



# FAMILY INDEPENDENCE ADMINISTRATION

James K. Whelan, Executive Deputy Commissioner

Jill Berry, Deputy Commissioner  
Office of Program Support

Stephen Fisher, Assistant Deputy Commissioner  
Office of Procedures

## **POLICY DIRECTIVE #15-17-ELI** *(This Policy Directive Replaces PD #14-03-ELI)*

### **GRANTS OF ASSISTANCE FOR GUIDE/SERVICE DOG FOOD PROGRAM**

<b>Date:</b> June 29, 2015	<b>Subtopic(s):</b> SSI, Project Support
<b>AUDIENCE</b>	The instructions in this policy directive are for staff in Job Centers, Non Cash Assistance (NCA) Supplemental Nutrition Assistance Program (SNAP) Centers, and the Office of Project Support (OPS). It is informational for all other staff.
<b>REVISIONS TO THE ORIGINAL DIRECTIVE</b>	<p>This policy directive has been revised as follows:</p> <ul style="list-style-type: none"> <li>The Office of Project Support has relocated to 150 Greenwich Street, 36<sup>th</sup> Floor, New York, NY 10007. All references to the address have been updated accordingly.</li> </ul>
<b>POLICY</b>	Blind, hearing impaired, and/or disabled individuals that maintain a guide, hearing, or service dog may be eligible to receive a monthly Grant of Assistance for Guide Dogs (GAGD) in order to provide food for the dog.
<b>BACKGROUND</b>	<p>A guide, hearing or service dog is trained to assist a person with a disability (blind, hearing impaired, and/or disabled). These dogs are used to help bridge the gap between a disabled person’s physical abilities and the architectural, cultural and other requirements of our society.</p> <p>A Grant of Assistance for Guide Dogs (GAGD) allows the owner to purchase food for the dog’s maintenance. Eligibility for this grant is determined based on information contained in the Application/Recertification Guide/Service Dog Food Program form (<b>LDSS-3087</b>). Continued eligibility is thereafter redetermined every six months. A face to face interview is not required as recertification</p>

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

is done by mail. A recertification cover letter (**LDSS-3097**) and form **LDSS-3087** are mailed 60 days prior to the recertification date.

**Determination of Eligibility**

In order to be eligible to receive a Grant of Assistance for Guide Dog (GAGD) an applicant must:

NOTE: The SDX screen identifies an individual as disabled but does not indicate the actual disability. Therefore, a physician’s statement establishing the individual’s handicap is acceptable.

- Reside in New York City.
- Be determined eligible for or in receipt of SSI benefits or additional State payments.
- Be visually handicapped, hearing impaired, or disabled.
- Not have any earned income exempted for maintenance of a guide dog pursuant to Federal law or regulations.
- Maintain a guide, hearing or service dog.

**REQUIRED ACTION**

When an individual makes an inquiry via telephone or in person at a Job Center or NCA SNAP Center regarding a grant of assistance to provide food for a guide, hearing or service dog, staff must advise the individual to call the OPS Guide Dog Food Program at (929) 221-6692 or (929) 221-6688.

An authorized representative can complete and sign the **LDSS-3087** for applicants/participants.

Upon request, the OPS Guide Dog Food Program Coordinator must mail Form **LDSS-3087** to the applicant or his/her authorized representative. The **LDSS-3087** instructs the applicant/participant to complete, sign, and mail the application back to the OPS Guide Dog Food Program Coordinator at:

New address

Office of Project Support  
 150 Greenwich Street, 36th Floor  
 New York, NY 10007  
 Attention: Guide Dog Food Program

Inform applicant of the correct address in the event that the form does not have the correct address.

If an applicant brings the **LDSS-3087** to a Job Center or NCA SNAP Center, staff must instruct the applicant to mail the application back to the OPS Guide Dog Food Program Coordinator at the address indicated on the form.

When the completed **LDSS-3087** is received, the OPS Guide Dog Food Program Coordinator must determine eligibility within 30 days and advise the applicant of the decision using the Notice of Determination on Application for Guide Dog Food Assistance Program (**M-686C**). If the applicant is eligible, a monthly grant will be issued in the amount of \$35.00. The Coordinator of the Guide Dog Food Program is responsible for mailing a single issuance check

each month to participants.

