Human Resources Administration
Department of Social Services

FAMILY INDEPENDENCE ADMINISTRATION

Matthew Brune, Executive Deputy Commissioner

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

Stephen Fisher, Assistant Deputy Commissioner
Office of Procedures

POLICY DIRECTIVE #13-26-ELI

(This Policy Directive Replaces PD # 00-18R)

INTENTIONAL PROGRAM VIOLATIONS

Date: November 7, 2013	**Subtopic(s):** Eligibility, Budgeting

AUDIENCE

This Policy Directive is for Job Center and Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Center Staff and is informational for all other staff.

REVISIONS TO THE PRIOR DIRECTIVE

This Policy Directive has been revised to inform staff that:

- Job Center and SNAP Center Workers are responsible to report suspected Intentional Program Violations (IPVs) to the Bureau of Fraud Investigation (BFI).
- the BFI referral process to report suspected fraudulent activity has been automated.
- the Cash Assistance (CA) and SNAP processing of IPVs has been combined into one process, with some exclusions.
- Job Center/SNAP Center Workers will contact SNAP-CR via e-mail. Job Center/SNAP Center Workers cannot lift IPVs.
- the Supplemental Nutrition Assistance Program Claims and Recovery (SNAP-CR) Unit, located at 98 Flatbush Avenue, 1st Floor, Brooklyn, New York 11217, will implement and lift all IPVs.
- SNAP-CR will take appropriate action and inform Center Staff so that they can make an eligibility determination.
- applicants/participants will receive a notice of disqualification for benefits when an IPV has been implemented.
- a message on the Turn-Around Document (TAD) is generated to alert the worker that an IPV action has been taken.

Formerly known as the Food Stamp Claims and Recovery Unit.

POLICY

The case of an applicant/participant who is suspected of committing an IPV should be referred to BFI by a JOS/Worker. If necessary, BFI will refer the case to the District Attorney's office for criminal prosecution or to the Office of Temporary and Disability Assistance (OTDA) to schedule an Administrative Disqualification Hearing (ADH) to assess the evidence and render a decision. An IPV can *only* be established in court or by an ADH.

BACKGROUND

Revised

An Intentional Program Violation (IPV) for Cash Assistance (CA), or for the Supplemental Nutrition Assistance Program (SNAP), is defined as the commission of one or more acts in violation of the program standards. An IPV occurs when an individual intentionally misrepresents, conceals or withholds facts in order to establish a CA or SNAP case or increase benefits.

The number of previous offenses and the dollar amount of the overpayment determine the period of disqualification. The IPV period of disqualification will be counted against the CA time limit. It should be noted that an IPV can exist where there is no overpayment.

Job Center/SNAP workers are responsible to refer suspected fraudulent activity, which may or may not result in an overpayment, to the Bureau of Fraud Investigation (BFI).

Once BFI receives the referral, it will conduct an investigation of the allegations and determine if the case should be referred to the District Attorney's office for prosecution.

If BFI determines that the participant has committed fraud and a potential CA or SNAP IPV exists, and a referral to the District Attorney has not been made, BFI will refer the case to OTDA for an ADH.

When BFI requests an ADH and receives a decision favorable to the applicant/participant, it will notify the Division of Financial Review and Processing (DFRP) to initiate CA recoupment and SNAP-CR to initiate SNAP recoupment, and take no further action on the case.

In instances where BFI requests an ADH and receives a decision favorable to the agency, it will notify SNAP-CR of the CA and/or SNAP decision.

Revised

The Supplemental Nutritional Assistance Program Claims and Recovery (SNAP-CR) Unit located at 98 Flatbush Avenue, 1st Floor, Brooklyn, New York 11217, general telephone number (718) 666-4314, will receive a packet from BFI containing notifications of decisions which are favorable to the Agency.

IPV Indicators

In certain instances, individuals will be found guilty of an IPV. In these cases the following indicators will be data entered on the **Individual Inquiry** screen (**NQIN2A**):

- A "**P**" (CA IPVs only) for an applicant/participant disqualified from receiving **CA** only and is not entitled to immediate needs but may be eligible for expedited SNAP benefits. The other members of the household, if otherwise eligible, are entitled to receive immediate needs and expedited SNAP benefits.

- An "**F**" (SNAP IPVs only) for an applicant/participant disqualified from receiving SNAP benefits and is not entitled to expedited SNAP benefits but may be eligible for immediate needs. The other members of the household, if otherwise eligible, are entitled to receive immediate needs and/or SNAP benefits.

- A "**B**" (both CA and SNAP IPVs), for an applicant/participant disqualified from receiving CA and SNAP benefits and is not entitled to any immediate needs or expedited SNAP benefits. The other members of the household, if otherwise eligible, are entitled to receive immediate needs and SNAP benefits.

- An "**L**" for applicants/participants whose IPV has been lifted.

All indicators are Client Identification Number (CIN) specific and will follow the applicant from case to case. Codes **P, F,** and **B** are used to identify individuals with an IPV sanction period that must be served before receiving benefits.

The action is identified with "EPF (SNAP-CR)" as the originating center in the Welfare Management System (WMS). No other Center can enter IPV codes. These codes are entered by using the Intentional Program Violation (IPV) Ancillary Document (**LDSS-4707**) form.

REQUIRED ACTION:

Processing Potential CA and SNAP IPVs

When the Worker suspects that an applicant/participant is involved in fraudulent activity he/she should:

Revised

- obtain copies of all questionable documents or information;
- scan and index all non-Paperless Office System (POS) forms and notices that are signed by the individual and all documents received from other program areas (**except domestic violence related documents**) into the electronic case record;
- make an entry in the applicant's/participant's case record;
- make an automated fraud referral to BFI using the electronic Referral to Bureau of Fraud Investigation, form **BFI-105(E)** via the HRA intranet homepage or POS; and

See PD #12-12-OPE Fraud Referrals to BFI

- fax all scanned and indexed relevant documents from the electronic case record to the **BFI Intake & Tracking Control Division** at (212) 274-5612. Include the case name, Case number, Center name and number, Worker number, and a list of the documents that are being faxed.

  The Worker must not:

  - inform the applicant/participant that suspected fraudulent activity has been referred to BFI.
  - refer recoupments resulting from an untimely report of new income, a change in income, or changes in household composition to BFI.

If, after its investigation, BFI receives an ADH decision favorable to the Agency, BFI will send a packet to SNAP-CR. Within 10 days of receiving the packet, SNAP-CR will:

- for closed cases, place an IPV indicator (see IPV indicators on page 3), on the case utilizing Form **LDSS-4707**.
- for active cases, impose an incremental sanction only as follows:
  - calculate a new budget to reduce the number of household members by the number of sanctioned individuals on the **Household/Suffix Financial Data** screen (**NSBL02**).
  - On the **Individual Income/Needs** screen (**NSBL06**):
    - Change the **PA** status to **SN**.
    - Enter Code **42** in the **Income Source** field
    - Enter the budget deficit prior to the sanction in the **Gross Income** amount field so that SNAP benefits are not increased.

