



FAMILY INDEPENDENCE ADMINISTRATION

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POLICY DIRECTIVE #14-11-ELI (This Policy Directive Replaces PD #05-09-ELI)

CHANGE OF RESIDENCE OUT OF NEW YORK STATE

Date: June 23, 2014	Subtopic(s): Housing Issues, Cash Assistance (CA), Supplemental Nutrition Assistance Program (SNAP) Benefits
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AUDIENCE The instructions in this policy directive are for staff in the Job Centers and informational for all other staff.

REVISIONS

This policy directive has been revised to:

See [CD #13-35](#) for Relocation of the FIA's Transportation Unit

- Inform staff that the Human Resources Administration (HRA)/Family Independence Administration (FIA) has relocated the FIA's Transportation Unit to 25 Chapel Street, 6th Floor, Room #606, Brooklyn, NY 11201-5208; the contact persons are:
 - Sylvia Hambright, Director, (718) 473-8296, hambrights@hra.nyc.gov;
 - Marcella P. Parker, Office Manager, (718) 473-8299, parkermar@hra.nyc.gov; and
 - Raquel Diaz, Senior Transportation Worker, (718) 473-8303, diazraq@hra.nyc.gov;
- Remove Wyoming from a non-Electronic Benefit Transfer (EBT) state;
- Remove references and explanations regarding applicants/participants moving to a non-EBT state;
- Update information for obtaining verification that moving companies meet certain criteria;
- Add instructions outlining the POS steps required to process an out of state moving expense request;

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or
send an e-mail to *FIA Call Center Fax* or fax to: (917) 639-0298

The **M-442j** has been revised

- Inform staff that the Referral Summary Form For Participants Moving Permanently Out of New York State (**M-442j**) has been revised as follows:
 - The title now reads: Referral Summary Form For Applicants/Participants Moving Permanently Out of New York State;
 - The logo has been updated; and
 - The Transportation Unit location has been updated;

The **W-145HH** has been revised

- Inform staff that the Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (**W-145HH**) has been revised as follows:
 - The following statement has been removed from page 1: **NOTE:** As of August 29, 2012, any reference to the Food Stamp Program in this notice shall mean the Supplemental Nutrition Assistance Program (SNAP), and any reference to Food Stamps shall mean SNAP benefits;
- Remove references to the obsolete Emergency Assistance for an Active Public Assistance Case Form (**W-145N**).

POLICY

New York City may authorize the move of an applicant/participant to another state or country when it is determined that the applicant/participant:

- Has residence in another state or country;
- Belongs in another state or country;
- Has legally responsible relatives able or willing to support or aid in supporting him/her; or
- Has friends willing to support or aid in supporting him/her.

Authorization may also be granted in cases where the welfare of the person requesting the move and the interest of the State will both benefit. The Agency is responsible for issuing benefits until the applicant/participant physically moves out of the state, at which time the case is closed.

Federal SNAP rules require that states' EBT systems be interoperable so that Supplemental Nutrition Assistance Program (SNAP) applicants/participants in one state or territory can use their EBT cards to access their SNAP benefits while in another state or territory. However, Puerto Rico does not fall under the jurisdiction of the interoperability regulations.

SNAP participants
moving to Puerto Rico

For SNAP applicants/participants moving to Puerto Rico, the remaining SNAP benefits on the household's EBT card must not be converted to cash benefits. These households will have to reapply for assistance in Puerto Rico.

When an applicant/participant is moving out of the state or out of the country, the cost of the following items may be covered by the Agency:

- Transportation;
- Transfer of baggage; and
- Other reasonable and necessary expenses including lodging and transportation costs of an attendant, but excluding charges for the attendant's time and services.

The cost of shipping furniture to the new state or country is not an allowable expense except in the following circumstances:

- The move is to a less expensive rental property and the amount paid for a security deposit and moving expenses is less than the amount of two years' difference in rentals; or
- The move is necessitated by one of the following criteria:
 - A disaster/catastrophe and/or a vacate order is placed against the premises by a health agency or code enforcement agency;
 - A serious medical or physical handicap. Such need must be verified by specific medical diagnosis;
 - The individual or family is rendered homeless as a result of having been put out by another occupant with whom they were sharing accommodations;
 - The move is from temporary to permanent housing;
 - The move is from permanent housing to temporary housing due to the unavailability of permanent housing;
 - The move is from one temporary accommodation to another temporary accommodation due to the unavailability of permanent housing;
 - The move is from an approved relocation site to an approved cooperative apartment; or
 - There is a living situation that adversely affects the mental or physical health of the individual or family, and the need for alternative housing is urgent.