These payments will not appear in the Welfare Management System (WMS). Questions about the payments should be referred to the OPS Guide Dog Food Program Coordinator.

Form **LDSS-3087** advises the applicant/participant of his/her responsibility to provide immediate notification of the following changes that may affect eligibility for the Guide Dog Food Program:

- Loss of dog;
- Termination of Supplemental Security Income (SSI) benefits;
- Change of address; or
- Returning to employment.

**PROGRAM IMPLICATIONS**

Paperless Office System (POS) Implications

There are no POS implications.

SNAP Implications

Grants of Assistance for Guide Dogs are reimbursements and are excluded as income. Recipients of these grants cannot claim a SNAP deduction for guide dog expenses. However, if the SNAP participant can verify that the cost of maintaining the guide dog exceeds the amount of the grant, the excess amount can be included as a medical deduction.

Medicaid Implications

There are no Medicaid implications.

**FAIR HEARING IMPLICATIONS**

Avoidance/Resolution

An applicant/participant who is denied a grant of assistance for food for a guide dog is entitled to request a fair hearing. The individual should be given an opportunity for a conference/resolution of this issue.

Conferences at Job Centers

An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If an individual comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. In Model Centers, the Front Door Receptionist will issue an FH&C ticket to the applicant/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 call OPS at (929) 221-6692 or (929) 221-6688 to review the case and conduct a conference via telephone.

After reviewing the case and discussing the issue(s) with a Guide Dog Food Program Coordinator, the Guide Dog Food Program Coordinator will make a decision and explain the reason for the Agency's action(s) to the individual.

Should the individual elect to continue his/her appeal by requesting a Fair Hearing or proceeding to a 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 an applicant comes to the SNAP Center and requests a conference, the Receptionist must alert the Center Director's designee that the applicant is to be seen. If the applicant contacts the Eligibility Specialist directly, advise the applicant to call the Center Director's designee. In Model Centers, the Receptionist at Main Reception will issue a SNAP Conf/Appt/Problem ticket to the applicant to route him/her to the Non Cash Assistance (NCA) Reception area and does not need to verbally alert the Center Director. The NCA Receptionist will alert the Center Director once the applicant is called to the NCA Reception desk.

The Center Director's designee will call OPS at (929) 221-6692 or (929) 221-6688 to review the case and conduct a conference via telephone.

After reviewing the case and discussing the issue(s) with a Guide Dog Food Program Coordinator, the Guide Dog Food Program Coordinator will make a decision and explain the reason for the Agency's action(s) to the individual.

The Center Director’s designee is responsible for ensuring that further appeal by the applicant 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**

A case record containing the application/recertification and all subsequent actions is maintained in the Office of Project Support, located at:

**New address**


150 Greenwich Street, 36th floor  
 New York, NY 100078  
 (929) 221-6692 or (929) 221-6688

The Guide Dog Food Program Coordinator is available to the Fair Hearing unit as needed.

**REFERENCES**

18 NYCRR 397.10  
 NYS Social Services Law Section 207 – 210  
[10 INF-11-T](#)  
[01 INF-01](#)  
[Temporary Assistance Source Book](#), Chapter 12, section H; Chapter 23, section A  
[Supplemental Nutrition Assistance Program \(SNAP\) Source Book](#), Section 12 (D), Section 13

**ATTACHMENTS**

 Please use Print on Demand to obtain copies of forms.

- LDSS-3087** Application/Recertification Guide/Service Dog Food Program (Rev. 4/15)
- LDSS-3097** Letter for 3087 (Rev. 1/13)
- M-686c** Notice of Determination on Application for Guide Dog Food Assistance Program (Rev. 6/29/15)
- M-686c (S)** Notice of Determination on Application for Guide Dog Food Assistance Program (Spanish) (Rev. 6/29/15)

## APPLICATION/RECERTIFICATION GUIDE/DOG FOOD PROGRAM

Directions:

1. **PLEASE PRINT CLEARLY AND DO NOT WRITE IN THE SHADED AREAS.**
2. **BE SURE TO SIGN THE FORM.**
3. **RETURN THE FORM TO YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES.**

The Local Department is listed in the White Pages of your telephone directory, alphabetically, under the name of your County. New York City residents should send application to: Office of Program Support, Attention: Guide Dog Food Program Coordinator, 150 Greenwich Street, 36<sup>th</sup> Floor, New York, NY 10007. If you need assistance, contact your local Department of Social Services or the NYS Office of Temporary & Disability Assistance - Hotline toll-free at 1-800-342-3009.