See PD #03-48-ELI for code **42** usage.

The income and resources of a disqualified individual must be considered in determining the remaining case member's eligibility and degree of need for receiving CA/SNAP benefits.

- prepare a **TAD** as follows:
  - If the case is closed due to an IPV sanction, **PA "To"** (element **227**) should be used to indicate the start date of the sanction.
  - If the case is denied due to an IPV sanction, **PA "From"** (element **226**) should be used to indicate the start date for the sanction.
  - Calculate and save a budget, and enter the budget number in element **015**.
  - If a line on a multi-person case is sanctioned/denied due to an IPV sanction, **PA "Date"** (element **332**) should be used to indicate the start date for the sanction.
- if applicable, process a recoupment for any CA/SNAP IPV overpayment.

  Note: If a claim is amended from an Inadvertent Household Error (IHE) to an IPV due to an ADH, SNAP-CR will use the Supplemental Nutrition Assistance Program (SNAP) Recoupment Data Entry Form-WMS (**LDSS-3513**) form to change the claim type from IHE to IPV.

Revised

- send a manual Intentional Program Violation (IPV) Disqualification Notice for The Public Assistance Program (**LDSS-4827 NYC**) form**,** and/or the Intentional Program Violation (IPV) Disqualification Notice for Supplemental Nutrition Assistance Program (SNAP) (**LDSS-4799**) form, to inform the applicant/participant that he/she must contact SNAP-CR no later than 30 days before the disqualification period ends in order to prevent a delay in receiving assistance.

- generate a Client Notice System (CNS) notice to the applicant/participant explaining the actions taken on the case.

Revised

A message on the **TAD** ("IPV on Line 01"), is generated in the lower left corner to alert the worker that an IPV action has been taken on a particular line. These indicators can also be found in WMS on the **Client Infraction** screen (option **14**) of the **Individual Inquiry Menu** screen (**NQIN00**).

New

Note: Job Center/SNAP Center Workers cannot lift IPVs. If a Worker attempts to lift an IPV, the WMS error message "**IPV Reason CDS ORIG-ID MUST BE EPF**" will appear.

If WMS has IPV indicators of **P, F**, and **B,** benefits are not to be issued for the individual in question. If the WMS has an IPV indicator of **L**, SNAP-CR has lifted the individual's sanction and benefits can be issued, if otherwise eligible.

Revised

Re-Application of Single Person Household

When an individual re-applies and an IPV indicator is associated with his/her CIN number, the Job Center/SNAP Center Worker should:

- proceed with the normal application process.
- determine if the individual is otherwise eligible.
    - If the applicant fails to comply with the application process or is otherwise *ineligible* (i.e. excess income or resources) the case should be denied.
    - If the applicant is otherwise *eligible*, an email must be sent to the SNAP-CR Director, Emma McMillin, and the Unit Supervisors, Jacqueline Frazier and Sharon Ringer, with a cc: to the Executive Director Martin Cornish and Deputy Director Shirika Francis, asking for the sanction to be lifted.

New

When contacted by the Center, SNAP-CR will:

- review WMS for a valid IPV status (**WF** or **WS 1**, **2**, or **3**)
- check the HRA ONE VIEWER for documentation of the original sanction implementation and whether the sanction period has or has not expired:
    - If the sanction has not expired, SNAP-CR immediately contacts the Center via email to inform the on site designee that the applicant is not eligible to receive benefits.
    - If the sanction has expired, SNAP-CR will:
        - lift the sanction, place the sanctioned line in **SI** status, and then close the line.
        - contact the Center via email to inform the on site designee of the action and to continue with eligibility processing.

Revised

Re-Application of an Individual in a Multi-Person Household

When a multi-person household applies for assistance and an IPV indicator for an individual is associated with the case, the Job Center/SNAP Center Worker should:

- proceed with the normal application process.
- determine eligibility for the entire household.

  Note: SNAP-CR should not be contacted if the failure of any household member to cooperate with the application process results in a rejection (**RJ**) of the entire case, or if the household is otherwise ineligible (i.e., excess income or resources).

- after the eligibility process is completed and the household, including the IPV individual, is determined eligible, contact SNAP-CR to acquire the email address of the SNAP-CR Unit Coordinator. Send an e-mail to the SNAP-CR Unit Coordinator (with a "cc:" to the Director and Deputy Director) asking for the sanction.

  Note: If any member of the household is **RJ** for **CA** only, not resulting in the entire case being **RJ**, and a Separate Determination for SNAP benefits is required, SNAP-CR must be contacted.

Within 10 days of receiving the e-mail, SNAP-CR will:

- review WMS for the IPV sanction status (**WF** or **WS 1**, **2**, or **3**) and/or an IPV indicator (**P**, **F** or **B**).
- check the HRA ONE VIEWER for documentation concerning implementation of the original sanction and to verify if the sanction has or has not expired.

  If a sanction has not expired, SNAP-CR will:

  - prepare the **LDSS-4707** for data entry to lift the IPV indicator (**P**, **F** or **B**), for the Job Center/SNAP worker to take action on the case, or;
  - prepare a **TAD** if the IPV sanction status is **WF** or **WS 1**, **2**, or **3** to remove the sanction (see page 8 for preparing a **TAD** to lift the sanction), for the Job Center/SNAP worker to take action on the case.
  - close the individual's line by entering the following on the **TAD**:

- The **CIN** in element **301**
- The appropriate **Categorical Code** in element **372**
- The **PA** Status of **CL** in element **330**.
- The appropriate IPV code in the **PA** Reason element **331**.
- The **date of eligibility** in the **PA** "**Date**" element **332** (same date as element **226**).

- contact the Center via email to inform the on site designee that the individual is not eligible to receive benefits.

  Note: SNAP-CR will re-implement the sanction on the individual's line once a case has been accepted (**AC**).

See PB #08-121-SYS for appropriate Food Stamp Interview (FSINTW) code for NCA SNAP cases.

- annotate the History Sheet (**W-25**).

If the sanction has expired, SNAP-CR will:

- prepare the **LDSS-4707** for data entry to lift the IPV indicator or;
- take the following action and prepare the **TAD** by making entries in the following elements to lift the sanction:

  - Calculate and save a new budget in WMS.
  - Change the saved budget number in **015**.
  - Enter **PA** Status of **SI** (to lift the sanction) in **221**.
  - Enter the appropriate **PA** opening reason code in **222** (see codes manual for reference).
  - If applicable, enter the appropriate **FSINTW** code (**F**, **P**, **H**, or **N**) in **060**.
  - Enter the date of eligibility in the **PA** "**From**" date in **226**.
  - Enter **FS** Status of **SI** in **230**.
  - Enter **099** as the **FS** opening reason code in **231**.
  - Enter the date of eligibility in the **FS** "**From**" date in **235**.
  - Enter the **CIN** of each household member in **301**.
  - Enter the **social security validation code** for each household member in **321**.
  - Enter the appropriate **categorical code** for each household member in **372**.
  - Enter the **employability status code** for each household member in **375**.