**REQUIRED
ACTION**

Once the applicant/participant has informed the JOS/Worker of his/her intention to move, the JOS/Worker must:

Authorization of Moving
Expenses

- Discuss the move, the applicant/participant's plans for financial maintenance at the new location, and a possible alternate means of financing the move;
- Request documentation as follows:
 - Verification of employment in the new location (statement from the employer with starting date, salary, position);
 - A written statement from the primary tenant will be required, as will verification of address (e.g., utility bill), if the applicant/participant will be living with family or friends. If the applicant/participant's move to the home of a family member or friend is temporary until s/he gets his/her own residence, and the move includes his/her furniture and other belongings, the statement from the primary tenant must specify that there is room to accommodate the applicant/participant and his/her belongings;
 - A statement from the child care services agency that will be releasing the child/children which indicates to whom and when the child is being discharged;
 - Documentation from family court to verify that all parties are consenting to the permanent relocation of the child/children out of the state/country, when there is an order of child support/child visitation in effect;
 - If the applicant/participant is a victim of domestic violence include:
 - domestic violence referral
 - current order of protection
 - police/incident reports;
 - When an applicant/participant is moving or transferring his/her Section 8 to another state, obtain:
 - the Section 8 voucher (portability voucher)
 - the new Section 8 lease
 - the documentation that the Section 8 apartment passed inspection;

- If eviction is pending, obtain the Order of Show Cause/court documents;
- Instruct the applicant/participant to obtain estimates from three licensed moving companies that agree to be paid once the move is completed. The estimates must be original, itemized, binding and based on visual assessment of items to be moved;
- Verify that the movers are licensed and insured interstate moving companies that are willing to move and deliver the applicant/participant’s belongings and abide by the Agency’s process of payment. Verification can be obtained by contacting:
 - NY State Department of Transportation, Office of Safety and Security Services at (800) 786-5368 or e-mail at nymoving@dot.state.ny.us; or
 - U.S. Department of Transportation, Federal Motor Carrier Safety Administration at (888) 368-7238 or www.safer.fmcsa.dot.gov.
- Contact the new social service district for verification of both the maximum rent allowance and the address at which the applicant/participant can apply for assistance (if applying for Cash Assistance (CA)/SNAP in the new state in that particular district);
- After the estimates from the licensed and insured movers have been verified and all data obtained, request a written approval for the lowest estimate from the Center Director or the Center Director’s designee.

Paperless Office System (POS)

If the applicant/participant makes a request for the furniture/moving allowance and meets the established criteria, the JOS/Worker must enter the request in the POS **SI Record Special Grant Requests** window. POS will log in the request for moving allowance on the POS automated Participant Request Control Card (**W-111F**) to track the request.

Refer to [PD #10-22-SYS](#)

Note: **SI Grant Requests Task List** window appears in the **Application Interview, Change Case Data, Recertification Interview, and Non-Food Emergency Interview** POS Activities.

Revised

The JOS/Worker will:

Refer to [PD #10-22-SYS](#) for detailed instructions on how to process single issuance grant requests in POS

- Go to the **Task 2** (Record Special Grant Requests) and click **Yes** for the Housing Related Benefits;
- In the **Response to Question** window, click **Yes** for Moving Allowance;

- In the Moving Allowance drill down window indicate that the move is out of State and enter the moving allowance request;

New

Refer to [PB #14-54-SYS](#)

Note: If the answer is **Yes** for **Move out of State**, the request does not require a referral to Rental Assistance Unit (RAU). The case is referred to the transportation unit. The JOS/Worker sees the following message in the window: *“For moves out of New York State, a referral to the Rental Assistance Unit is not required. A referral to the Transportation Unit is required”*

- Click **OK** and **Next** and the **SI Grant request** window appears;
- Complete **Task 3** (Request Details) and **Task 4** (EAF/E-SNA and EAA Eligibility Determination);
- After completing **Task 1-4**, for active CA cases, The Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137A**) is automatically prefilled. The JOS/Worker will print the **W-137A** in **Task 5** (Print Forms for Client to Sign), and capture the participant’s signature;
- Once all signatures are saved, click **Next** to continue. The status of **Task 5** will change to **Completed** and POS will display the updated **SI Grant Requests and Issuance Task List** screen;
- Suspend the **Activity**;
- Prepare the **M-442j**;

