Social ya hizo un pago inicial de SSI, ya sea en base a mi solicitud o después de un período de suspensión o cancelación, o cuando el Estado y yo, de mutuo acuerdo, decidamos cancelar la autorización.

Esta autorización caducará un año (1) después de que el distrito local de servicios sociales la reciba y no tendrá ningún efecto en las futuras solicitudes de SSI que se hagan después de esa fecha.

LIFELINE – Para solicitantes/participantes de Asistencia Temporal y/o Cupones para Alimentos es posible que la Oficina de Asistencia Temporal y para Incapacitados del Estado de Nueva York (NYS Office of Temporary and Disability Assistance) revele su nombre y domicilio a la compañía telefónica. El suministrador de servicios telefónicos puede usar esos datos con objeto de brindarle la tarifa de descuento conocida como Lifeline.

Si no desea que se revele este tipo de información, marque esta casilla ☐ .

Puede comunicarse directamente con la compañía de servicios telefónicos y solicitar el servicio de descuento de Lifeline. Sólo los solicitantes/participnates de Medicaid deben comunicarse directamente con la compañía de servicios telefónicos y solicitar inscripción en el servicio económico de Lifeline.

Adultos Aptos para Trabajar sin Dependientes (ABAWD) – si un miembro del grupo familiar que recibe cupones es un Adulto Apto para Trabajar sin Dependientes debe informarnos cuando las horas laborales mensuales de esta persona sean menos de 80.

NOTA: La última página de esta solicitud es una solicitud de registro de votante. Si necesita ayuda para llenar la solicitud de registro de votante, pídale a la persona a cargo de su caso que le ayude. La inscripción o no para votar no afecta de ninguna manera la decisión de esta agencia en cuanto a la cantidad de concesiones que se le otorgue. Regrese este formulario a la Agencia, aunque no lo haya llenado completamente.

Inscripción en el Registro Electoral / Emitido por una agencia del Estado de Nueva York

This form is available in English
本表格有中文文本

Si todavía no está inscrito en el registro electoral de su localidad, ¿le gustaría hacerlo en este momento?

❑ **Sí** (Si contesta «Sí», rellene la INSCRIPCIÓN EN EL REGISTRO ELECTORAL al pie de esta página)

❑ NO porque elijo no inscribirme

❑ Ya estoy inscrito en mi lugar de residencia actual

❑ Ya solicité y recibí la inscripción por correo.

Si usted no marca una de las casillas anteriores, se interpretará que ha decidido no inscribirse para votar en esta ocasión.

_____ ____/____/____

(Firma) (Fecha)

(Escriba su nombre en letra de imprenta)

Requisitos de inscripción

Usted puede utilizar este formulario para:

- **inscribirse para votar en el Estado de Nueva York;**
- **cambiar su nombre y/o domicilio, si se produjo alguna modificación desde la última vez que usted votó;**
- **inscribirse en un partido político o modificar su inscripción.**

Si desea inscribirse, usted debe:

- **ser ciudadano estadounidense;**
- **tener 18 años de edad para el 31 de diciembre del año en el que usted rellena este formulario (nota: tiene que haber cumplido los 18 años para la fecha de las elecciones primarias, generales, u otras elecciones en las que usted desee votar);**
- **haber residido en el condado o en la ciudad de Nueva York, por lo menos 30 días antes de la elección;**
- **no estar en prisión o en libertad condicional por haber cometido un delito grave; y**
- **no tener derecho a votar en otro lugar.**

IMPORTANTE

El hecho de inscribirse o no en el Registro Electoral no afectará el monto de beneficios de asistencia que esta agencia le suministrará.

Si necesita ayuda para rellenar este formulario, solicítela; de lo contrario, puede rellenarlo en privado sin que nadie le asista.

Si cree que alguien, de alguna manera, ha interferido con su derecho a inscribirse o a rehusar inscribirse en el registro electoral; o con su derecho a mantener privacidad al respecto; o a seleccionar un partido político en particular u otra expresión política de su preferencia, puede presentar un reclamo en la siguiente dirección:

New York State Board of Elections, 40 Steuben Street
Albany, New York 12207-2109
Teléfono: 1-800-469-6872;
usuarios de TDD/ TTY contacten el New York State Relay al 711; o
visite nuestro sitio web: www.elections.state.ny.us

La decisión de inscribirse o no se mantendrá confidencialmente, así como también la información suministrada y la oficina donde sometió su solicitud; sólo se utilizarán con fines de registro electoral

FORMULARIO DE INSCRIPCIÓN EN EL REGISTRO ELECTORAL

FORMULARIO DE INSCRIPCIÓN EN EL REGISTRO ELECTORAL (instrucciones al reverso)

NVRA -05 (01/07)

