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 #13-32-ELI

(This Policy Directive Replaces PD #13-01-ELI)

JANUARY 2014 RSDI/SSI COLA INCREASES

Date:	Subtopic(s):
December 24, 2013	Budgeting

AUDIENCE

The instructions in this policy directive are for Job Center and Non Cash Assistance (NCA) Supplemental Nutrition Assistance Program (SNAP) 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 for the following year.

The increase in Social Security and SSI, if any, must be reflected in the budgets for Cash Assistance (CA) and SNAP 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, 2014, all individuals in receipt of Social Security Retirement and Survivors Disability Insurance (RSDI) and/or SSI will receive a COLA of 1.5 percent. This 1.5 percent COLA results in an average increase of $11 per month for SSI recipients.

The SSI Benefit Levels Chart effective January 1, 2014 (**Attachment A**) reflects the 1.5 percent federal COLA 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 2014 are as follows:

Congregate Care Level 1 = $69.50 s/m
Congregate Care Level 2 = $80.00 s/m
Congregate Care Level 3 = $95.00 s/m

In addition to the increases in the PNA, the CA shelter amounts used to budget Congregate Care cases will change effective January 2014 as follows:

Shelter Type Code	Semi-monthly shelter rate
28	$405.00
15	$424.00
29, 32	$483.00
16, 31, 43	$498.00
42	$612.50

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 2014 because of the RSDI/SSI increase.

NYSNIP benefit level changes resulting from the 2014 COLA

The standardized SNAP 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 by $4. The standardized SNAP benefit levels for NYSNIP households with Shelter Type Codes **95** and **97** that receive SSI only and all NYSNIP households with Shelter Type Codes **94** and **96** will remain the same. The NYSNIP benefit levels effective January 2014 are as follows:

	SSI only	**SSI and other income**
Shelter Type Code **94**	$189	$189
Shelter Type Code **95**	$189	$183
Shelter Type Code **96**	$189	$189
Shelter Type Code **97**	$189	$183
Shelter Type Code **98**	$ 69	$ 65

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 $239 per month to greater than $242 per month and the shelter cost threshold to be considered as "Low Shelter" (Shelter Type Codes **95** and **97**) will change from $239 or less per month to $242 or less per month effective January 2014.

A Notice of Mass Change (**Attachment C**) was sent to all participants whose SNAP benefits will be reduced effective January 2014 because of the RSDI/SSI increase.

Mass rebudgeting

A mass rebudget (MRB) was run on December 22, 2013 to update the cases in receipt of RSDI/SSI or Veterans Benefits. The MRB included the automatic recalculation of all pending budgets affected by the RSDI/SSI COLA. Cases that were 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 were 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 in Job Centers excluded from the MRB has been forwarded to the Regional Offices for distribution to the appropriate Centers for rebudgeting and the list of all cases in NCA SNAP Centers excluded from the MRB has been forwarded to SNAP Center 25 for rebudgeting.

See PB #13-42-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 make a referral to the SOLQ Liaison to obtain 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 SNAP benefits, 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). WMS will process an automated SNAP separate determination. CNS will generate the appropriate closing notice.
- If the household remains eligible for CA but is no longer eligible for SNAP benefits, close the SNAP portion of the CA/SNAP case using closing code **E39** (Excess Income – COLA). CNS will generate the appropriate SNAP closing notice.

NCA SNAP Budgeting

For SNAP participants, the Worker at SNAP Center 25 must make a referral to the SOLQ Liaison to get 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 SNAP benefits, authorize a budget that reflects the change in income. CNS will generate the appropriate reduction notice.
- If the household is no longer eligible for SNAP benefits, close the SNAP case using closing code **E39** (Excess Income – COLA). CNS will generate the appropriate closing notice.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications

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

SNAP Implications

A separate SNAP benefit 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 PROFICIENT (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

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 2014 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 SNAP Centers

If a participant comes to the SNAP Center requesting a conference, the Receptionist must alert the SNAP Center Director'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.