The referral packet

- Create the FIA’s Transportation Unit referral packet by scanning and indexing the following original documents into the HRA One Viewer:

(**Note:** make sure that all scanned documents are clear and legible)

- the **M-442j**;
- the **W-137A** (for participants only);
- the three moving estimates;
- the approval of the lowest estimate on a separate document signed with a person’s name and title;
- the verification that the moving company has met all requirements or a written statement that a collateral contact and verification have been made;
- all related documents;

New
E-mail to the FIA’s
Transportation Unit

- Send an e-mail to the FIA’s Transportation Unit at diazraq@hra.nyc.gov and/or parkermar@hra.nyc.gov and/or hambrights@hra.nyc.gov to inform them that the referral packet is in the HRA One Viewer.

Role of the
Transportation Unit

Upon receipt of the documentation, the Transportation Unit will schedule and conduct an in-person interview with the applicant/participant requesting the moving expenses.

Once the interview is completed, the case is forwarded to the Center Director’s designee for approval. Upon approval, moving expenses such as transportation and lodging (when appropriate) are provided to the participant in the form of a voucher. In most circumstances, transportation is via bus; however, in special circumstances airfare may be provided to the applicant/participant (e.g., cross country or out of country moves).

Approval of the Request

When the cost of moving furniture has been approved, the Transportation Unit will:

- Notify the approved moving company and the JOS/Worker; and
- Contact the applicant/participant via telephone to inform him/her to set up a moving date with the moving company.

Revised

Upon notification, the JOS/Worker will:

Refer to [PD #10-22-SYS](#)

- Return to the POS Activity that is suspended in the queue;
- Access the **SI Grant Requests and Issuance Task List** window; Go to **Task 6** (Outstanding Requests List) window and select the moving allowance request;

New

- Click the **Edit** button to access the **Request Action** screen;

Refer to [PB #14-54-SYS](#)

Note: POS displays the following message in the **Single Issuance Request Action** window: *“A referral to the Transportation Unit is required for this moving allowance request. A referral to RAU is not required.”*

The screenshot shows the 'Request Action' window with the following details:

- Request Type:** Moving Expenses
- Financially Eligible for:** EAF? No, E-SNA? Yes, EAA?
- Grant Info:** Incomplete
- Referrals and Outcomes:** Complete
- Documentation and Verification:** Complete
- CA Household Size:** 2
- Monthly Home Energy Allowance:** \$39.50
- Monthly Rent Allowance:** \$250.00
- Monthly Fuel for Heating Allowance:** \$0.00
- SI Grant Details:**
 - SI Grant Needed? Yes No
 - Decision Due Date: 03/19/2014
 - Overdue? Yes
 - Overdue Reason: [Dropdown]
 - Approved Mover Name: [Text Field]
 - Mover License: [Text Field]
 - Comments: [Text Field]
 - View Benefit Issuance History [Button]
- SI Grant Decision:**
 - RAU Referral Required? Yes No
 - Ready for Referral to RAU? Yes No
 - Was Decision Received? Yes No
 - Decision: Issue Grant, Issue Grant Conditionally, Deny Grant
 - Conditions: [Text Field]
 - Retrieve Prior Payment History: [Text Field]
 - Decision: Not ready for decision, Accept, Deny
 - Approved Amount: \$0.00
 - Approved Period: From: 00/00/0000 To: 00/00/0000
 - Denied Amount: \$0.00

- Click **Yes** for **Was Decision Received?** question;
- If the request is denied, click on the **Deny** radio button in the **Decision** field of the window and record the reason for denial;
- If the request is approved, click on the **Accept** radio button in the **Decision** field of the window and enter the approved amount;
- Enter all required information in the **Request Action** window;
- Enter detailed case comments;
- Complete the **Activity**; and
- Send the case to the AJOS I for approval.

The AJOS I will:

- Review and approve the case;
- Print either the **W-145HH** to notify an applicant of the decision, or the Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137B**) to notify a participant;

- The **W-145HH** or the **W-137B** must be saved in the HRA One Viewer.

Payment for the cost of moving furniture will not be issued to the moving company until the applicant/participant has physically left New York State. The moving company mails an invoice to the Transportation Unit after the move is completed. The Transportation Unit worker processes the required paperwork on the request for payment to the moving company and submits it to the Transportation Unit Director for approval. The contents of the request for payment to the moving company is then submitted to the Finance Office. Payment is sent directly from the Division of Accounts Payable within the Finance Office to the Vendor.