  Elements **304** (**TASA**), **382** (**ACI**), **324** (**Veteran status**), **387** (**Marital status**), **388** (**Educational level**), **390** (**Highest Degree Obtained**), and **391** (**Relationship**) are must fill areas based on line specific characteristics.

To the close the individual's line when the sanction has expired (for Job Center staff to continue eligibility processing), SNAP-CR will enter the following on the **TAD**:

- The **CIN** in element **301**.
- The appropriate **Categorical Code** in element **372**
- The **PA** Status of **CL** in element **330**.
- The **date of eligibility** in the **PA** "**Date**" element **332** (same date as element **226**).

Time Limits

When an individual is sanctioned or rejected due to an IPV and subsequently exhausts his/her 60 month lifetime CA limit, the individual can only be found eligible in the Safety Net Non-Cash category upon reapplication.

The following are IPV Individual/Case (HH=1) Rejection, Removal, Closing, and Sanction codes:

PA (CA) codes:

Code M78 (Case Rejection code only) – Committed an IPV previously.

Code WS1 1st Offense – found guilty of committing an IPV and wrongly received an amount less than $1000 - 6 month disqualification

Code WS2 2nd Offense – found guilty of committing an IPV and wrongly received an amount less than $3,900 - 12 month disqualification

Code WS3 1st Offense – found guilty of committing an IPV and wrongly received an amount between $1,000 and $3,900 – 12 month disqualification

Code WS4 3rd Offense – found guilty of committing an IPV and wrongly received any amount of money – 18 month disqualification

Code WS5 1st Offense – found guilty of committing an IPV and wrongly received an amount more than $3,900 – 18 month disqualification

Code WS6 2nd Offense – found guilty of committing an IPV and wrongly received an amount more than $3,900 – 18 month disqualification

Code WS7 4th or subsequent offense – found guilty of committing an IPV and wrongly received any amount of money – 5 year disqualification

Code WS8 Court ordered disqualification based on findings that the client has been found guilty of committing an IPV. The period of disqualification is determined by the court and may differ from those listed above.

FS (SNAP) codes:

Code N90 Conviction for using FS to obtain firearms, ammunition or explosives – permanent disqualification.

Code NF1 1st Violation – conviction for using FS to obtain illegal drugs – 12 month disqualification.

Code NF2 2nd Violation – second conviction for using FS to obtain illegal drugs – permanent disqualification.

Code WF1 1st Occurrence – Intentionally violated food stamp rules – 1 year disqualification.

Code WF2 2nd Occurrence – Intentionally violated food stamp rules – 2 year disqualification.

Code WF2 3rd Occurrence – Intentionally violated food stamp rules – permanent disqualification.

PA (CA) Opening Override code:

Code Y47 Used to override an IPV sanction and open a case/suffix during the infraction period. **This code is restricted to SNAP-CR, with EPF as the originating Center (Manual Notice Required).**

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications	None
Supplemental Nutrition Assistance Program Implications Revised	It is important to note that SNAP IPV penalties differ from CA IPV penalties. The disqualification penalty will begin on the date it is imposed, whether or not the applicant/ participant is currently receiving SNAP benefits. If the IPV sanction is for CA only, then a separate SNAP determination must be made. If the reason for a CA IPV is the same for a SNAP IPV, then the case will be consolidated and one packet will be utilized in referring the case for an Administrative Fraud Hearing, but separate decisions will be delivered.
Medicaid Implications	For applicants/participants who are sanctioned or disqualified from CA because of an IPV, a separate Medicaid determination must be made. One exception to this rule occurs when an individual with an IPV has a categorical code of **09** (**SN** or **SNNC**) or **26** (parent in an intact household). In this instance, the individual will also be sanctioned for Medicaid.

LIMITED ENGLISH PROFICIENCY (LEP) AND HEARING IMPAIRED IMPLICATIONS

For Limited English Proficient (LEP)) and hearing-impaired applicants/participants, make sure to obtain appropriate interpreter services in accordance with PD #11-33-OPE and PD #08-20-OPE.

FAIR HEARING IMPLICATIONS

A fair hearing cannot reverse an ADH decision that an IPV has been committed. An applicant/participant whose benefits are reduced, discontinued or denied pursuant to a decision after an ADH may request a fair hearing **only** to review:

- The amount of the overpayment or over-issuance, if such amount has not been established by an ADH or court determination.

- The length of the sanction period if the wrong codes were used.
- The CA grant amount provided to the remaining household members during the sanction period.
- The untimely lifting of the sanction after the sanction period is over and a request was made by the participant to be restored to the budget.

The participant is not entitled to a fair hearing to review the ADH decision. Applicants/participants are entitled to seek relief in a court pursuant to article 78 of the CPLR

Avoidance/ Resolution

None

Conferences

Revised

Job Center staff:

If a participant/applicant comes to the Job Center and requests a conference, the Center's Receptionist must alert the Fair Hearing and Conciliation (FH&C) unit that the individual is requesting a conference. The FH&C supervisor will contact SNAP-CR. SNAP-CR will advise as to what action should be taken (if any). If the applicant/participant calls his/her Job Center worker directly, the worker must tell the applicant/participant to go to the Receptionist and be referred to FH&C.

SNAP Center staff:

If a participant comes into a SNAP Center and request a conference the receptionist must alert the Center Director's designee that the participant is to be seen. The designee will contact the SNAP-CR. SNAP-CR will advise as to what action (if any) should be taken.

Evidence Packets

SNAP-CR or the BFI will prepare the evidence packet used in the ADH. FH&C will prepare evidence packets for other hearable issues.

REFERENCES

NYCRR 273.16
NYCRR 359.1
NYCRR 359.3
NYCRR 359.10(b)(5)(l)
93 ADM-8
Temporary Assistance Source Book (TASB), Chapter 6, Section D
Supplemental Nutrition Assistance Program (SNAP) Source Book, Section 6

RELATED ITEMS

PD #12-12-OPE
PD #03-48-ELI
PB #08-121-SYS

ATTACHMENTS

Please use Print on Demand to obtain copies of forms.