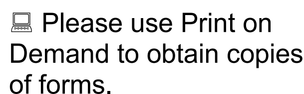
REFERENCES

13-INF-07
ABEL Transmittal 13-4
18 NYCRR 352.8, 352.29, 387.10, 387.12, 387.15
Chap. 57 of the Laws of 2013

RELATED ITEMS

PB #13-42-SYS	State Online Query (SOLQ) System
PB #10-102-OPE	Introduction to the Congregate Care Budget Worksheet (W-648J)
PD #09-31-ELI	Revision to Processing of Cases Referred by the Division of Voluntary and Proprietary Homes for Adults (DVPHA)

ATTACHMENTS


Please use Print on Demand to obtain copies of forms.

Attachment A	SSI Benefit Levels Chart effective January 1, 2014
Attachment B	Notice of Intent to Change Benefits: NYC PA COLA
Attachment C	Notice of Mass Change
W-200G	Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (Rev. 12/24/13)
W-648J	Congregate Care Budget Worksheet (Rev. 12/24/13)
W-648J (S)	Congregate Care Budget Worksheet (Spanish) (Rev. 12/24/13)

Attachment A

SSI Benefit Levels Chart effective January 1, 2014 (reflects the 1.5% federal COLA for January 2014)

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**	$721	$87	**$808**	$1, 082	$104	**$1,186**
A, C (B)	B (F)	**Living With Others** (Living in the Household of Another) [2]	721 (480.67)	23	**744** **(503.67)**	1,082 (721.34)	46	**1,128** **(767.34)**
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*	721	266.48	**987.48**	1,082	892.96	**1,974.96**
		Rest of State	721	228.48	**949.48**	1,082	816.96	**1,898.96**
A	D	**Congregate Care Level 2 - *Residential Care*** ❑ OMH or OPWDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services *NYC, Nassau, Rockland, Suffolk and Westchester Counties*	721	435	**1,156**	1,082	1,230	**2,312**
		Rest of State	721	405	**1,126**	1,082	1,170	**2,252**
A	E	**Congregate Care Level 3 – *Enhanced Residential Care*** ❑ DOH certified Adult Homes and Enriched Housing programs ❑ OPWDD certified Schools for the Mentally Retarded	721	694	**1,415**	1,082	1,748	**2,830**
D	Z	**Title XIX (Medicaid certified) Institutions** [3]	30	0 [4]	**30** [4]	60	0 [4]	**60** [4]
A	Z	(see below) [5]	721	0	**721**	1,082	0	**1,082**

Minimum Personal Needs Allowances

- ❑ Congregate Care Level 1 - $139
- ❑ Congregate Care Level 2 - $160
- ❑ Congregate Care Level 3 - $190

Limits on Countable Resources

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

Revised 6 Nov 2013

Statutory References: Chap. 57 of L. 2013

[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: **December 2, 2013**

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, **2014**.

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 1.5** percent which will take effect in December **2013** and be contained in payments received in **January 2014**. 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 2014**, 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.

Supplemental Nutrition Assistance Program (SNAP): Even though your public assistance grant will change, your SNAP benefits will not change unless you get a separate notice telling you that your SNAP benefits 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 NECESIDADES	____________	PA GRANT CONCESIÓN DE PA	____________

Sincerely,
Matthew Brune, Executive Deputy Commissioner
Family Independence Administration

XL0074 (11/13)

Attachment B

Notice of Intent To Change SNAP 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 SNAP 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 SNAP 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 SNAP 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 SNAP 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: December 2, 2013 **Effective Date: January 1, 2014** **NYC SNAP COLA '14**

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

Center :
CASE No :
CLI :

FAM SIZE:
DATE: December 2, 2013
FECHA: 2 de deciembre de 2013

NOTICE OF MASS CHANGE
PREAVISO DE REDUCCIÓN EN SU SUBSIDIO SNAP

DEAR SIR/MADAM:
ESTIMADO(A) SR./SRA./SRITA:

THIS IS TO INFORM YOU THAT YOUR SNAP BENEFITS MAY BE REDUCED EFFECTIVE **JANUARY 1, 2014** FOR THE FOLLOWING REASON:

BEGINNING JANUARY **2014**, SOCIAL SECURITY, SSI AND/OR VETERAN'S BENEFITS WILL INCREASE **BY 1.5%**. IF YOU ARE IN RECEIPT OF ANY OF THESE FEDERAL BENEFITS, THIS INCREASE IN INCOME TO YOUR HOUSEHOLD MUST BE CONSIDERED IN DETERMINING YOUR **SNAP** 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*** **SNAP** ***BENEFITS***.

