Human Resources Administration
Department of Social Services

FAMILY INDEPENDENCE ADMINISTRATION

Matthew Brune, Executive Deputy Commissioner

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POLICY DIRECTIVE #11-32-ELI

(This Policy Directive Replaces PD #09-01-ELI and PB #10-121-ELI)

JANUARY 2012 RSDI/SSI COLA INCREASES

Date: December 12, 2011	**Subtopic(s):** Budgeting

AUDIENCE

The instructions in this policy directive are for Job Center and Non Cash Assistance Food Stamp (NCA FS) Center staff, and are informational for all others.

POLICY

Social Security and Supplemental Security Income (SSI) benefits are adjusted to reflect the increase, if any, in the cost-of-living adjustment (COLA), as measured by the federal Consumer Price Index (CPI) for Urban Wage Earners and Clerical Workers (CPI-W).

The average CPI-W for the third quarter of the last year that a COLA was determined is compared to the average CPI-W for the third quarter of the current year. The resulting percentage increase, if any, represents the percentage that will be used to increase Social Security and SSI benefits.

The increase in income, if any, must be reflected in the budgets for Cash Assistance (CA) and Food Stamp (FS) participants. However, SSI benefits are only budgeted on CA cases when the SSI recipient is receiving CA benefits in the Safety Net Assistance (SNA) category.

BACKGROUND

Effective January 1, 2012, all individuals in receipt of Social Security Retirement and Survivors Disability Insurance (RSDI) and/or SSI will receive a COLA of 3.6 percent. This 3.6 percent COLA results in an average increase of $24 per month for SSI recipients.

The SSI Benefit Levels Chart effective January 1, 2012 (**Attachment A**) reflects the 3.6 percent federal COLA increase and increases in the Personal Needs Allowance (PNA) for individuals residing in Congregate Care facilities. The new semi-monthly (s/m) PNA amounts effective January 2012 are as follows:

Congregate Care Level 1 = $67.50 s/m
Congregate Care Level 2 = $77.50 s/m
Congregate Care Level 3 = $92.00 s/m

In addition to the increases in the PNA, the CA shelter amounts used to budget Congregate Care cases will change effective January 2012 as follows:

Shelter Type Code	Semi-monthly shelter rate
28	$395.50
15	$414.50
29, **32**	$474.00
16, **31**, **43**	$489.00
42	$604.00

Revised **W-200G** and **W-648J**

Changes in the PNA and the Shelter amounts for Congregate Care cases will be reflected in the revised Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (**W-200G**) and the Congregate Care Budget Worksheet (**W-648J**).

A Notice of Intent to Change Benefits: NYC PA COLA (**Attachment B**) was sent to all participants whose CA grants will be reduced effective January 2012 because of the RSDI/SSI increase.

NYSNIP benefit level changes resulting from the 2012 COLA

The standardized food stamp benefit levels for New York State Nutrition Improvement Project (NYSNIP) households with Shelter Type Codes **95** and **97** that receive SSI and other income and all NYSNIP households with Shelter Type Code **98** will decrease. The NYSNIP benefit levels effective January 2012 are as follows:

	SSI only	**SSI and other income**
Shelter Type Code **94**	$200	$200
Shelter Type Code **95**	$200	$195
Shelter Type Code **96**	$200	$200
Shelter Type Code **97**	$200	$195
Shelter Type Code **98**	$ 51	$ 47

Change in NYSNIP shelter cost threshold

The NYSNIP shelter cost threshold to be considered as "High Shelter" (Shelter Type Codes **94** and **96**) will change from greater than $229 to greater than $235 and the shelter cost threshold to be considered as "Low Shelter" (Shelter Type Codes **95** and **97**) will change from $229 or less to $235 or less effective January 2012.

A Notice of Intent to Reduce Food Stamp Benefits (**Attachment C**) was sent to all participants whose food stamp benefits will be reduced effective January 2012 because of the RSDI/SSI increase.

Mass rebudgeting

During the week ending December 18, 2011, a mass rebudget (MRB) effective 01/A/12 will be conducted for most of the cases affected by the RSDI/SSI COLA. The MRB will include the automatic recalculation of all pending budgets affected by the RSDI/SSI COLA. Cases that are included in the MRB can be identified by the unique authorization number **33333238**, and can be seen on the **Case Action History** screen. The following cases will be excluded from the MRB:

Cases excluded from mass rebudgeting

- Cases requiring bottom-line budgeting
- Cases with invalid financial involvement codes
- Cases in error status

A list of all the cases excluded from the MRB will be forwarded to the Regional Offices who will forward them to the appropriate Centers for rebudgeting and will monitor the lists for completion. JOS/Workers must rebudget these cases with the correct RSDI/SSI amount.

See PB #11-50-SYS for the SOLQ procedure.

Note: Updated RSDI/SSI amounts can be obtained from the State Online Query (SOLQ) System.

REQUIRED ACTION

CA Budgeting

When the list of cases not included in the MRB is received by the JOS/Worker, he/she must access SOLQ to set the new RSDI/SSI amount for the affected individual and take all required actions to budget the income appropriately.

- If the household remains eligible for CA and FS, authorize a budget that reflects the change in income. The Client Notices System (CNS) will generate the appropriate reduction notice.
- If the household is no longer eligible for CA, close the CA case using closing code **E39** (Excess Income – COLA). CNS will generate the appropriate closing notice.

- If the household remains eligible for CA but is no longer eligible for FS, close the FS portion of the CA/FS case using closing code **E39** (Excess Income – COLA). CNS will generate the appropriate FS closing notice.

NCA FS Budgeting

For FS participants, the Worker must access SOLQ to set the new RSDI/SSI amount for the affected individual and take all required actions to budget the income appropriately.

- If the household remains eligible for FS, authorize a budget that reflects the change in income. CNS will generate the appropriate reduction notice.
- If the household is no longer eligible for FS, close the FS case using closing code **E39** (Excess Income – COLA). CNS will generate the appropriate closing notice.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications

Cases that are excluded from the MRB budgeting must be rebudgeted in POS.

Food Stamp Implications

A separate FS determination is required for CA cases that will be closed as a result of the COLA increase.