LDSS-3513 NYC	Supplemental Nutrition Assistance Program (SNAP) Recoupment Data Entry Form-WMS (Rev. 8/12)
LDSS-4707	Intentional Program Violation (IPV) Ancillary Document (Rev. 8/12)
LDSS-4799	Intentional Program Violation (IPV) Disqualification Notice For The Supplemental Nutrition Assistance Program (SNAP) (Rev. 8/12)
LDSS-4799 SP	Intentional Program Violation (IPV) Disqualification Notice For The Supplemental Nutrition Assistance Program (SNAP) (Spanish)(Rev. 8/12)
LDSS-4827 NYC	Intentional Program Violation (IPV) Disqualification Notice For The Public Assistance Program (Rev. 8/12)
LDSS-4827 SP	Intentional Program Violation (IPV) Disqualification Notice For The Public Assistance Program (Spanish) (Rev. 8/12)
BFI-105 (E)	Referral to Bureau of Fraud Investigation (Rev. 1/26/11)
W-25	History Sheet (Rev. 12/9/10)

LDSS-3513 NYC (Rev. 8/12)

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) RECOUPMENT DATA ENTRY FORM - WMS

(**ROUTING:** Original to Control Unit, Duplicate Filed in IM Record)

NEW YORK STATE — OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

CASE NAME

SURNAME	FIRST NAME

ACTION CODE — NEW / CHANGE

(Place "X" in applicable box; only one)

(1) ☐ NEW CLAIM

(2) ☐ CHANGE IN DATA

(3) ☐ SUSPEND CLAIM

(4) ☐ DELETE CLAIM

(5) ☐ FAIR HEARING AND CONTINUING

(6) ☐ LIFT FAIR HEARING AND CONTINUING

(7) ☐ TRANSFER RECOUPMENT TO NEW CASE

(8) ☐ REINITIALIZE CLAIM

SNAP CLAIM TYPE

IPV ☐ Intentional Program Violation — Sub Type ☐ #1 ☐ #2 ☐ #3

IHE ☐ Inadvertent Household Error — Sub Type ☐ #1 ☐ #2 ☐ #3

AE ☐ Agency Error — M3E ☐

RECOUPMENT ID NUMBER

CASE DATA

AUTHORIZATION NUMBER

IM CENTER

ORG. ID

CLIENT ID NUMBER (CIN)

CASE NUMBER

SUFFIX

FORM PREP DATE

OFFENSE DATA

OFFENSE AMOUNT

C I

PERIOD OF OVER-ISSUANCE — FROM — TO

CHECK NUMBER

DATE OF DISCOVERY — MM DD YY

COURT ORDERED RESTITUTION (COR)

QUICK REPAYMENT AMOUNT

FOR ACTION CODE 7

NEW CASE NUMBER

NEW SUFFIX

FOR IPV CLAIM TYPE ONLY

NUMBER OF PERSONS

ELIGIBILITY SPECIALIST	DATE	SUPERVISOR'S SIGNATURE	DATE

CONTROL CLERK	DATE	CRT OPERATOR	DATE

LDSS-4707 (Rev. 8/12)

INTENTIONAL PROGRAM VIOLATION (IPV) ANCILLARY DOCUMENT

IS/JOB CTR.	CASE NAME	
	LAST	FIRST

CASE NUMBER	SUFFIX

AUTH #

FORM PREP DATE

IPV IND. NAME			CIN NUMBER	IPV: CODE	Item # 394			
Ln. #	Last	First			P (PA)	SNAP (FS)	B (BOTH)	L (ACTION LIFTED)

LDSS- 4799 (Rev. 8/12)

INTENTIONAL PROGRAM VIOLATION (IPV) DISQUALIFICATION NOTICE FOR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This is to inform you and members of your family or household that you, _____, are disqualified from receiving SNAP, as explained below:

I. Reason For Disqualification - The reason for the disqualification is that you:

- ☐ Were determined to have committed a SNAP-IPV by an administrative disqualification hearing held on _____, which resulted in a decision dated _____ .
- ☐ Waived rights to an administrative disqualification hearing by signing a waiver on _____.
- ☐ Were found guilty of a crime or offense by a court of law on _____ for committing a SNAP-IPV.
- ☐ Signed a disqualification consent agreement on _____.

The regulation that allows us to disqualify you is 18 NYCRR 359.9.

II. Period of Disqualification - You, the recipient named in this notice, are disqualified from receiving SNAP for the period(s) checked:

- ☐ For 12 months, because this is your first SNAP-IPV, and it is not a drug or firearms or explosives-related offense.
- ☐ For 24 months, because this is your:
  - ☐ second SNAP-IPV that is not a drug or firearms or explosives-related offense
  - ☐ first SNAP-IPV and it is based on a court finding of trafficking in controlled substances in exchange for SNAP.
- ☐ For 120 months, because you were found guilty about making a false statement about who you are or where you live in order to get multiple SNAP.
- ☐ **Permanently**, because this is your:
  - ☐ third SNAP-IPV that is not a drug or firearms or explosives-related offense
  - ☐ second SNAP-IPV and it is based on a court finding of trafficking in controlled substances in exchange for SNAP
  - ☐ first SNAP-IPV and it is based on a court finding of trading in firearms, ammunition, or explosives in exchange for SNAP.
  - ☐ first SNAP-IPV and it is based on a court finding of trafficking in SNAP worth $500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP, authorization cards or access devices.
- ☐ For _____ months because this is the penalty ordered by the court. This is your _____ SNAP-IPV.
- ☐ This is your _____ SNAP-IPV. Normally, this means you cannot get SNAP for _____ months, but because we did not notify you in time:
  - ☐ you will be disqualified for _____ months, beginning _____.
  - ☐ you will not be disqualified.
- ☐ Other: _____

III. Dates of Disqualification - Your disqualification period will begin _____ and will end _____.

IV. Revised SNAP Amount

- ☐ Your household's monthly amount of SNAP will be reduced from $ _____ to $ _____ for your disqualification period. In figuring the amount of SNAP your household will get, we do not count the disqualified person in the household, but we must count the disqualified person's income. You will **not** automatically be added back into the SNAP case when your disqualification period ends. To prevent a delay in getting SNAP again, you must contact us at the number above no later than 30 days before your disqualification period ends.

  In the future if your case is closed, you will receive a separate notice providing repayment options and guidelines to ensure paying back the remaining claim balance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance.

  This decision is based on Regulation 18 NYCRR 387.19.
- ☐ Your SNAP will be discontinued, effective _____. Your SNAP case will **not** automatically be reopened when your disqualification period ends. To prevent a delay in getting SNAP again, you must reapply for SNAP no later than 30 days before your disqualification period ends.

V. Amount of Overpayment and Overpayment Period - Your household got $_____ more in SNAP than it should have during _____ to _____.

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges. This decision is based on 31 CFR 285.

If you do not access your SNAP within 365 days, they will be expunged (taken back). If you have a SNAP overpayment, your expunged SNAP will be put towards your overpayment. If you apply for SNAP again, and have not repaid the amount you owe, your SNAP will be reduced if you begin to get SNAP again. You will be notified, at that time, of the amount of reduced SNAP you will get.

LDSS-4799 (Rev.2/12)

INTENTIONAL PROGRAM VIOLATION (IPV) DISQUALIFICATION NOTICE FOR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

NAME:	ADDRESS:	CASE NUMBER:

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

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

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.

2. **STATE FAIR HEARING**

   You or any members of your family or household may request a fair hearing ONLY to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined, (2) the amount of the SNAP allotment to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration.

   You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

   You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

   You have **90** days from the date of this notice to ask for a fair hearing.

   If this notice is telling you that you got too much in SNAP benefits and that you must pay them back and you do not agree, you **must** call for a fair hearing within 90 days of the date of this notice. If you do not call for a fair hearing within 90 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

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

Mail: Send a copy of this notice 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** or

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, by fax, or online, 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 or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that 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 us at the Record Access phone number on the **front** of this notice or write to us at the address on the **front** of this notice.