The Transportation Unit will inform the JOS/Worker when the applicant/participant actually leaves the state via the Referral/Information Form (**W-34A**). Upon receipt of the **W-34A**, the JOS/Worker will scan and index it into the HRA One Viewer. The JOS/Worker must ensure that all due benefits have been issued to the applicant/participant and then proceed to close the case using CA case closing code **E66** (Not a Resident of the State).

Closing the Case

Note: If the applicant applied for Emergency Assistance “One-Shot Deal” only, the case should be closed using CA case closing code **Y96** (Case Closed After Being Accepted for Emergency Assistance).

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications

POS implications are included in the procedure.

SNAP Implications

SNAP benefits will be accessible in the other state via the EBT system.

Medicaid Implications

There are no Medicaid implications associated with this procedure.

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 To avoid any delay in benefits issuance or incorrect denial of moving expenses, ensure that all case actions are taken as outlined in this policy directive.
- Conferences If the participant comes to the Job Center to request a conference because s/he has not received benefits from the “move from” district, the Receptionist must alert the Fair Hearing and Conference (FH&C) Unit that the participant needs to be seen by an AJOS/Supervisor I. If the participant calls the JOS/Worker directly, the JOS/Worker must tell the participant to call the FH&C Unit. 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 AJOS/Supervisor I will listen to and evaluate the participant’s complaint and contact the “move from” district for instructions. After reviewing the case record and discussing the issue with the Worker and Group Supervisor, the AJOS/Supervisor I will determine if the participant’s complaint can be resolved. The AJOS/Supervisor I is responsible for ensuring that further appeal by the participant through a Fair Hearing request is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.
- Evidence Packets All evidence packets must contain all relevant documentation submitted with the referral to the Transportation Unit, the electronic case record, and any other relevant documentation.


RELATED ITEMS

- [PD #10-22-SYS](#) Single Issuance Grant Requests in POS
[PD #01-31](#) Continuation of Food Stamps on Public Assistance Cases During a Move from One District to Another
- [PB #14-54-SYS](#) CA POS Release Notes Version 18.1.1
[CD #13-35](#) Relocation of the FIA’s Transportation Unit
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REFERENCES

- [01 INF 14](#)
[02 INF 39](#)
[05-INF-03](#)
 18 NYCRR 352.6(a)(1)

ATTACHMENTS

 Please use Print on Demand to obtain copies of forms.

- | | |
|--------------------|--|
| M-442j | Referral Summary Form for Applicants/Participants Moving Permanently Out of New York State (Rev. 6/23/14) |
| W-34A | Referral/Information Form (Rev. 8/16/10) |
| W-145HH | Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Rev. 6/23/14) |
| W-145HH (S) | Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Spanish) (Rev. 6/23/14) |

Reason for arrival (if applicable):

Brief social history including any health problems:

Relatives or friends who can contribute toward transportation expenses:

Current budget (for participants only):

SAMPLE

Worker Date Phone Number

Sponsor Date Phone Number

Case Supervisor Date Phone Number

Date: _____
Case Name: _____
Case Number: _____

Referral/Information Form

<input type="checkbox"/> Referral	<input type="checkbox"/> Message	<input type="checkbox"/> Enclosure	<input type="checkbox"/> Inquiry	<input type="checkbox"/> Report
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To (Agency): <input type="checkbox"/> Job Center <input type="checkbox"/> Other	From (Agency): <input type="checkbox"/> Job Center <input type="checkbox"/> Other
Attention (Name of Agency Representative):	By (Name of Agency Representative):

Applicant/Participant Name: _____

Present Address: _____ Telephone Number: _____

City _____ State _____ Zip Code _____

Subject: _____

Comments:

_____	_____	<input type="checkbox"/> Job Center	_____	_____
Worker Signature	Worker Title	<input type="checkbox"/> Other	Telephone Number	Date

_____	_____	_____	_____
Supervisor Signature	Section	Telephone Number	Date

Date: _____
Case Number: _____
Case Name: _____
Caseload: _____
Worker Name: _____
Worker Telephone Number: _____
FH&C Telephone Number: _____

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

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

Immediate Needs

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

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

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

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

- An emergency preinvestigation grant in the amount of \$ _____ will be available to you on _____.
(Date)
- An emergency grant (one-shot deal) has been provided in the amount of \$ _____ for _____.
- A personal care kit has been provided on _____.
(Date)
- A Goodwill Voucher has been provided in the amount of \$ _____ for _____ on _____.
(Date)
- If this box is checked, you are responsible for repaying \$ _____ as shown:
 - This amount must be repaid to us in accordance with the agreement to repay that you signed on _____.
(Date)
 - You must repay the amount shown above because it is more than the Human Resources Administration (HRA) shelter maximum of \$ _____ for your family size of _____ for each month of arrears that HRA agreed to pay.