Medicaid Implications

A separate Medicaid determination is required for CA cases that are closed as a result of the COLA increase.

LIMITED ENGLISH SPEAKING ABILITY (LESA) AND HEARING IMPAIRED IMPLICATIONS

For Limited English Speaking Ability (LESA) and hearing-impaired applicants/participants, make sure to obtain appropriate interpreter services in accordance with PD #10-12-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 participants must receive either adequate or timely and adequate notification of all actions taken on their case.

Conferences at Job Centers

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 participant is waiting to be seen. In Model Centers, 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/Supervisor I will listen to and evaluate any material presented by the participant, review the case file, and explain the reason for the Agency's action(s) to the participant. If the participant has shown that the outstanding adverse action related to the January 2012 COLA needs to be withdrawn, 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 participant to the appropriate JOS/Worker for corrective action to be taken.

If the determination is that the Agency action was correct, the FH&C AJOS/Supervisor I will explain the reason for the determination to the participant. If the explanation is accepted, no further action is necessary. The AJOS/Supervisor I must complete a Conference Report (**M-186a**).

Should the participant elect to continue his/her appeal by requesting or proceeding to a Fair 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.

Conferences at Food Stamp Centers

If a participant comes to the FS Center requesting a conference, the Receptionist must alert the FS Center Manager's Designee that the participant is to be seen. If the participant contacts the Worker directly, advise the participant to call the Designee.

The Designee will listen to and evaluate any material presented by the participant, and explain the reason for the Agency's action to the participant. If the participant has shown that the Agency's action needs to be withdrawn, the Designee will SIC the adverse action. If the determination is that the Agency action is correct, the Designee will explain the reason for the determination to the participant. If the explanation is accepted, no further action is necessary.

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

Evidence Packets

For Fair Hearing purposes, all complete and relevant evidence packages must include a copy of the state mass rebudgeting notice.

REFERENCES

11-INF-12
GIS 11 TA/DC026
ABEL Transmittal 11-4
18 NYCRR 352.29, 352.8(c)(1)(ii), 387.17(g)(3)

RELATED ITEMS

PB #11-50-SYS
PB #10-102-OPE
PD #09-31-ELI

ATTACHMENTS

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

Attachment A	SSI Benefit Levels Chart effective January 1, 2012
Attachment B	Notice of Intent to Change Benefits NYC PA COLA
Attachment C	Notice of Intent to Reduce Food Stamp Benefits
W-200G	Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (Rev. 12/12/11)
W-648J	Congregate Care Budget Worksheet (Rev. 12/12/11)
W-648J (S)	Congregate Care Budget Worksheet (Spanish) (Rev. 12/12/11)

Attachment A

SSI Benefit Levels Chart effective January 1, 2012 (reflects the 3.6% federal COLA for January 2012)

Fed L/A Code	State Supp Code	New York State Living Arrangement	Individual			Couple		
			Federal	State	TOTAL [1]	Federal	State	TOTAL [1]
A	A	**Living Alone**	$698	$87	**$785**	$1,048	$104	**$1,152**
A, C (B)	B (F)	**Living With Others** (Living in the Household of Another) [2]	698 (465.34)	23	**721** (488.34)	1,048 (698.67)	46	**1,094** (744.67)
A	C	**Congregate Care Level 1 - *Family Care*** ❑ OCFS certified Family Type Homes ❑ OMH or OPWDD certified Family Care Homes						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	698	266.48	**964.48**	1,048	880.96	**1,928.96**
		Rest of State	698	228.48	**926.48**	1,048	804.96	**1,852.96**
A	D	**Congregate Care Level 2 - *Residential Care*** ❑ DOH certified Residences for Adults ❑ OMH or OPWDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	698	435	**1,133**	1,048	1,218	**2,266**
		Rest of State	698	405	**1,103**	1.048	1,158	**2,206**
A	E	**Congregate Care Level 3 – *Enhanced Residential Care*** ❑ DOH certified Adult Homes and Enriched Housing programs ❑ OPWDD certified Schools for the Mentally Retarded	698	694	**1,392**	1,048	1,736	**2,784**
D	Z	**Title XIX (Medicaid certified) Institutions** [3]	30	0 [4]	**30** [4]	60	0 [4]	**60** [4]
A	Z	(see below) [5]	698	0	**698**	1,048	0	**1,048**

Minimum Personal Needs Allowances

- ❑ Congregate Care Level 1 - $135
- ❑ Congregate Care Level 2 - $155
- ❑ Congregate Care Level 3 - $184

Limits on Countable Resources

- ❑ Individuals $2,000
- ❑ Couples $3,000

Revised 19 Oct 2011

Statutory References: Chap. 58 of L. 2011

[1] The combined federal and State SSI benefit provided to eligible individuals and eligible couples with no countable income.

[2] The *Living With Others* category includes recipients whose federal benefit has been reduced by the "value of the 1/3 reduction" (VTR) due to the federal determination that they are both: *a)* living in someone else's household, *and b)* receiving some amount of free or subsidized food and shelter (room and board).

[3] Applies when an SSI recipient is residing in a medical facility, is not expected to return home within 90 days, and Medicaid is paying for at least 50% of the cost of care.

[4] Recipients in nursing homes licensed by DOH receive an additional monthly grant of $25 issued by OTDA called a State Supplemental Personal Needs Allowance (SSPNA). Residents of other medical facilities receive an SSPNA of $5.

[5] This zero federally-administered State supplement applies: *a)* when an SSI recipient is residing in a private medical facility and Medicaid is paying for less than 50% of the cost of care, *or b)* when a recipient resides in certain publicly operated residential facilities serving 16 or fewer residents, *or c)* while a recipient resides in a public emergency shelter for 6 calendar months during a 9 month period.

Attachment B

NOTICE OF INTENT TO CHANGE BENEFITS:
NYC PA COLA

Notice Date: **November 28, 2011**

Case Number:
Loc. Off./Unit/Worker:

General Telephone No. for
Questions or Help:

This Notice is to tell you that this agency intends to change your benefits as follows:

PUBLIC ASSISTANCE GRANT YOUR PUBLIC ASSISTANCE GRANT WILL BE **REDUCED FROM** **TO** EFFECTIVE JANUARY 1, **2012**.