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.

LDSS 4799 SP (Rev. 8/12)

VIOLACIÓN INTENCIONAL DEL PROGRAMA (IPV)
NOTIFICACIÓN DE INHABILITACIÓN DEL PROGRAMA DE ASISTENCIA NUTRICIONAL SUPLEMENTARIA (SNAP)

FECHA DE LA NOTIFICACIÓN:	NÚMERO DE CASO	NÚMERO CIN/RID	NOMBRE Y DIRECCIÓN DE LA AGENCIA / CENTRO U OFICINA DEL DISTRITO

CASO A NOMBRE DE (y nombre de la persona a cargo, si está presente) Y DOMICILIO

NO. DE TELÉFONO GENERAL PARA PREGUNTAS O AYUDA _____

Conferencia con la Agencia _____

Información y Asistencia sobre Audiencias Imparciales _____

Acceso a los Archivos _____

Información sobre Asistencia Legal _____

Nº DE OFICINA	Nº DE UNIDAD	Nº DEL TRABAJADOR(A) DE CASOS	NOMBRE DE LA UNIDAD O TRABAJADOR(A) DE CASOS	Nº DE TELÉFONO

Por la presente se le informa a usted y a los miembros de su familia o grupo familiar que usted, _____, está inhabilitado(a) para recibir SNAP tal como se explica a continuación:

I. Razón de inhabilitación - La razón de la inhabilitación es que:

☐ La audiencia administrativa de inhabilitación, realizada el _____ determinó que usted cometió una SNAP - IPV, debido a esto se tomó una decisión el _____

☐ Usted renunció a sus derechos de tener una audiencia administrativa de inhabilitación cuando firmó el documento de renuncia el día _____.

☐ El tribunal de justicia lo declaró culpable de un delito o infracción el día _____ por incurrir en una SNAP-IPV.

☐ Usted firmó un acuerdo de autorización de inhabilitación el _____.

El reglamento que nos permite inhabilitarlo es 18 NYCRR 359.9.

II. Periodo de inhabilitación - Usted, el beneficiario mencionado en esta notificación, queda inhabilitado para recibir SNAP por el/los periodo(s) indicado(s):

☐ Por 12 meses, por ser este su primer delito de SNAP-IPV, y por no ser un delito relacionado con drogas, armas de fuego o explosivos.

☐ Por 24 meses, por ser este su:

☐ segundo delito de SNAP-IPV no relacionado con drogas, armas de fuego o explosivos

☐ primer delito de SNAP-IPV: tráfico de sustancias controladas a cambio de SNAP, según un fallo judicial.

☐ Por 120 meses, porque se le declaró culpable de dar una declaración falsa sobre su identidad o su comicilio, con el fin de obtener múltiples SNAP.

☐ Permanentemente, por ser este su:

☐ tercer delito de SNAP-IPV no relacionado con drogas, armas de fuego o explosivos

☐ segundo delito de SNAP-IPV: tráfico de sustancias controladas a cambio de SNAP, según un fallo judicial.

☐ primer delito de SNAP-IPV: comercio de armas de fuego, municiones o explosivos a cambio de SNAP, según un fallo judicial

☐ primer delito de SNAP-IPV: tráfico de SNAP por un valor de $500 o más, según un fallo judicial. El tráfico incluye uso, transferencia, obtención, alteración o posesión ilegal de fondos de subsidio SNAP, tarjetas de autorización o dispositivos de acceso.

☐ Por _____ meses por ser esta la penalización ordenada por el juez. Esta es su _____ SNAP-IPV.

☐ Esta es su _____ SNAP-IPV. Normalmente, esto significaría que usted no podría obtener SNAP por _____ meses, pero dado que no le notificamos a tiempo:

☐ será inhabilitado por _____ meses, comenzando el _____.

☐ usted no será inhabilitado.

☐ Otro: _____

_____

III. Fechas de Inhabilitación – Su periodo de inhabilitación comenzará el _____ y terminará el _____.

IV. Monto modificado de SNAP

☐ El monto mensual de subsidio SNAP de su grupo familiar será reducido de $ _____ a $ _____ durante su periodo de inhabilitación. Al calcular el monto del subsidio SNAP que su grupo familiar recibirá, no se ha tomado en cuenta a la persona inhabilitada del grupo familiar, sin embargo, debemos tomar en cuenta el ingreso de esa persona. A usted no se le reincorporará automáticamente al caso de SNAP cuando termine su periodo de inhabilitación. Para evitar demoras en la nueva obtención de SNAP, llámenos al número que aparece arriba, a más tardar 30 días antes de que su periodo de inhabilitación termine.

En el futuro, si su caso está cerrado, recibirá una notificación por separado con datos sobre opciones de rembolso y sobre las pautas, con motivo de cerciorarnos que se harán los pagos del balance pendiente. Tendrá 30 días, contados a partir de la fecha que recibe esta notificación, para acordar en la modalidad de pago del balance restante.

Esta decisión se basa en Reglamentación 18 NYCRR 387.19.

☐ Su subsidio SNAP se suspenderá a partir del _____. Su caso de SNAP no se reabrirá automáticamente cuando concluya su periodo de inhabilitación. Con motivo de evitar una demora en el recibo nuevamente del subsidio SNAP, usted debe de someter nuevamente una solicitud 30 días antes de la fecha de vencimiento del periodo de inhabilitación.

V. Monto y Periodo de Pago Excesivo – Su grupo familiar recibió $_____ adicionales en subsidio SNAP de lo que debería haber recibido durante el periodo que va del _____ al _____.

Si usted recibió un pago en exceso que aún no ha rembolsado, dicho pago se le cobrará de diversas maneras, inclusive por medio del cobro automático por parte del gobierno federal. Las prestaciones federales (tal como el Seguro Social) y los rembolsos de impuestos a los que usted tenga derecho, se podrán retener como pago de la deuda. A la deuda se le sumarán los costos pertinentes de procesamiento. Esta decisión se basa en 31 CFR 285.

Si no usa el subsidio SNAP en un plazo de 365 días, dicho monto se retirará (se devolverá a la Agencia). Si recibió un pago excesivo de SNAP, el subsidio SNAP extraído se acreditará a la deuda del pago excesivo. Si solicita nuevamente SNAP, y no ha pagado la cantidad que adeuda, se reducirá el subsidio SNAP si comienza a recibir SNAP nuevamente. En cuyo caso, se le notificará la cantidad que recibirá de subsidio SNAP reducido.

LDSS-4799 SP (Rev.8/12)

VIOLACIÓN INTENCIONAL DEL PROGRAMA (IPV)
NOTIFICACIÓN DE INHABILITACIÓN DEL PROGRAMA DE ASISTENCIA NUTRICIONAL SUPLEMENTARIA (SNAP)

NOMBRE:	DOMICILIO:	NÚMERO DE CASO:

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

Si cree que nuestra determinación es incorrecta, solicite una revisión. Si hemos cometido un error, lo corregiremos.