☐ Sí, necesito una boleta de votación por correo **Rellene en letra de imprenta con tinta azul o negra** ☐ Sí, me gustaría trabajar en una mesa electoral el día de elecciones

1	¿Es usted ciudadano estadounidense? Sí ☐ No ☐ Si respondió NO, no rellene este formulario	**2**	¿Tendrá 18 años de edad o más, el día las elecciones o antes? Sí ☐ No ☐ Si responde NO, no rellene este formulario a menos que vaya a cumplir 18 años a fin de año.	Uso exclusivo de la Junta electoral
3	Apellido / Nombre / Inicial del segundo nombre / Sufijo distintivo			
4	Domicilio (no incluya dirección de apartado postal) / Apto. №. / Ciudad / Pueblo / Aldea / Código postal / Condado			
5	Dirección donde recibe correspondencia (si difiere de la anterior) / Apartado postal, *star route*, etc. / Oficina postal / Código postal			
6	Fecha de nacimiento	**7** Sexo (trace un círculo) M F	**8** Número de teléfono (optativo)	
10	Último año en que usted votó / Condado / Estado	Domicilio anterior (escriba el número, calle y ciudad) / Nombre que usó (si es diferente al actual)		

9 № de identificación: marque la casilla que corresponda y escriba el número.

☐ Número DMV de Nueva York __ __ __ __ __ __ __ __ __

Si no cuenta con un número de DMV de Nueva York, suministre:

☐ Los cuatro últimos dígitos de su Seguro Social __ __ __ __

☐ No tengo número de licencia de conducir de Nueva York ni número de Seguro Social.

11 **Elija un partido.** Marque sólo un casilla

- ☐ PARTIDO DEMÓCRATA
- ☐ PARTIDO REPUBLICANO
- ☐ PARTIDO INDEPENDENCIA
- ☐ PARTIDO CONSERVADOR
- ☐ PARTIDO FAMILIAS TRABAJADORAS
- ☐ OTRO (especifique) _____
- ☐ NO DESEO INSCRIBIRME EN UN PARTIDO

Nota: para votar en las **elecciones primarias**, tiene que estar inscrito en uno de estos partidos. *Vea al reverso

12 **DECLARACIÓN JURADA.** Juro o afirmo que:

- Soy ciudadano de Estados Unidos.
- Habré residido en el condado, ciudad o aldea por un mínimo de 30 días antes de las elecciones.
- Reúno todos los requisitos para inscribirme como votante en Estado de Nueva York.
- La firma o marca a continuación es de mi puño y letra.
- La información suministrada es verdadera. Entiendo que de no serlo, se me puede condenar y multar por hasta $5,000 y/o encarcelar por un máximo de cuatro años.

→ _____

(Firma o marca en tinta) (Fecha)

REQUISITOS DE IDENTIFICACIÓN

Se deberá verificar su identidad antes del día de las elecciones a fin de que no tenga que presentar identificación al momento de votar. Se puede verificar su identidad por medio de su número de DMV (número de licencia de conducir o número de identificación de no conductor) o con los cuatro últimos dígitos de su número de seguro social, tal como se solicita en la casilla 9 de esta planilla.

Si no se verifica su identidad antes del día de las elecciones, se le pedirá identificación cuando vote por primera vez. Algunos ejemplos de identificación son una credencial válida con foto, una factura actual de servicios públicos (gas, agua, etc.), un estado de cuenta bancaria, un cheque del gobierno o algún otro documento gubernamental en el que aparezca su nombre y dirección.

CÓMO RELLENAR ESTE FORMULARIO

***Recuadro 1*: debe rellenarse. Si respondió NO, no rellene este formulario.**

***Recuadro 2*: debe rellenarse; pero, si marcó la casilla que dice no, no lo rellene A MENOS QUE usted sea un residente del Estado de Nueva York y cumpla 18 años de edad a finales de este año.**

***Recuadro 4*: Escriba su domicilio.**

***Recuadro 5*: Escriba su dirección postal, si difiere de su domicilio (número de apartado postal, *star route*, número de ruta rural etc.).**

Recuadro 8: Es opcional rellenar este recuadro.