The reason for this action is that according to our records you and/or your dependent(s) are receiving Social Security and/or SSI payments and/or Veteran's Benefits from the Federal Government and a Family Assistance (FA) or Safety Net Assistance (SNA) grant from this Department. As you probably know, Congress has passed a Law (Public, 93-233) providing for an automatic cost of living adjustment in Social Security and/or SSI benefits and/or Veteran's Benefits. This has resulted in an **increase of 3.6** percent which will take effect in December **2011** and be contained in payments received in **January 2012**. Under Law these increases must be counted in determining the amount of the grant you receive from this Department. However, SSI grants are never used to calculate FA payments. SSI can only be counted in SNA cases when the SSI recipient is also receiving SNA.

INCREASE TO SOCIAL SECURITY/SSI/VETERAN'S BENEFITS

WE CALCULATE THAT STARTING **JANUARY 2012**, THE MONTHLY FEDERAL BENEFIT(S) OF YOU AND/OR YOUR DEPENDENTS WILL BE INCREASED BY A TOTAL OF $.

Because of this increase, your FA or SNA grant must be reduced by an equal amount.

This decision is based on Department Regulation 352.29.

MEDICAL ASSISTANCE: Your Medical Assistance will continue unchanged. This decision is based on Department Regulation 360-3.3.

FOOD STAMPS: Even though your public assistance grant will change, your food stamps will not change unless you get a separate notice telling you that your food stamps will change. This decision is based on Department Regulation(s) 387.10 and 387.15.

If you do not understand this notice or are in disagreement with the action we are taking, you may request a conference. To do so, visit your center or call on the telephone as soon as possible.

THE TELEPHONE NUMBER TO CALL FOR A CONFERENCE IS ( ) - .

BY REQUESTING A CONFERENCE YOU ARE NOT GIVING UP YOUR RIGHTS TO A FAIR HEARING PROVIDED THAT YOU REQUEST A HEARING WITHIN THE TIME LIMITS DESCRIBED ON THE ENCLOSED PAGE. SEE THE ENCLOSED PAGE FOR APPEAL PROCESS INFORMATION.

SEE BELOW FOR EXPLANATION OF YOUR NEW PA GRANT.

PRE-ADD CONCESIÓN PRE-SUMADA	_____	SSA INCOME INGRESO DE SEGURO SOCIAL	_____
SHELTER VIVIENDA	_____	SSI INCOME INGRESO DE SSI	_____
ENERGY ENERGÍA	_____	OTHER INCOME OTRO INGRESO	_____
ENERGY SUPPLEMENT SUPLEMENTO DE ENERGÍA	_____	TOTAL INCOME INGRESO TOTAL	_____
OTHER NEEDS OTRAS NECESIDASES	_____		
TOTAL NEEDS TOTAL DE NECESIDAADES	_____	PA GRANT CONCESIÓN DE PA	_____

Sincerely,
Matthew Brune, Executive Deputy Commissioner
Family Independence Administration

Attachment C

P.O. BOX 02-9121
Brooklyn GPO
Brooklyn, N.Y. 11202-9121

The City Of New York
HUMAN RESOURCES ADMINISTRATION
FAMILY INDEPENDENCE ADMINISTRATION

CONFERENCE PHONE
NÚMERO PARA CONFERENCIA

IMC/FSO :
CASE :
CLI :

FAM SIZE:
DATE: November 28, 2011

NOTICE OF INTENT TO REDUCE FOOD STAMP BENEFITS
PREAVISO DE REDUCCIÓN EN SUS BENEFICIOS DE CUPONES PARA ALIMENTOS

DEAR SIR/MADAM:

THIS IS TO INFORM YOU THAT WE INTEND TO REDUCE YOUR FOOD STAMP BENEFITS EFFECTIVE **JANUARY 1,2012** FOR THE FOLLOWING REASON:

BEGINNING JANUARY **2012**, SOCIAL SECURITY, SSI AND/OR VETERAN'S BENEFITS WILL INCREASE **BY 3.6%**. IF YOU ARE IN RECEIPT OF ANY OF THESE FEDERAL BENEFITS, THIS INCREASE IN INCOME TO YOUR HOUSEHOLD MUST BE CONSIDERED IN DETERMINING YOUR FOOD STAMP BENEFIT LEVEL. ***IF YOU ARE IN RECEIPT OF BOTH SOCIAL SECURITY BENEFITS AND SSI, YOUR JANUARY SSI BENEFITS WILL BE REDUCED BY THE AMOUNT OF YOUR SOCIAL SECURITY BENEFIT INCREASE. THESE INCOME CHANGES MUST ALSO BE CONSIDERED IN DETERMINING YOUR FOOD STAMP BENEFITS***.

IF YOU ARE AN SSI RECIPIENT LIVING ALONE IN THE COMMUNITY WHO IS PARTICIPATING IN THE NEW YORK STATE NUTRITION IMPROVEMENT PROJECT (NYSNIP), AND YOUR ONLY SOURCE OF INCOME IS SSI, YOUR MONTHY FOOD STAMP BENEFIT OF $200 WILL NOT CHANGE. IF YOU ARE AN SSI RECIPIENT LIVING ALONE IN THE COMMUNITY WHO IS PARTICIPATING IN THE NEW YORK STATE NUTRITION IMPROVEMENT PROJECT (NYSNIP), AND YOU RECEIVE INCOME IN ADDITION TO SSI AND YOUR RENT IS BELOW $235.00, BEGINNING IN **JANUARY 2012** YOU WILL RECEIVE $195.00.

IF YOU ARE A NYSNIP PARTICIPANT WHO WAS RECEIVING $60 PER MONTH IN FOOD STAMP BENEFITS, BEGINNING IN JANUARY 2012 YOU WILL RECEIVE $51 PER MONTH, IF YOU WERE RECEIVING $56 PER MONTH IN FOOD STAMP BENEFITS, BEGINNING IN JANUARY 2012 YOU WILL RECEIVE $47 PER MONTH, AS STATED ABOVE. THIS REDUCTION IN YOUR FOOD STAMP GRANT IS DUE TO THE INCREASE IN YOUR FEDERAL BENEFITS.