Immediate Needs (Continued)

- Assistance to meet a food-related immediate need is denied because you:
- failed to establish/document identity
 - have excess resources
 - are an undocumented alien
 - received an immediate needs grant in the past 90 days and failed to subsequently comply with eligibility requirements
 - were issued same day SNAP
 - other reason for denial (please specify):

- Assistance to meet a nonfood-related immediate need is denied because you:
- failed to establish/document identity
 - have excess resources
 - are an undocumented alien
 - received an immediate needs grant in the past 90 days and failed to subsequently comply with eligibility requirements
 - applied for Cash Assistance on _____ (within the last three months) and were issued one of the following: _____ (Date)
 - immediate need(s) grant(s)
 - personal care kit(s)
 - Goodwill Voucher(s)
 - other grants (please specify):

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

- Other action taken on your application:

Medical Assistance

- If you need help with your medical bills, you must apply separately for Medical Assistance. If you want more information about eligibility for Medical Assistance, call the Worker's telephone number listed on **page 1**.
- Your Medical Assistance stays the same.
- Your application for Medical Assistance is being reviewed. We will send you our decision within 30 days.

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

Conference and Fair Hearing Section

If you think our decision was 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

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

2) STATE FAIR HEARING

You have the following number of days from the date of this notice to ask for a Fair Hearing:

Benefit Area	Time Limit
Cash Assistance, Medical Assistance, Social Services	60 days
SNAP Benefits	90 days

If this notice is telling you that you must repay cash assistance because you signed a repayment agreement, or because the shelter arrears that HRA agreed to pay is more than the HRA shelter maximum, and if you do not agree that you must repay or you do not agree with the amount HRA says you must repay, you must call for a Fair Hearing. If you do not call for a Fair Hearing, you cannot claim in the future that the Agency's decision that you owe the debt was wrong. The time limit for calling for a Fair Hearing on the issue of the repayment is the same as the limit for any cash assistance action this notice is telling you about, 60 days.

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

- 1) TELEPHONE:** Call **(800) 342-3334**. (Please have this notice in hand when you call.)
- (2) WRITE:** Send a copy of the entire notice, with the "Fair Hearing Request" section completed, to:
Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930, Albany, NY 12201
(Please keep a copy for yourself.)
- (3) FAX:** Fax a copy of the entire notice, with the "Fair Hearing Request" section completed, to:
(518) 473-6735.
- (4) IN PERSON:** Bring a copy of the entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at:
14 Boerum Place, Brooklyn, NY 11201.
- (5) 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 telephone, 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.

If you have a disability, and cannot travel, you may appear through a representative, either a friend, relative or lawyer. If your representative is not a lawyer, or an employee of a lawyer, your representative must bring the hearing officer a written letter, signed.

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, or 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.

IF YOUR SITUATION IS EXTREMELY SERIOUS, THE STATE WILL ATTEMPT TO PROCESS YOUR REQUEST FOR A FAIR HEARING AS QUICKLY AS POSSIBLE. IF YOU CALL TO REQUEST A FAIR HEARING, PLEASE BE PREPARED TO EXPLAIN YOUR SITUATION TO THE PERSON WHO ANSWERS THE TELEPHONE. IF YOU WRITE, FAX OR CONTACT US ONLINE INSTEAD, PLEASE BE SURE TO EXPLAIN YOUR SITUATION.