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. En algunos casos, ésta es la forma más rápida de resolver problemas. Le recomendamos hacerlo, aunque haya solicitado una audiencia imparcial.
2. **AUDIENCIA IMPARCIAL ESTATAL** usted, o un miembro de su familia o grupo familiar, puede solicitar una audiencia imparcial SÓLO para revisar (1) el monto del pago excesivo, pero solamente si no se calculó el monto cuando su inhabilitación fue determinada, (2) el monto de SNAP que recibirá el resto de su familia o grupo familiar durante el periodo de inhabilitación y (3) la imposibilidad de restituirlo al grupo familiar una vez que el periodo de inhabilitación haya terminado y usted haya solicitado tal restitución

   Usted, o los miembros de su familia o grupo familiar, no tienen derecho a una audiencia imparcial que tenga como objetivo examinar la decisión de inhabilitarlo del programa.

   Usted puede disputar esta acción en un tribunal de justicia, conforme el Artículo 78 del *New York Civil Practice Law and Rules (CPLR).*

   Usted tiene **90** días, a partir de la fecha de esta notificación, para solicitar una audiencia imparcial.

   Si esta notificación le indica que usted ha recibido un monto excesivo de SNAP y que debe rembolsarlo, y usted no está de acuerdo con esta acción, debe llamar para solicitar una audiencia imparcial dentro de los 90 días contados a partir de la fecha de esta notificación. Si no llama para solicitar una audiencia imparcial dentro de los 90 días contados a partir de la fecha de esta notificación, no podrá reclamar en el futuro que la decisión de la agencia, con respecto a su deuda, fue incorrecta.

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

Por correo: envíe una copia de esta notificación 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

Por internet: rellene una petición electrónica en **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 o por internet, mande una carta solicitando 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 usted no puede presentarse, puede enviar a otra persona en su representación.

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, facturas, cuentas médicas.

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 o nos escribe, le brindaremos, sin cargo, copias de documentos contenidos en su archivo; los mismos que entregaremos al funcionario de la audiencia imparcial. Además, si nos llama o nos escribe, le brindaremos, sin cargo, copias de otros documentos contenidos 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 número de teléfono de Acceso a Archivos señalado en el **anverso** de esta nota o mande una carta a la dirección indicada en el **anverso** de esta notificación.

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 esa misma página.

LDSS- 4827 NYC (Rev.8/12)

INTENTIONAL PROGRAM VIOLATION
DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This is to inform you and members of your family, household or other assistance unit that you, _____ are disqualified from receiving the benefits for the time stated in Section II.

I. Reason For Disqualification

The reason for the disqualification is that you:

- ☐ were determined to have committed an Intentional Program Violation. This was determined by an administrative disqualification hearing held on _____ , which resulted in a decision dated _____ .
- ☐ waived rights to an administrative disqualification hearing by signing a Waiver on _____ .
- ☐ were found guilty of a crime or offense by a court of law on _____ for committing an Intentional Program Violation.
- ☐ signed a disqualification consent agreement on _____ and this agreement:
  - ☐ did not need to be confirmed by a court.
  - ☐ was confirmed by a court on _____ .

The regulation which allows us to disqualify you is 18 NYCRR 359.9.

II. Disqualification Period(s)

You, the recipient named in this notice, are disqualified from receiving Public Assistance for the period(s) checked:

- ☐ for 6 months because this is the first time that you committed a Public Assistance-IPV and you wrongfully received an amount less than $1,000.
- ☐ for 12 months because this is the second time that you committed a Public Assistance-IPV, or you wrongfully received between $1,000 and $3,900.
- ☐ for 18 months because this is the third time that you committed a Public Assistance-IPV, or you wrongfully received over $3,900.
- ☐ for 5 years because you have committed three or more previous Public Assistance-IPV's.
- ☐ for _____ months because this is the penalty ordered by the court. This is the _____ time that you committed a Public Assistance-IPV.

NOTE: Your eligibility for other assistance programs, such as Medical Assistance, Child Care Assistance, Emergency Assistance or other Social Services Assistance or Services, may be affected if you must be eligible for Public Assistance in order to receive the particular assistance or for services.

III. When does the disqualification begin and end?

- ☐ Your disqualification will begin _____ and will end _____ .
  Your case will **not** automatically be reopened when the disqualification period ends. To prevent a delay in getting Public Assistance again, you Must contact your Social Services District no later than 30 days before the disqualification period ends if you want to reapply for Public Assistance.
- ☐ You are not receiving benefits under Public Assistance. You will be subject to the above disqualification penalties if you apply for and are found eligible for assistance or benefits for these programs in the future.

IV. Revised Benefit Levels and Recoupment/Repayment Information

How much Public Assistance will the remaining members of your Public Assistance unit get?

- ☐ Your Public Assistance will be discontinued as noted in Section II.
- ☐ Your household's Public Assistance will be reduced from $ _____ to $_____ . The reduction will begin as noted in Section II. (We do not count the disqualified person in the Public Assistance household, but we must count that person's income.)

Public Assistance Repayment

The amount of the Public Assistance overpayment made to your household is $ _____ .

- ☐ The amount of the Public Assistance owed by your household is $ _____ . (This is different from $ _____ because you have already repaid $ _____) .
- ☐ A recoupment at the rate of _____ percent (%) is being taken against the grant of the remaining household members. If you believe that this reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase general incidentals, or to pay for extraordinary medical needs that are not covered by Medical Assistance. Your worker will let you know what kind of evidence you will need to support your hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction of between 5 and 10 percent (%).
  - ☐ The recoupment is for the recovery of the overpayment that resulted from the IPV.
  - ☐ The recoupment is to repay a previous overpayment. The overpayment that resulted from this IPV will be recouped when the previous overpayment(s) has been recouped.

  The regulation which allows us to do this is 18 NYCRR 352.31(d).
- ☐ You are not currently receiving assistance, but you will be responsible to repay the overpayment.

The regulation which allow us to do this is 18 NYCRR 359.9(f).

V. Effect On Your Supplemental Nutrition Assistance Program (SNAP) Benefits

- ☐ You do not receive SNAP Benefits.
- ☐ Your SNAP Benefits will continue unchanged.
- ☐ You will receive a separate notice about your SNAP Benefits.
- ☐ In the future if your case is closed, you will receive a separate notice providing repayment options and guidelines to ensure paying back the remaining claim blalance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance. This decision is based on Regulation 18 NYCRR 387.19.

VI. Effect On Your Medical Assistance Benefits

- ☐ You do not receive Medical Assistance.
- ☐ Your Medical Assistance will continue unchanged.
- ☐ Your Medical Assistance is discontinued for the same reason your Public Assistance is discontinued.
- ☐ Your Medical Assistance will continue pending a separate Medical Assistance eligibility determination.

This decision is based on Section 366(1) (a) of the Social Services Law.

LDSS-4827 NYC (Rev.8/12)

INTENTIONAL PROGRAM VIOLATION DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

NAME:	ADDRESS:	CASE NUMBER:

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

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

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.