PAGE 2 OF THIS NOTICE IS A FINANCIAL FACT SHEET WHICH SHOWS YOUR NEW FOOD STAMP BENEFIT AMOUNT AND ALL THE INCOME INFORMATION ON OUR COMPUTER FILE THAT WAS USED TO CALCULATE YOUR NEW FOOD STAMP BENEFIT. WE HAVE ENCLOSED BUDGET WORKSHEETS WHICH YOU CAN USE TO DETERMINE WHETHER WE HAVE CORRECTLY DETERMINED YOUR NET FOOD STAMP INCOME. SEE 18 NYCRR 387.10, 387.12 AND 387.15.

POR MEDIO DE LA PRESENTE LE INFORMAMOS QUE REDUCIREMOS SUS BENEFICIOS DE CUPONES PARA ALIMENTOS A PARTIR DEL **1º DE ENERO DE 2012** POR LA SIGUIENTE RAZÓN:

COMENZANDO EN ENERO DE **2012**, LOS BENEFICIOS DE SEGURO SOCIAL, SSI Y/O BENEFICIOS A VETERANOS, AUMENTARÁN POR UN **3.6%**. SI USTED RECIBE ALGUNO DE LOS BENEFICIOS FEDERALES ANTES MENCIONADOS, ESTE AUMENTO EN EL INGRESO DE SU GRUPO FAMILIAR SE TOMARÁ EN CUENTA AL CALCULAR EL MONTO DE BENEFICIOS DE CUPONES PARA ALIMETOS QUE USTED RECIBE. ***SI USTED ACTUALMENTE RECIBE AMBOS BENEFICIOS, SEGURO SOCIAL Y SSI, EL MONTO DEL BENEFICIO DE SSI PARA EL MES DE ENERO SERÁ REDUCIDO POR EL MONTO DEL AUMENTO EN SU BENEFICIO DE SEGURO SOCIAL. ESTOS CAMBIOS EN INGRESO TAMBIÉN DEBEN TOMARSE EN CUENTA EN EL CÁLCULO DE SUS BENEFICIOS DE CUPONES PARA ALIMENTOS***.

SI USTED ES UN BENEFICIARIO DE SSI QUE VIVE SOLO(A) EN LA COMUNIDAD Y PARTICIPA EN EL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP), Y SU ÚNICA FUENTE DE INGRESOS ES SSI, SU BENEFICIO MENSUAL DE CUPONES PARA ALIMENTOS DE $200 NO CAMBIARÁ. SI USTED ES UN BENEFICIARIO DE SSI QUE VIVE SOLO(A) EN LA COMUNIDAD Y PARTICIPA EN EL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP), Y RECIBE INGRESOS ADEMÁS DEL SSI Y SU ALQUILER ES INFERIOR A LOS $235.00, COMENZANDO EN **ENERO DE 2012** USTED RECIBIRÁ $195.00.

SI USTED ES UN PARTICIPANTE DEL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP) QUE RECIBÍA $60 AL MES EN BENEFICIOS DE CUPONES PARA ALIMENTOS, COMENZANDO EN ENERO DE 2012, USTED RECIBIRÁ $51 AL MES; SI USTED RECIBÍA $56 AL MES EN CUPONES PARA ALIMENTOS, COMENZANDO EN ENERO DE 2012, USTED RECIBIRÁ $47 AL MES, TAL COMO SE ESTIPULA ARRIBA. ESTA REDUCCIÓN EN SU SUBVENCIÓN DE CUPONES PARA ALIMENTOS SE DEBE AL INCREMENTO EN SUS BENEFICIOS DEL GOBIERNO FEDERAL.

LA PÁGINA 2 DE ESTE AVISO ES UNA HOJA DE DATOS FINANCIEROS LA CUAL MUESTRA SU NUEVO MONTO DE BENEFICIOS DE CUPONES PARA ALIMENTOS COMO TAMBIÉN TODOS LOS DATOS SOBRE INGRESOS CONTENIDOS EN NUESTRO ARCHIVO COMPUTARIZADO Y EL CUAL FUE UTILIZADO EN EL CÁLCULO DE SU NUEVO MONTO DE BENEFICIOS DE CUPONES PARA ALIMENTOS. HEMOS ADJUNTADO HOJAS DE CÁLCULO DE PRESUPUESTO LAS CUALES USTED PUEDE UTILIZAR PARA DETERMINAR SI HEMOS CALCULADO CORRECTAMENTE SU INGRESO NETO EN RELACIÓN CON LA SUBVENCIÓN DE CUPONES PARA ALIMENTOS. CONSULTE 18 NYCRR 387.10, 387.12 Y 387.15.

SINCERELY,
ATENTAMENTE,
MATTHEW BRUNE, EXECUTIVE DEPUTY COMMISSIONER / SUBCOMISIONADO EJECUTIVO FAMILY INDEPENDENCE ADMINISTRATION

Attachment C

YOUR FINANCIAL FACTS CURRENTLY ON FILE
SUS DATOS FINANCIEROS ACTUALMENTE EN ARCHIVO

Previous Net Food Stamp Income
Ingreso anterior de cupones

Previous Monthly Coupon Amount
Cantidad anterior mensual de cupones

New Net Food Stamp Income
Nuevo Ingreso neto de cupones

New Monthly Coupon Amount
Nueva cantidad mensual de cupones

A. MONTHLY INCOME
Ingreso Mensual

1a. **Monthly Gross Income from Employment or Training.** *Ingreso bruto mensual por empleo o entrenamiento.*	
b. **Monthly Net Income from Self Employment.** *Ingreso neto mensual por trabajo por cuenta propia.*	
2a. **Net Monthly Income from Boarder/Lodger.** *Ingreso neto mensual que recibe del huesped/ inquillino*	
b. **Net Monthly Income from Lodger.** *Ingreso neto mensual que recibe del inquillino*	
3. **Total of Lines 1 and 2.** *Total de las liñeas 1 y 2.*	
4a. **Monthly Gross Unearned Income.** *Ingreso bruto mensual no devengado.*	
b.	
c.	
5. **Monthly Income from Educational Loans, Scholarships.** *Ingreso mensual por préstamos y becas educacionales.*	
6. **Total of Lines 3, 4, and 5.** A. *Total de lineas 3, 4 y 5*	$