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

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

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

FAIR HEARING REQUEST

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

Print Name: _____ Case Number: _____
Name M.I. Last Name

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Signature: _____ Date: _____

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Unidad de Casos: _____
Nombre del Trabajador: _____
Número de Tel. del Trabajador: _____
Número de Tel. de FH&C: _____

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

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

Necesidades Inmediatas

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

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

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

Por medio del presente aviso le informamos que hemos evaluado su solicitud respecto a una concesión para cubrir necesidades inmediatas y la decisión es la siguiente:

- Una concesión de emergencia preinvestigación por la cantidad de \$ _____ estará a su disposición el _____
(Fecha)
- Se le ha otorgado una concesión única de emergencia por la cantidad de \$ _____ para _____
- Se le ha facilitado un botiquín de cuidado personal (personal care kit) el _____
(Fecha)
- Se le ha otorgado un Comprobante de Buena Voluntad de \$ _____ para _____ el _____
(Fecha)
- Si se marca esta casilla, usted es responsable por el reembolso de \$ _____ como indicado:
 - Esta cantidad se nos tiene que pagar conforme al acuerdo de reembolso que usted firmó el _____
(Fecha)
 - Usted tiene que reembolsar la cantidad indicada más arriba porque es superior al máximo de albergue de la Administración de Recursos Humanos (Human Resources Administration – HRA) de \$ _____ para el tamaño de su familia con _____ personas para cada mes de atraso que HRA acordó pagar.

Necesidades Inmediatas (Continuación)

- Asistencia para cubrir una necesidad inmediata relacionada con la alimentación se le ha rechazado porque:
- no estableció/documento la identidad
 - tiene recursos en exceso
 - es un extranjero indocumentado
 - recibió una concesión para necesidades inmediatas en los últimos 90 días y no cumplió posteriormente los requisitos de elegibilidad
 - a usted se le expedieron beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP) el mismo día
 - Otro razón por el rechazo (por favor especifique):

- Asistencia para cubrir una necesidad inmediata no relacionada con la alimentación se le ha rechazado porque:
- no estableció/documento la identidad
 - tiene recursos en exceso
 - es un extranjero indocumentado
 - recibió una concesión para necesidades inmediatas en los últimos 90 días y no cumplió posteriormente los requisitos de elegibilidad
 - solicitó Asistencia en Efectivo el _____ (dentro de los últimos tres meses), usted recibió:

- (Fecha)
- concesión(es) para necesidades inmediatas
 - botiquín(es) de cuidado personal
 - Comprobante(s) de Buena Voluntad
 - Otras concesiones (por favor especifique).

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

- Otras acciones tomadas hacia su solicitud:

Asistencia Médica

- Si usted necesita ayuda para pagar sus facturas médicas, tiene que solicitar Asistencia Médica por separado. Si desea más información sobre elegibilidad para Asistencia Médica, llame al número de teléfono de su Trabajador en la **página 1**.
- Su Asistencia Médica permanecerá sin cambios.
- Se está evaluando su solicitud de Asistencia Médica. Le enviaremos nuestra decisión dentro de 30 días.

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

Sección sobre Conferencias y Audiencias Imparciales

Si usted cree que nuestra decisión fue equivocada, puede solicitar una revisión de nuestra decisión. Corregiremos nuestros errores. Usted puede tomar ambas medidas 1 y 2:

1. Solicitar una reunión (conferencia) con unos de nuestros supervisores;
2. Solicitar una audiencia imparcial Estatal con un Oficial de Audiencia Imparcial.

1) CONFERENCIA

Si usted cree que nuestra decisión es errónea, o si no entiende nuestra decisión, favor de llamarnos para programar una conferencia (reunión informal con nosotros). Para ello, llame al número de teléfono de la unidad de Audiencias Imparciales (Fair Hearing and Conference – FH&C) en la **página 1** de este aviso o escriba a la dirección en la **página 1** de este aviso. A veces esta resulta ser la manera más rápida de resolver un problema que usted pueda tener. Le recomendamos a que así haga, aun si ha solicitado una Audiencia Imparcial. El solicitar una conferencia no le impide solicitar además una Audiencia Imparcial.

2) AUDIENCIA IMPARCIAL ESTATAL

Usted tiene el siguiente número de días desde la fecha de este aviso para solicitar una Audiencia Imparcial:

Tipo de Beneficios	Plazo Límite
Asistencia en Efectivo, Asistencia Médica, Servicios Sociales	60 días
Beneficios de SNAP	90 días

Si este aviso le indica que usted debe reembolsar Asistencia en Efectivo porque firmó un acuerdo de reembolso, o porque los pagos atrasados de albergue que la HRA acordó reembolsar suman más que el máximo para albergue de la HRA, y si usted no está de acuerdo en efectuar este reembolso o si no está de acuerdo con la cantidad que la HRA estipula que usted debe reembolsar, debe llamar para solicitar una Audiencia Imparcial. Si usted no llama para una Audiencia Imparcial, no podrá reclamar posteriormente que la decisión de la agencia que usted tiene una deuda fue errónea. El plazo límite para llamar para una audiencia imparcial sobre el reembolso es el mismo que el plazo límite para cualquier medida de Asistencia en Efectivo sobre la cual este aviso le informa, 60 días.