BEGINNING IN **JANUARY 2014**, 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 RENT IS ABOVE **$242.00**, YOUR MONTHLY SNAP BENEFIT OF $189.00 WILL NOT CHANGE. HOWEVER, IF YOUR RENT IS **$242.00 OR LESS**, BEGINNING IN **JANUARY 2014**, YOU WILL RECEIVE **$183.00** IN SNAP BENEFITS IF YOU RECEIVE INCOME IN ADDITION TO SSI.

IF YOU ARE A NYSNIP PARTICIPANT WHO WAS RECEIVING **$73** PER MONTH IN **SNAP** BENEFITS, BEGINNING IN JANUARY **2014** YOU WILL RECEIVE **$69** PER MONTH, IF YOU WERE RECEIVING **$69** PER MONTH IN **SNAP** BENEFITS, BEGINNING IN JANUARY **2014** YOU WILL RECEIVE **$65** PER MONTH, AS STATED ABOVE. THIS REDUCTION IN YOUR **SNAP** GRANT IS DUE TO THE INCREASE IN YOUR FEDERAL BENEFITS.

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

POR MEDIO DE LA PRESENTE LE INFORMAMOS QUE REDUCIREMOS SU SUBSIDIO SNAP A PARTIR DEL **1º DE ENERO DE 2014** POR LA SIGUIENTE RAZÓN:

COMENZANDO EN ENERO DE **2014**, LOS BENEFICIOS DE SEGURO SOCIAL, SSI Y/O BENEFICIOS A VETERANOS, AUMENTARÁN POR UN **1.5%**. 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 DEL SUBSIDIO **SNAP** 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 SU SUBSIDIO*** **SNAP**.

COMENZANDO EN **ENERO DE 2014**, 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 ALQUILER ES SUPERIOR A LOS **$242.00**, EL MONTO MENSUAL DE $189.00 DE SU SUBSIDIO SNAP NO CAMBIARÁ. SIN EMBARGO, SI SU ALQUILER ES DE **$242.00 O MENOS**, COMENZANDO EN **ENERO DE 2014** USTED RECIBIRÁ $183.00 EN SUBSIDIO SNAP SI SU ÚNICA FUENTE DE INGRESOS ES SSI; O RECIBIRÁ **$183.00** EN SUBSIDIO SNAP SI RECIBE OTROS INGRESOS ADEMÁS DEL SSI.

SI USTED ES UN PARTICIPANTE DEL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP) QUE RECIBÍA **$73.00** AL MES EN SUBSIDIO **SNAP**, COMENZANDO EN ENERO DE **2014**, USTED RECIBIRÁ **$69.00** AL MES; SI USTED RECIBÍA **$69.00** AL MES EN SUBSIDIO **SNAP**, COMENZANDO EN ENERO DE **2014**, USTED RECIBIRÁ **$65.00** AL MES, TAL COMO SE ESTIPULA ARRIBA. ESTA REDUCCIÓN EN SU SUBVENCIÓN **SNAP** 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 SUBSIDIO **SNAP** 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 SUBSIDIO **SNAP**. 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 **SNAP**. 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 Supplemental Nutrition Assistance Program (SNAP) *Ingreso anterior del subsidio de Asistencia Nutritional Suplementaria (SNAP)*		**Previous Monthly Benefit Amount** *Monto anterior mensual del subsidio*	
New Net SNAP Income *Nuevo Ingreso neto del subsidio SNAP*		**New Monthly Benefit Amount** *Nuevo monto mensual del subsidio*	

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 huésped/ inquilino*	
b. **Net Monthly Income from Lodger.** *Ingreso neto mensual que recibe del inquilino*	
3. **Total of Lines 1 and 2.** *Total de las lineas 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.** *Total de líneas 3, 4 y 5* A.	$