B. DEDUCTIONS
Deducciones

7. **% of Line 3.** *% de linea 3*	
8. **Standard Deduction** **Monthly** *Deducción mensual estandar*	
9. **Monthly Child Care/Dependent Care Costs.** *Gastos mensuales por cuidado de ninos / de dependientes* **(Mamimum)** *(Maximo)*	
10. **Monthly Automatic Recoupment (from Public Assistance Grant)** *Recuperación mensual automatica(de subsidio de Asistencia Publica)*	
11. **Monthly Tuition and Mandatory Fees** *Gastos mensuales de colegiatura y cuotas obligatorias*	
12a. **Monthly Medical Expense (less $35 Deductible)** *Gasto medicos mensuales (menos $35 de deducible)*	
b.	
13. **Total Lines 7, 8, 9, 10, 11, and 12** *Total de lineas 7, 8, 9, 10, y 12* B.	$

C. ADJUSTED INCOME
Ingreso ajustado

14. **Subtract B from A.(Line 13 from Line 6.)** *Reste B de A. (Linea 13 de linea 6.)* C.	$

D. SHELTER COSTS
Gastos de Vivienda

15. **Monthly Rent or Mortgage actually paid.** *Renta o hipoteca actualmente pagada cada mes.*	
16. **Monthly Heating Expense** *Gasto mensual por calefacción.*	
17. **Monthly Utility Expense** *Gasto mensual por utilidades.*	
18. **Monthly Telephone Expense** *Gasto mensual por teléfono.*	
19. **Other Monthly Shelter Expense. (Real Estate Taxes, Insurance, Installation of Utilities, etc.)** *Otros gastos mensuales de vivienda. (Impuestos inmobiliarios, seguro, conexion de servicios publicos etc.)*	
20. **Total of Lines 15, 16, 17, 18, and 19.** *Total de lineas 15, 16, 17, 18 y 19* D.	$

E. FOOD STAMP NET INCOME
Ingreso neto por Cupones de Alimentos

21. **Excess Shelter Deduction (Line 20 minus ½ of Line 14. The total cannot be more than** *Deduccion de gastos de vivenda en exceso (linea 20 menos ½ de linea 14. El total no puede ser mas de)*	
22. **MONTHLY NET FOOD STAMP INCOME (Subtract Line 21 from Line 14.)** *Ingreso neto mensual de cupones (reste linea 21 de linea 14)*	
23. **MONTHLY COUPONS AMOUNT** *Cantindad mensual de cupones* E.	$

MINUS RECOUPMENT OF
MENOS EL REEMBOLSO DE

ADJUSTED COUPON AMOUNT
MONTO AJUSTADO DE CUPONES

Attachment C

Notice of Intent To Change Food Stamp Benefits Due To An Increase In Social Security, SSI and/or Veteran's Benefits

CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

If you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2:

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

1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

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

2. **STATE FAIR HEARING** – You have **90 days** from the date of this notice to ask for a fair hearing:

   KEEPING YOUR BENEFITS THE SAME: We will restore your Food Stamp Benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any Food Stamp Benefits you got, but should not have gotten, while you were waiting for the decision.

   If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a fair hearing or, if you send back this notice, check the box below:

   ☐ I do not want to keep my Food Stamp Benefits the same until the Fair Hearing decision is issued.

   If at the hearing, the hearing officer determines that you are not complaining about an incorrect computation of your benefits or that there has been a misapplication or misinterpretation of Federal Law or regulations, the hearing officer may determine that you were not entitled to have your Food Stamp Benefits continue unchanged until the fair hearing decision is issued, and order that the reduction take effect immediately.

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by **mail**, by **phone**, by **fax,** by **walk-in** or **online**.

Mail: Send a copy of the notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

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

_____

_____

Phone: **800-342-3334** (Please have this notice with you when you call.)

Fax: Fax a copy of the front and reverse of this notice to: **(518) 473-6735**.

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn.

Online: Complete an online request form at: **http://www.otda.ny.gov/oah/forms.asp**.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, fax, walk-in or on-line, please write to ask for a fair hearing before the deadline.

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

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

To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements.

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

LEGAL ASSISTANCE: If you think you need a lawyer to help you with this problem, you may be able to get a lawyer at no cost to you by contacting your local Legal Aid Society or other legal advocate group. For the names of other lawyers, check your 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 file. If you call, write or fax to 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 to us, we will send you free copies of other specific documents from your files which you think you may need to prepare for your Fair Hearing. To ask for documents or to find out how to look at your file, call **(718) 722-5012**, or fax **(718) 722-5018** or write to **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201.**

If you want copies of 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 us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

Notice Date: November 28, 2011 **Effective Date: January 1, 2012** **NYC FS COLA '12**

XL263C (11/11)

Attachment C

Preaviso de cambios en los beneficios de Cupones para Alimentos debido a un aumento en los beneficios del Seguro Social, SSI y/o beneficios para Veteranos

CONFERENCIAS Y AUDIENCIAS IMPARCIALES: ¿CREE QUE NOS HEMOS EQUIVOCADO?

Si cree que nuestra decisión es incorrecta, puede solicitar una revisión de nuestra decisión. Corregiremos nuestro error. Usted puede tomar ambas acciones, 1 y 2:

1. Solicitar una reunión (conferencia) con un supervisor; 2. Solicitarle al Estado una audiencia imparcial con un funcionario estatal de audiencias.

1. **CONFERENCIA** (reunión informal con nosotros): si usted cree que nuestra decisión es incorrecta o si no comprende nuestra decisión, sírvase llamarnos para solicitar una reunión. Llame al número de teléfono para conferencias que aparece en el **anverso** de esta notificación o escríbanos a la dirección que aparece en el **anverso** de esta notificación. En algunos casos, ésta es la forma más rápida de resolver problemas. Le recomendamos hacerlo, aunque haya solicitado una audiencia imparcial.
   Si solamente solicita una reunión con nosotros, no mantendremos sus beneficios al mismo nivel mientras dure el proceso de apelación. Sus beneficios se mantendrán sin cambios solamente si usted solicita una audiencia imparcial estatal. (Vea la sección abajo titulada «Mantener sus Beneficios sin Cambios»).