***Recuadro 9*: debe rellenarse. Si usted posee una licencia de conducir de Nueva York vigente, debe proporcionar dicho número. De lo contrario, debe proporcionar los últimos cuatro dígitos de su número de seguro social.**

***Recuadro 10*: si usted nunca antes ha votado, escriba *«None»* (ninguno). Si no recuerda cuándo votó por última vez, coloque un signo de interrogación (?). Si usted votó anteriormente utilizando otro nombre, escriba dicho nombre. Si no, escriba *«Same»* (el mismo).**

***Recuadro 11*: para poder votar en las elecciones primarias de un partido, usted debe estar inscripto en uno de los 5 partidos constituidos de Nueva York. Marque sólo un recuadro. (*A excepción del Partido Independencia *[independence party]* que permite que los votantes no afiliados voten en elecciones primarias).**

***Recuadro 12*: Firme y feche con bolígrafo.**

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

Form M-327hh LLF Rev. 7/9/09

Date: _____

Case Number: _____

Case Name: _____

Center: _____

Important Notice Regarding Your Eligibility for Cash Assistance and Food Stamps

The Human Resources Administration (HRA) will send you an eligibility questionnaire in the mail in the coming months because you have a 12-month certification period. The law requires HRA to evaluate your eligibility for cash assistance and food stamps every six months. HRA will send you this questionnaire so that you do not have to come into the Center for your 6-month recertification. When you receive the questionnaire you must complete it, provide the necessary documentation, and return it in the self-addressed envelope provided with the questionnaire.

Failure to return the questionnaire and the necessary documentation may adversely affect your Cash Assistance and/or Food Stamp case.

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

Form M-327hh (S) LLF Rev. 7/9/09

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Aviso Importante Respecto a Su Elegibilidad de Asistencia en Efectivo y Cupones para Alimentos

La Administración de Recursos Humanos (HRA) le enviará por correo un cuestionario de elegibilidad en los próximos meses porque usted tiene un período de certificación de 12 meses. La ley estipula que la HRA evalúe su elegibilidad de asistencia en efectivo y cupones para alimentos cada seis meses. La HRA le enviará este cuestionario para que no tenga que presentarse al Centro para su recertificación de 6 meses. Cuando reciba el cuestionario debe llenarlo, proporcionar la documentación necesaria, y devolverlo en el sobre adjunto al cuestionario con dirección del remitente. El no devolver el cuestionario y la documentación necesaria puede afectar adversamente sus beneficios de asistencia en efectivo y/o cupones para alimentos.

El no devolver como debido este cuestionario y la documentación necesaria puede afectar adversamente su caso de asistencia en efectivo y/o cupones para alimentos.

Form M-327m LLF
Rev. 8/18/09

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

Date: _____

Case Number: _____

Case Name: _____

Center Number: _____

Center Telephone Number: _____

Six-Month Mailer Notice to Report to the Job Center

You responded to the Mail-in Recertification/Eligibility Questionnaire (**M-327h**) and indicated a change in your household's circumstance. In order for us to implement the change, we need additional information.

We have scheduled an appointment for you as follows:

Appointment Date: _____ Time: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please provide verification of the following:

- ☐ Change of address
- ☐ Case composition
  - ☐ Add an adult (specify name below)
  - ☐ Remove an adult (specify name below)
  - ☐ Add/Remove a child (specify name below)
- ☐ Income (specify name, type and amount below)
- ☐ Participant's Signature
- ☐ Other (specify name of person with income type and amount)

Details:

Attached is the Eligibility Factors and Suggested Documentation Guide (**W-119D**), which describes what documentation is needed for reporting changes in your household circumstances.

FAILURE TO KEEP THIS APPOINTMENT WILL RESULT IN A CLOSING OF YOUR CASH ASSISTANCE CASE.

Form M-327m (S) LLF
Rev. 8/18/09

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

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Número del Centro: _____

Número de Teléfono del Centro: _____

Aviso Automático por Correo de Seis Meses para Presentarse al Centro de Trabajo

Usted respondió al Cuestionario de Recertificación/Elegibilidad Por Correo (Mail-in Recertification/Eligibility Questionnaire – **M-327h [S]**) e indicó un cambio en las circunstancias de su hogar. Para implementar el cambio, necesitamos información adicional.

Le hemos programado una cita según se indica a continuación:

Fecha de la Cita: _____ Hora: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Favor de proporcionar verificación de lo siguiente:

- ☐ Cambio de dirección
- ☐ Composición del caso
  - ☐ Añada a un adulto (especifique el nombre abajo)
  - ☐ Retire a un adulto (especifique el nombre abajo)
  - ☐ Añada/Retire a un niño (especifique el nombre abajo)
- ☐ Ingreso (especifique el nombre, tipo y cantidad abajo)
- ☐ Firma del Participante
- ☐ Otros comprobantes (especifique el nombre de la persona con el tipo de ingreso y la cantidad)

Detalles:

Adjunta se encuentra la Guía de Factores de Elegibilidad y Documentación Sugerida (**W-119D [S]**), que describe la documentación necesaria para reportar cambios en las circunstancias de su hogar.

EL NO CUMPLIR ESTA CITA RESULTARÁ EN
EL CIERRE DE SU CASO DE ASISTENCIA EN EFECTIVO.