2. **STATE FAIR HEARING** – You or any members of your family or household may request a fair hearing ONLY to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined, (2) the amount of the Public Assistance benefits to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration

   You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

   You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

   You have **60** days from the date of this notice to ask for a fair hearing.

   If this notice is telling you that you got to much in Public Assistance benefits and that you must pay them back and you do not agree, you must, call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt is wrong.

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 this 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: 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, by fax, by walk-in or online, 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.

LDSS-4827 SP (9/05)

VIOLACIÓN INTENCIONAL DEL PROGRAMA
NOTIFICACIÓN DE INHABILITACIÓN DEL PROGRAMA DE ASISTENCIA PÚBLICA

FECHA DE LA NOTIFICACIÓN:		NOMBRE Y DIRECCIÓN DE AGENCIA / CENTRO U OFICINA DE DISTRITO
NÚMERO DE CASO	NÚMERO CIN/RID	
CASO A NOMBRE DE (y nombre de persona a cargo, de estar presente) Y DOMICILIO		NÚMERO GENERAL DE TELÉFONO PARA PREGUNTAS O AYUDA _____ Conferencia con la Agencia _____ Información y Asistencia sobre Audiencias Imparciales _____ Acceso a los Archivos _____ Información sobre Asistencia Legal _____

Nº DE OFICINA	Nº DE UNIDAD	NÚMERO DE TRABAJADOR(A)	NOMBRE DE LA UNIDAD O PERSONA A CARGO DEL CASO	NÚMERO DE TELÉFONO

Por la presente se le informa a usted y a los miembros de su familia, grupo familiar o unidad de asistencia, que usted, _____, está inhabilitado(a) para recibir beneficios durante el periodo indicado en la Sección II.

I. Razón de la Inhabilitación

La razón de la inhabilitación es porque usted:

- ☐ Cometió una violación intencional del programa, según se determinó en la audiencia administrativa de inhabilitación realizada el _____, y como resultado, se tomó una decisión el _____
- ☐ Usted renunció sus derechos a una audiencia administrativa de inhabilitación cuando firmó el documento de renuncia el día _____.
- ☐ El tribunal de justicia lo declaró culpable de un delito u ofensa el día _____ por cometer una FS-IPV.
- ☐ Usted firmó un acuerdo de autorización de inhabilitación el _____ y este acuerdo:
  - ☐ no necesitaba aprobación judicial
  - ☐ recibió aprobación judicial el día _____

El Reglamento que nos permite inhabilitarlo es el 18 NYCRR 359.9.

II. Periodo(s) de Inhabilitación

Usted, el beneficiario mencionado en esta notificación, no puede recibir Asistencia Pública por el/los periodo(s) indicado(s) a continuación:

- ☐ Por 6 meses por ser esta la primera vez que usted comete una violación intencional del programa (IPV) de Asistencia Pública y por haber recibido, incorrectamente, un monto menor de $1,000.
- ☐ Por 12 meses por ser esta la segunda vez que usted comete una violación intencional del programa (IPV) de Asistencia Pública, o porque usted recibió, incorrectamente, un monto de entre $1,000 y $3,900.
- ☐ Por 18 meses, por ser esta la tercera vez que usted comete una violación intencional del programa (IPV) de Asistencia Pública, o porque usted recibió, incorrectamente, un monto mayor de $3,900.
- ☐ Por 5 años, porque usted cometió tres o más violaciones intencionales (IPV) del programa de Asistencia Pública.
- ☐ Por _____ meses, por ser esta la sanción ordenada por el juez. Esta es la _____ vez que usted comete una violación intencional del programa de Asistencia Pública.

NOTA: Su habilitación para recibir asistencia de otros programas, tales como: Asistencia Médica, Asistencia para el Cuidado de Niños, Asistencia de Emergencia o de otros programas de asistencia o servicios, puede verse afectada, si como condición para participar en tales programas de asistencia o servicios, usted debe reunir los requisitos de Asistencia Pública.

III. ¿Cuándo comienza y termina el periodo de inhabilitación?

- ☐ Su periodo de inhabilitación comenzará el _____ y terminará el _____

Su caso **no** se reabrirá automáticamente al terminar el periodo de inhabilitación. Para evitar demoras en la nueva obtención de Asistencia Pública, usted debe comunicarse con el distrito de Servicios Sociales, a más tardar 30 días, antes de que termine su periodo de inhabilitación si desea volver a solicitar Asistencia Pública.

- ☐ Usted no recibe beneficios del programa de Asistencia Pública. Usted estará sujeto a las sanciones de inhabilitación indicadas anteriormente si en el futuro usted solicita y reúne los requisitos de un programa de asistencia o beneficios.

IV. Niveles modificados de beneficios e información sobre el reintegro / devolución

¿Qué monto de Asistencia Pública recibirán los miembros restantes de mi unidad de Asistencia Pública?

- ☐ Su Asistencia Pública se suspenderá, tal como se indica en la Sección II.
- ☐ El monto de Asistencia Pública que recibe su hogar se reducirá de $_____ a $_____. La reducción comenzará según se indica en la Sección II. (No se toma en cuenta la persona inhabilitada para recibir Asistencia Pública, pero sí sus ingresos).

Devolución de pagos de Asistencia Pública

El monto en pagos excesivos de Asistencia Pública que recibió su hogar es de $ _____.

- ☐ El monto de Asistencia Pública que adeuda su hogar es de $ _____. (Este monto difiere por $_____ porque usted ya reembolsó $_____).
- ☐ Estamos realizando un reintegro a una taza del _____ por ciento (%) contra el monto subvencionado a los miembros restantes del hogar. Si usted considera que esta deducción ocasionará privaciones a su familia, le sugerimos comunicarse con la persona a cargo de su caso para explicar sus razones. Privaciones significa que la persona no posee ingresos suficientes para comprar alimentos, pagar los gastos de vivienda o servicios públicos, obtener la vestimenta necesaria, pagar por gastos imprevistos, o gastos médicos que Asistencia Médica no cubre. La persona a cargo de su caso le indicará qué tipo de comprobantes necesita presentar para comprobar las privaciones. Si decidimos que la recuperación le ocasionará privaciones, modificaremos el porcentaje de entre un 5 y 10 %.
  - ☐ El reintegro representa la cantidad adeuda del pago excesivo causado por la violación intencional del programa (IPV).
  - ☐ El reintegro representa el reembolso de un pago excesivo pendiente. El pago excesivo causado por esta violación intencional del programa (IPV) se reintegrará una vez se haya devuelto el pago excesivo pendiente. Esta decisión se basa en Reglamentación 18 NYCRR 352.31 (d).
- ☐ Usted no recibe por el momento asistencia, pero será responsable de reembolsar el pago excesivo.

Esta decisión se basa en Reglamentación 18 NYCRR 359.9 (f).