2. **AUDIENCIA IMPARCIAL ESTATAL:** usted tiene **90 días**, contados a partir de la fecha de esta notificación, para solicitar una audiencia imparcial:

   MANTENER SUS BENEFICIOS SIN CAMBIOS: reanudaremos sus beneficios de Cupones para Alimentos al mismo nivel en que estaban antes de esta notificación si usted solicita una audiencia imparcial antes de la fecha de vigencia señalada en esta notificación. Sin embargo, si la audiencia imparcial no se decide a su favor, tendrá que devolver todos los beneficios de Cupones para Alimentos que recibió, pero que no debería haber recibido mientras esperaba por la decisión de la audiencia.

   Si usted no quiere que sus beneficios continúen al mismo nivel hasta que se remita la decisión, deberá informárselo al Estado cuando llame para solicitar una audiencia imparcial o si usted devuelve esta notificación, marque la casilla a continuación:

   ☐ No deseo que mis beneficios de Cupones para Alimentos continúen al mismo nivel hasta que se remita la decisión de la audiencia imparcial.

   Si durante la audiencia, el oficial a cargo, determina que su queja no tiene que ver con un cálculo incorrecto de sus beneficios o si determina que la ley federal o reglamento se interpretó o se aplicó de la manera indebida, el oficial puede dictaminar que usted no tenía derecho a que continuarán sus beneficios de cupones para alimentos sin cambios en espera de la decisión de la audiencia imparcial, y como resultado ordenar que la reducción entre en vigor inmediatamente.

CÓMO SOLICITAR UNA AUDIENCIA IMPARCIAL: puede solicitar una audiencia imparcial por **correo,** por **teléfono,** por **fax,** en **persona o** por **internet.**

Por correo: envíe una copia de esta notificación rellenada a: *Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201*. Favor de quedarse con una copia.

☐ Deseo una audiencia imparcial. No estoy de acuerdo con la decisión de la agencia. (Puede explicar a continuación por qué no está de acuerdo, aunque no tiene que incluir una explicación por separado). _____

_____

Por teléfono: 800-342-3334 (Favor de tener a mano este aviso cuando llame).
Por fax: envíe por fax una copia del anverso y reverso de esta notificación al: **(518) 473-6735**.
En persona: traiga una copia de todas las partes de esta notificacion al New York State Office of Temporary and Disability Assistance ubicado en el 14 Boerum Place, Brooklyn.
Por internet: Complete an online request form at: **http://www.otda.ny.gov/oah/forms.asp**.

Si no puede comunicarse con la Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York por teléfono, por fax, en persona o por Internet, favor de solicitar por escrito una audiencia imparcial antes del vencimiento del plazo.

LO QUE SUCEDE EN UNA AUDIENCIA IMPARCIAL: el Estado le enviará un aviso informándole cuándo y dónde se realizará la audiencia imparcial. En la audiencia, usted tendrá la oportunidad de explicar por qué cree que nuestra decisión es incorrecta. Puede traer consigo a un abogado, a un familiar o a un(a) amigo(a), o a alguien más que pueda ayudarle a exponer su caso. Si usted no puede presentarse, puede enviar a otra persona en su representación. Si la persona que lo representará no es un abogado, debe entregarle a esta persona una carta, dirigida al funcionario de audiencias, en la cual usted declara que desea que dicha persona lo represente en la audiencia.

En la audiencia, usted y su abogado u otro representante, tendrán la oportunidad de explicar por qué creen que nuestra decisión es incorrecta, como también la oportunidad de presentar, ante el funcionario de audiencias, documentos que demuestren nuestra equivocación.

Con el fin de ayudarle a exponer el motivo de nuestra equivocación, le sugerimos presentar testigos que puedan avalar su caso. También, le sugerimos presentar documentos tales como: comprobantes de pagos salariales, contrato de alquiler, recibos, cuentas médicas, etc.

En la audiencia, usted y su abogado u otro representante, podrán interrogar a los testigos que nosotros presentemos o los que usted presente con motivo de avalar su caso.

ASISTENCIA LEGAL: si cree que necesita representación legal en la resolución de este problema, puede obtener los servicios de un abogado, sin costo alguno, comunicándose con la Sociedad de Ayuda Legal *(Legal Aid Society)* u otra asociación de defensa legal de su localidad. Puede encontrar los nombres de otros abogados en las páginas amarillas, bajo «Abogados» *("Lawyers").*

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: en preparación para la audiencia imparcial, usted tiene derecho a revisar el archivo de su caso. Si nos llama, nos escribe o nos envía un fax, le enviaremos copias gratis de documentos en su archivo; los mismos que entregaremos al funcionario de audiencias en la audiencia imparcial. Además, si nos llama o nos escribe o nos manda un fax, le enviaremos copias gratis de documentos específicos en su archivo y los cuales usted considere necesarios en preparación para la audiencia imparcial. Si desea solicitar documentos o averiguar la modalidad a seguir para consultar su archivo, llámenos al **(718) 722-5012,** fax **(718) 722-5018** o mande una carta a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201.**

Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Se le proporcionarán dentro de un lapso de tiempo razonable antes de la fecha fijada de la audiencia. Los documentos se le enviarán por correo sólo si usted específicamente los solicita.

INFORMACIÓN: si desea información adicional sobre su caso, cómo solicitar una audiencia imparcial, cómo consultar su archivo o cómo obtener copias adicionales de documentos, sírvase llamarnos al número de teléfono señalado en el **anverso** de este aviso o mande una carta a la dirección que figura en el **anverso** de esta notificación.

Fecha del aviso: 28 de noviembre de 2011 **Fecha de vigencia: 1 de enero de 2012** **NYC FS COLA 2012**

Form W-200G
Rev. 12/12/11

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

Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid

(Effective January 1, 2012)

The Human Resources Administration (HRA) provides a shelter allowance and a personal needs allowance so that low-income aged or disabled adults who need a supervised and supportive living arrangement can afford housing in state licensed homes and residences. The type of care that is offered in these homes and residences is known as congregate care. HRA provides an allowance for each individual receiving care in a Level 1, Level 2, or Level 3 certified congregate care facility who files an application and is deemed eligible for Cash Assistance (CA). The allowance is based on the rates provided for care and maintenance under the Supplemental Security Income (SSI) Program for SSI beneficiaries residing in the same facility, less the amount of any personal needs allowance included in the SSI rate. There are three (3) levels of congregate care facilities, each with a different rate of payment. These rates change each year in accordance with the Cost of Living Adjustment (COLA) received by SSI recipients.