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

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

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

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

(4) EN PERSONA: Traiga una copia de todo el aviso, con la sección "Petición de Audiencia Imparcial" llenada, a la Oficina de Audiencias Administrativas, Oficina de Asistencia Temporal y para Incapacitados del Estado de Nueva York (Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance) a: **14 Boerum Place, Brooklyn, NY 11201**.

(5) POR INTERNET: Complete una solicitud electrónica conectándose a:
<http://www.otda.ny.gov/oah/forms.asp>

Si usted no puede comunicarse con la Oficina de Asistencia Temporal y para Incapacitados del Estado de Nueva York por teléfono, por fax o por Internet, favor de escribir para solicitar una Audiencia Imparcial antes de la fecha límite.

Qué Puede Esperar de la Audiencia Imparcial: El Estado le enviará una notificación que le informará de cuándo y dónde se llevará a cabo la Audiencia Imparcial. En la audiencia, usted tendrá la oportunidad de explicar la razón por la que considera que nuestra decisión es errónea. Usted puede traer a la audiencia a un abogado, un pariente, un amigo, o alguien para que le ayude con este propósito. Si usted no puede presentarse en persona, puede enviar a alguien que le represente. Si va a enviar a alguien que no es abogado a la audiencia que le represente, debe darle a esa persona una carta para el oficial de audiencias que indique que usted desea que esta persona le represente en la audiencia.

Si usted está incapacitado(a), y no puede transportarse, puede comparecer mediante un representante, ya sea un amigo, pariente o abogado. Si su representante no es abogado, ni empleado(a) de abogado, su representante debe traer una carta firmada al oficial de Audiencias Imparciales.

Durante la audiencia, usted y su abogado u otro representante tendrán la oportunidad de explicar por qué estamos equivocados y la oportunidad de entregarle al Oficial de Audiencias documentos que aclaren por qué estamos equivocados.

Para ayudarle a explicar en la audiencia por qué usted cree que estamos equivocados, usted debe traer a cualquier testigo que le puedan ayudar. Además, debe traer cualquier documento que tenga, como: talones de paga, contratos de arrendamiento, recibos, cuentas, declaraciones médicas.

En la audiencia, usted y su abogado u otro representante pueden interrogar a los testigos por parte nuestra o suya.

SI SU SITUACIÓN ES EXTREMADAMENTE GRAVE, EL ESTADO INTENTARÁ TRAMITAR SU PETICIÓN DE AUDIENCIA IMPARCIAL LO MÁS RÁPIDO POSIBLE. SI USTED LLAMA PARA SOLICITAR UNA AUDIENCIA, FAVOR DE ESTAR LISTO PARA EXPLICAR SU SITUACIÓN A LA PERSONA QUE CONTESTE EL TELÉFONO. SI ESCRIBE, FAXEA O SE COMUNICA CON NOSOTROS POR INTERNET, NO FALTE EN EXPLICAR SU SITUACIÓN.

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

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un facsímil, le proporcionaremos copias gratuitas de los documentos que se encuentran en su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por facsímil, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para pedir documentos o para averiguar cómo revisar su archivo, llámenos al (718) 722-5012, por facsímil al (718) 722-5018 o escriba a: HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201. Si desea copias de documentos contenidos en su archivo, debe pedirlos con anticipación. Éstos se le enviarán dentro de un plazo adecuado antes de la fecha de la audiencia. Los documentos serán enviados por correo sólo si lo solicita específicamente.

INFORMACIÓN: Si desea más información sobre su caso, cómo pedir una Audiencia Imparcial, cómo revisar su archivo o cómo obtener copias adicionales de documentos, llame o escribanos al número telefónico y/o dirección que aparecen en la **página 1** de este aviso.

PETICIÓN DE AUDIENCIA IMPARCIAL

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

Nombre en Letras de Molde: _____ Núm. del Caso: _____
Nombre I. Apellido

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____ Teléfono: _____

Firma: _____ Fecha: _____