B. DEDUCTIONS
Deducciones

7. **% of Line 3.** *% de línea 3*	
8. **Standard Deduction Monthly** *Deducción mensual estándar*	
9. **Monthly Child Care/Dependent Care Costs.** *Gastos mensuales por cuidado de niños / de dependientes* **(Maximum)** *(Máximo)*	
10. **Monthly Automatic Recoupment (from Public Assistance Grant)** *Recuperación mensual automática(de subsidio de Asistencia Pública)*	
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 líneas 7, 8, 9, 10, 11, y 12* B.	$

C. ADJUSTED INCOME
Ingreso ajustado

14. **Subtract B from A.(Line 13 from Line 6.)** *Reste B de A. (Línea 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, conexión de servicios públicos etc.)*	
20. **Total of Lines 15, 16, 17, 18, and 19.** *Total de líneas 15, 16, 17, 18, y 19* D.	$

E. SNAP NET INCOME
Ingreso neto por subsidio SNAP

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

MINUS RECOUPMENT OF
MENOS EL REEMBOLSO DE

ADJUSTED SNAP AMOUNT
MONTO AJUSTADO DEL SUBSIDIO SNAP

Attachment C

Notice of Intent To Change SNAP 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 SNAP 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 SNAP 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 SNAP 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 SNAP 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: December 2, 2013 **Effective Date: January 1, 2014** **NYC SNAP COLA '14**

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

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

(Effective January 1, 2014)

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.

SAMPLE

Congregate Care Level	Shelter Type Code	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. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	$424.00	$69.50
	28	Same as above in a rest of the state facility.	$405.00	
Level 2	**16**	Adult homes licensed through the New York State Department of Health (DOH) and community residences licensed through OMH. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	$498.00	$80.00
	29	Same as above in a rest of the state facility.	$483.00	
	31	Residential Alcohol and Substance Abuse Treatment Programs. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	$498.00	
	32	Same as above in a rest of the state facility.	$483.00	
	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.	$498.00	
Level 3	**42**	DOH Adult Homes and Enriched Housing facilities. The case **must be** a family size of 1.	$612.50	$95.00

Human Resources Administration
Department of Social Services
Family Independence Administration

Date: ______________________
Case Number: ______________________
Case Name: ______________________
Caseload: ______________________
Center: ______________________

Congregate Care Budget Worksheet

(Effective January 1, 2014)

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

SAMPLE

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] (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)**			$

Total Amount of Child Support	
Income	**Number of Children**

[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)**	$

SAMPLE

Personal Needs Allowances and Shelter Rates		
Shelter Type	**S/M PNA**	**S/M Shelter Rate**
15	$69.50	$424.00
16 31 43	$80.00	$498.00
29 32	$80.00	$483.00
27	$22.50	Negotiated Rate
28	$69.50	$405.00
42	$95.00	$612.50

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 Supplemental Nutrition Assistance Program (SNAP) 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 Supplemental Nutrition Assistance Program (SNAP) eligibility.	$

SAMPLE

Authorization Period: From: ____________________ To: ____________________.

______________________________ Authorized by

______________________________ Date

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, 2014)

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.)

SAMPLE

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]			$
10.	Otro ingreso (incluyendo Sólo Pensión Alimenticia/Pensión Conyugal[2]) (especifique):			$
11.	**Total Quincenal de Ingresos no Salariales (sume las líneas 1 a 10)**			$

Línea 9:

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.)

[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)**	$

SAMPLE

Concesiones para Necesidades Personales y Tarifas de Albergue

Tipo de Albergue	PNA Quincenal	Tarifa Quincenal de Albergue
15	$69.50	$424.00
16 31 43	$80.00	$498.00
29 32	$80.00	$483.00
27	$22.50	Tarifa Negociada
28	$69.50	$405.00
42	$95.00	$612.50

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 el Programa de Asistencia de Nutrición Suplementaria (SNAP). (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.	☐ Inelegible ☐ 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 del Programa de Asistencia de Nutrición Suplementaria (SNAP).	$

SAMPLE

Período de Autorización: De: ______________ A: __________________.

______________________________________ Autorizado por

______________________ Fecha