Congregate Care Level	Shelter Type	Description	Semimonthly Shelter Rate	Semimonthly Personal Needs Allowance
Level 1	**15**	Family-type homes for adults licensed by the Office of Children and Family Services (OCFS), Office of Mental Health (OMH), or Office of Mental Retardation and Developmental Disabilities (OMRDD) and operated by HRA through the Division of Voluntary and Proprietary Homes for Adults (DVPHA). These are smaller residential programs serving the mentally retarded, the mentally ill, and the frail elderly.	$414.50	$67.50
Level 2	**16**	Adult homes licensed through the New York State Department of Health (DOH) and community residences licensed through OMH.	$489.00	$77.50
	43	Community residences licensed through OMH/OMRDD. These are principally small group homes and supported apartments. Cases that were previously coded as Shelter Type **16**, but live in an apartment-like setting and are now coded as Shelter Type **43**. The case can be larger than a family size of 1.		
Level 3	**42**	DOH Adult Homes and Enriched Housing facilities. The case **must be** a family size of 1.	$604.00	$92.00

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

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

Congregate Care Budget Worksheet

(Effective January 1, 2012)

Use this form for households residing in congregate care shelter (shelter type codes **15, 16, 27, 28, 29, 31, 32, 42,** or **43**) only.

Total Household size _____ Number in-Care _____ Number not-in-Care _____

Enter shelter type code _____

Section 1: Calculation of Income/Needs

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

A. Unearned Income:				**S/M Amounts**
		How Often	**Gross Income**	
1.	Workers' Compensation			$
2.	New York State Disability			$
3.	Unemployment Insurance Benefits			$
4.	Supplemental Security Income (SSI)			$
5	Social Security benefits (non SSI)			$
6.	Veterans' pension or compensation			$
7.	Black Lung disease program			$
8.	Spina bifida			$
9.	Child support/Combined Child and Spousal Support[1] **Total Amount of Child Support** **Income** | **Number of Children** (If household is in receipt of child support/combined child and spousal support income, subtract up to $50/$100 from the S/M amount above and enter the net amount on the right-hand side.)			$
10.	Other (including Alimony/Spousal Support Only[2]) (specify):			$
11.	**Total S/M Unearned Income (add lines 1 through 10)**			$

[1] CA households with one child are entitled to have up to $50 S/M disregarded and households with two or more children are entitled to have up to $100 S/M disregarded. If determined eligible for cash assistance, child support/combined child and spousal support is not budgetable but is assigned to the Agency through the Office of Child Support Enforcement (OCSE).

[2] No disregards are applied. Income received from combined child and spousal support where the last child on the CA case is 21 years of age or older, or alimony/spousal only support orders.

Section 1: Calculation of Income/Needs (continued)

Total number in household _____

B. Household Needs I. In-Care Household Member(s)		S/M Amounts
12.	Personal needs allowance (PNA)	$
13.	Actual shelter cost (see Maximum Shelter Rate on chart below)	$
14.	**Total S/M needs for in-care household member(s) (add lines 12 and 13)**	$

B. Household Needs II. Not-In-Care Shelter Resident(s)		S/M Amounts
15.	PNA* (see chart below based on shelter type code)	$
16.	Room and/or Board (rate negotiated by facility)	$
17.	**Total S/M needs for not-in-care shelter resident(s) (add lines 15 and 16)**	$

* For shelter type code 43, use the basic CA grant amount that includes the pre-added allowance, energy grant, and pro-rated shelter of the shelter maximum for the household size.

B. Household Needs III. All Household Members		S/M Amounts
18.	Other (specify):	$
19.	Pregnancy allowance (Enter the number of medically verified pregnant women on the case)	$
20.	**Total S/M household needs (add lines 14, 17, 18, and 19)**	$

Personal Needs Allowances and Shelter Rates		
Shelter Type	**S/M PNA**	**S/M Shelter Rate**
15	$67.50	$414.50
16 31 43	$77.50	$489.00
29 32	$77.50	$474.00
27	$22.50	Negotiated Rate
28	$67.50	$395.50
42	$92.00	$604.00

Section 2: 185% Gross Income Limitation Calculation

21.	Multiply amount on line 20 by 1.85	$
22.	Compare amount entered on line 11 with amount on line 21. (a) If the amount entered on line 11 is greater than the amount on line 21, the household does not meet the 185% Gross Income Limitation and is ineligible for Cash Assistance (CA) – check ☑ ineligible. Do not continue. Complete Form **W-122D/W-122DD** to determine Food Stamp (FS) eligibility. (b) If the amount entered on line 11 is equal to or less than the amount entered on line 21, the household meets the 185% Gross Income Limitation – check ☑ eligible. Complete Section 3.	☐ Ineligible ☐ Eligible

Section 3: Net Income Test

		S/M Amounts
23.	Total S/M unearned income (from line 11)	$
24.	Total S/M household needs (from line 20 - round down to the nearest 50¢)	$
25.	OCSE sanction: Enter 25% needs reduction amount, if applicable (multiply amount on line 24 by 0.25)	$
26.	S/M needs (line 24 minus line 25)	$
27.	Budget deficit (line 26 minus line 23 – round down to the nearest 50¢) Enter amount if greater than zero (0). If equal to or less than zero (0), do not enter amount here; enter amount on line 28.	CA Grant $
28.	Budget surplus – if amount on line 23 is equal to or more than line 26, the household has **failed the net income test** and is **not eligible for CA**. Complete Form **W-122D/W-122DD** to determine FS eligibility.	$

Authorization Period: From: _____ To: _____.

Authorized by

Date

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

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

Hoja de Cálculos de Presupuesto para Cuidado en Grupo

(A partir del 1ro de enero, 2012)

Use este formulario para hogares que residen en un refugio de cuidado en grupo (códigos de tipo de refugio **15, 16, 27, 28, 29, 31, 32, 42,** o **43**) solamente.