V. Efecto sobre sus Cupones para Alimentos

- ☐ Usted no recibe cupones
- ☐ Sus beneficios de cupones permanecerán sin cambios.
- ☐ Usted recibirá una notificación por separado sobre sus cupones

VI. Efecto en los beneficios de Asistencia Médica

- ☐ Usted no recibe Asistencia Médica
- ☐ Sus beneficios de Asistencia Médica permanecerán sin cambios.
- ☐ Se le suspende la Asistencia Médica por el mismo motivo que se le suspende la Asistencia Pública
- ☐ Continuará recibiendo Asistencia Médica pendiente una determinación por separado de habilitación.

Esta decisión se basa en la Sección 366 (1) (a) de la Ley de Servicios Sociales.

LDSS-4827 SP (9/05) REVERSO

VIOLACIÓN INTENCIONAL DEL PROGRAMA
NOTIFICACIÓN DE INHABILITACIÓN DEL PROGRAMA DE ASISTENCIA PÚBLICA

NOMBRE:	DOMICILIO:	Nº DE CASO:

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

Si cree que nuestra determinación es incorrecta, puede solicitar una revisión. Si hemos cometido un error, lo corregiremos. Usted puede tomar ambas medidas, 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 cree que nuestra determinación es incorrecta o si no entiende nuestra decisión, sírvase llamar para concertar una reunión. Llame al número para conferencias que aparece en el **anverso** de este aviso o escríbanos a la dirección que aparece en esa misma página. En algunos casos, ésta es la forma más rápida de resolver este tipo de problemas. Le recomendamos hacerlo, aunque haya solicitado una audiencia imparcial.

2. AUDIENCIA IMPARCIAL ESTATAL

Usted, o un miembro de su familia o grupo familiar, puede solicitar una audiencia imparcial SÓLO para revisar (1) el monto del pago excesivo, pero solamente si no se calculó el monto cuando su inhabilitación fue determinada, (2) el monto de FS que recibirá el resto de su familia o grupo familiar durante el periodo de inhabilitación y (3) la imposibilidad de restituirlo al grupo familiar una vez que el periodo de inhabilitación haya terminado y usted haya solicitado tal restitución.

Usted, o los miembros de su familia o grupo familiar, no tiene derecho a una audiencia imparcial que tenga como objetivo examinar la decisión de inhabilitarlo del programa.

Usted puede oponerse a esta acción en el juzgado pertinente conforme lo establece el Artículo 78 del *New York Civil Practice Law and Rules (CPLR).*

Usted tiene **60** días, a partir de la fecha de esta notificación, para solicitar una audiencia imparcial.

Si esta notificación le indica que usted ha recibido un monto excesivo Asistencia Pública y que debe reembolsarlo, y usted no está de acuerdo con esta acción, **debe** llamar para solicitar una audiencia imparcial dentro de los 60 días contados a partir de la fecha de esta notificación. Si no llama para solicitar una audiencia imparcial dentro de los 60 días contados a partir de la fecha de esta notificación, no podrá reclamar en el futuro que la decisión de la agencia, con respecto a su deuda, fue incorrecta.

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

Por correo: Envíe una copia rellenada de esta notificación 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) Si no puede comunicarse con el Estado por teléfono, mande una carta solicitando una audiencia imparcial antes del vencimiento del plazo.

Por fax: Envíe por fax una copia del anverso y reverso de este aviso al: **(518) 473-6735**

Por internet: Rellene una petición electrónica en el siguiente sitio: **http://www.otda.state.ny.us/oah/forms.asp**

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 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 que 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 el porqué de nuestra equivocación, 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.

Durante la audiencia, usted y su abogado u otro representante, podrán interrogar a nuestros testigos, o a los que usted presente para 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, usted tiene derecho a revisar el archivo de su caso. Si nos llama o nos escribe, le brindaremos, sin cargo, copias de documentos contenidos en su archivo; los mismos que entregaremos al funcionario a cargo de la audiencia imparcial. Además, si nos llama o nos escribe, le brindaremos, sin cargo, copias de otros documentos contenidos 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 número de teléfono de Acceso a Archivos señalado en el **anverso** de este aviso o mande una carta a la dirección indicada en esa misma página.

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 lo 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 esa misma página.

Human Resources Administration
Investigation, Revenue and Enforcement Administration

REFERRAL to BUREAU OF FRAUD INVESTIGATION

Fraud Hotline (212) 274-5030 Fax # (212) 274-5612

WELFARE FRAUD IS DEFINED AS THE INTENTIONAL MISREPRESENTATION, CONCEALMENT OR NONDISCLOSURE OF MATERIAL FACTS AFFECTING ELIGIBILITY TO RECEIVE SOCIAL SERVICE BENEFITS.

TO: ***INVESTIGATION, REVENUE AND ENFORCEMENT ADMINISTRATION, BUREA U OF FRAUD INVESTIGATION INTAKE UNIT, 250 CHURCH STREET, NEW YORK, NY 10013, 3rd FLOOR***

FROM: (Last name)_____ (First name):_____ DATE:_____

ADDRESS: _____ (If HRA, Ctr. #):_____ PHONE:_____

PLEASE PROVIDE SPECIFICS ABOUT THE UNCOVERED/SUSPECTED FRAUD IN THE APPROPRIATE SECTION(S) BELOW AND ATTACH COPIES OF ALL RELEVANT DOCUMENTS. ***PLEASE PRINT ALL INFORMATION***

Participant's Name (Last)_____ (First)_____

Category, Case Number/Suffix _____ SSN _____

☐ ***UNREPORTED EMPLOYMENT Type:*** ☐ **On Books** ☐ **Off Books** ☐ **Self-Employed**

Employer Name and Address_____

☐ ***UNREPORTED PERSON IN HOUSEHOLD***

Last Name_____ First _____ Relationship to Participant _____

☐ ***UNREPORTED RESOURCES*** Give Name/Address of Financial Institution, amount, and account # if known:

_____

☐ ***NOT LIVING AT ADDRESS OF RECORD*** Give actual home address if known:

_____

☐ ***QUESTIONABLE DOCUMENT(S)*** Give type of document and reason it is questionable:

_____

☐ ***PRESCRIPTION DRUG FRAUD (OBTAINING DRUGS WITH FALSE PRESCRIPTIONS)***

Detail: _____

☐ ***CHILD CARE PROVIDER NOT PROVIDING SERVICE (BABY SITTING)***

*Name of parent:*_____ *Address:* _____

*Name of babysitter:*_____ *Address:*_____

☐ ***ELECTRONIC BENEFITS TRANSFER (DISCOUNTING FOOD STAMP BENEFITS WITH THE EBT CARD)***

Detail: _____

☐ ***OTHER*** *(Including Fraud perpetrated against Participant):*

_____

DETAILS *Describe how Fraud was uncovered. Indicate any actions taken.*

_____

USE REVERSE SIDE IF NECESSARY

Form W-25 (page 1)
Rev. 12/9/10

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

History Sheet

Case Name	Address	Case Type/Case No./Suf.
		Page No.

Date	

History Sheet

Case Name	Address	Case Type/Case No./Suf.
		Page No.

Date	