Número Total de Personas en el Hogar_____ Número de Personas en Cuidado_____
Número de Personas fuera de Cuidado_____

Anote el código de tipo de refugio_____

Sección 1: Cálculos de Ingreso/Necesidades

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

A. Ingreso No Salarial:				**Cantidad Quincenal**
		Con qué Frecuencia	**Ingreso Bruto**	
1.	Indemnización para Trabajadores			$
2.	Indemnización para Incapacitados del Estado de Nueva York			$
3.	Beneficios de Seguro de Desempleo			$
4.	Ingreso Suplemental de Seguridad (SSI)			$
5	Beneficios de Seguro Social (no SSI)			$
6.	Pensión o indemnización para Veteranos			$
7.	Programa de enfermedad de Pulmón Negro (Black Lung disease program)			$
8.	Espina bífida			$
9.	Ingreso de Manutención de Niños/Manutención de Niños y Conyugal Combinada[1] **Total de la Manutención de Niños** **Ingreso** | **Número de Niños** (Si el hogar recibe ingreso de manutención de niños/manutención de niños y conyugal combinada, reste hasta $50/$100 de la cantidad quincenal de arriba y anote la cantidad neta correspondiente a la mano derecha.)			$
10.	Otro ingreso (incluyendo Sólo Pensión Alimenticia/Pensión Conyugal[2]) (especifique):			$
11.	**Total Quincenal de Ingresos no Salariales (sume las líneas 1 a 10)**			$

[1] Los hogares de Asistencia en Efectivo (CA) de un niño tienen derecho a que se omita hasta $50 quincenales, y los hogares de dos o más niños tienen derecho a que se omita hasta $100 quincenales. Si a usted se le determina elegible para asistencia en efectivo, la manutención de niños/pensión alimenticia y pensión conyugal combinada no es presupuestable, sino que se asignará a la Agencia mediante la Oficina de Aplicación de Manutención de Niños (Office of Child Support Enforcement - OCSE).

[2] No corresponden omisiones al ingreso recibido de órdenes de manutención de pensión alimenticia y conyugal combinada donde el último niño en Asistencia Efectivo (CA) tiene 21años de edad o más o sólo de pensión alimenticia/conyugal.

Sección 1: Cálculos de Ingreso/Necesidades(continuación)

Número total en el hogar _____

B. Necesidades del Hogar I. Miembro(s) del Hogar en Cuidado		Cantidad Quincenal
12.	Asignación para necesidades personales (PNA)	$
13.	Costo actual de alojamiento (vea la tarifa máxima de albergue en la tabla más abajo)	$
14.	**Total de necesidades quincenales para miembro(s) del hogar en cuidado (sume las líneas 12 y 13)**	$

B. Necesidades del Hogar II. Residente(s) en Refugio(s) Fuera de Cuidado		Cantidad Quincenal
15.	PNA* (vea la tabla más abajo basada en el código de tipo de albergue)	$
16.	Hospedaje y/o comidas (tarifa negociada por el local)	$
17.	**Total de necesidades quincenales para residente(s) en refugio(s) fuera de cuidado (sume las líneas 15 y 16)**	$

* Para tipo de código de refugio 43, use la cantidad de concesión básica de CA que incluye una asignación añadida anteriormente, concesión de energía, y alojamiento prorrateado del refugio máximo para el tamaño del hogar.

B. Necesidades del Hogar III. Todos los Miembro(s) del Hogar		Cantidad Quincenal
18.	Otra necesidad (especifique):	$
19.	Asignación para embarazo (Anote el número en el caso de embarazadas verificado por un médico ____)	$
20.	**Total de necesidades quincenales para miembro(s) del hogar (sume las líneas 14, 17, 18, y 19)**	$

Concesiones para Necesidades Personales y Tarifas de Albergue

Tipo de Albergue	PNA Quincenal	Tarifa Quincenal de Albergue
15	$67.50	$414.50
16 31 43	$77.50	$489.00
29 32	$77.50	$474.00
27	$22.50	Tarifa Negociada
28	$67.50	$395.50
42	$92.00	$604.00

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

21.	Multiplique la cantidad de la línea 20 por 1.85	$
22.	Compare la cantidad marcada en la línea 11 con la cantidad de la línea 21. (a) Si la cantidad de la línea 11 supera la cantidad de la línea 21, el hogar no cualifica según la Limitación del 185% del Ingreso Bruto y no es elegible para Asistencia en Efectivo (Cash Assistance – CA) – marque ☑ Inelegible. No siga llenando el formulario. Llene el formulario **W-122D (S)/W-12DD (S)** para determinar si es elegible para Cupones para Alimentos (Food Stamps – FS).	☐ Inelegible
	(b) Si la cantidad en la línea 11 es igual a o menor que la cantidad de la línea 21 el hogar cualifica según la Limitación del 185% del Ingreso Bruto – marque ☑ la casilla elegible. Llene la Sección 3.	☐ Elegible

Sección 3: Prueba de Ingreso Neto

		Cantidad Quincenal
23.	Total quincenal de ingresos no salariales (línea 11)	$
24.	Total de necesidades quincenales del hogar (cantidad de la línea 20 – redondee a los 50¢ inferiores)	$
25.	Sanción de OCSE: Anote la cantidad de la reducción del 25% de necesidades, si corresponde (multiplique la cantidad de la línea 24 por 0.25)	$
26.	Necesidades quincenales (línea 24 menos la línea 25)	$
27.	Déficit presupuestario (línea 26 menos línea 23– redondee a los 50¢ inferiores). Anote la cantidad si es más que cero (0). Si la cantidad equivale o es menos que cero (0), no anote la cantidad aquí; anótela en la línea 28.	Concesión CA $
28.	Excedente de presupuesto – si la cantidad de la línea 23 equivale o es más que la cantidad de la línea 26, el hogar **no ha pasado la prueba de ingreso salarial neto** y **no es elegible para Asistencia Efectivo**. Llene el Formulario **W-122D (S)/W-12DD (S)** para determinar la elegibilidad de Cupones para Alimentos.	$

Período de Autorización: De: _____ A: _____.

_____ _____

Autorizado por Fecha