CENTER/OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE <b>18</b>	CASE NUMBER	REGISTRY NUMBER	VERS.
CASE NAME				DISTRICT		NUMBER REUSE INDICATOR	
NAME		(LAST)	(FIRST)	(M.I.)	SOCIAL SECURITY NUMBER		

**PLEASE LIST HERE ANY MAIDEN NAME OR OTHER NAME BY WHICH YOU ARE KNOWN**

ONC	NAME	(LAST)	(FIRST)	(M.I.)
ONC	NAME	(LAST)	(FIRST)	(M.I.)

DATE OF BIRTH:	(MONTH)	(DAY)	(YEAR)	SEX	(M/F)	:	CLIENT ID NUMBER
ADDRESS:	(STREET)	(CITY)	(COUNTY)	(STATE)	(ZIP CODE):	PHONE NUMBER	

**MAILING ADDRESS IF DIFFERENT FROM ABOVE**

(STREET)	(CITY)	(COUNTY)	(STATE)	(ZIP CODE)
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If you are a blind, deaf or disabled Supplemental Security Income (SSI) recipient, or have been determined to be eligible for SSI, and/or have been determined to be eligible for or are in receipt of an additional state payment, you may be entitled to a \$35 monthly food grant for your guide/service dog. Grant eligibility will be based on your answers to the following:

	YES	NO
1. Are you a resident of New York State?		
2. Are you blind?		
3. Are you deaf?		
4. Are you disabled?		
5. Have you been determined eligible for Supplemental Security Income (SSI)?		
6. Are you a recipient of Supplemental Security Income (SSI)?		
7. Have you been determined eligible for an additional state payment?		
8. Are you a recipient of an additional state payment?		
9. Are you currently receiving an exemption of earned income, wages or salary from a job or self-employment for the purpose of purchasing guide/service dog food?		
10. Do you maintain a guide/service dog?		

**AFFIRMATION:** I swear (affirm) that the information I have given is correct and I consent to an investigation made by the Department of Social Services with regard to this application. Furthermore, I agree to notify the Department of Social Services of any of the following status changes: **Loss of Dog; Termination of SSI Benefits; Change of Address; or Returning to Employment.**

SIGNATURE OF APPLICANT (IF APPLICANT USES "X", HAVE WITNESS SIGN BELOW)	Date
SIGNATURE OF WITNESS	Date
ADDRESS OF WITNESS	(STREET) (CITY) (STATE) (ZIP CODE)

<input type="checkbox"/> OPENING	<input type="checkbox"/> DENIAL	<input type="checkbox"/> RECERTIFICATION	REASON CODE	EFFECTIVE DATE
<input type="checkbox"/> REOPENING	<input type="checkbox"/> WITHDRAWAL	<i>NOTE: For Recertification, Use Transaction Type 05 - Change</i>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
ELIGIBILITY DETERMINED BY (WORKER)	DATE	ELIGIBILITY APPROVED BY (SUPR.)	DATE	
SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION	DATE	EMPLOYED BY:		
		<input type="checkbox"/> PROVIDER AGENCY SPECIFY _____	<input type="checkbox"/> SOCIAL SERVICE DISTRICT	

Dear SSI eligible applicant/recipient:

The provision of the Guide/Service Dog Food Program (under which you are currently receiving a \$35.00 benefit) requires that you complete the attached Application/Recertification Guide/Service Dog Food Program (LDSS-3087) every six months.

In order to ensure the processing of or continuation of your current grant, please return the completed Application/Recertification form within 30 days to your local Social Services office listed above. It is important that you promptly respond to avoid disruption or cancellation of your benefits.

If you need any further assistance, please contact your local Department of Social Services or the New York State Office of Temporary and Disability Assistance (OTDA) toll-free number: 1- 800-342-3009.

Sincerely,

Attachment

Office Of Project Support  
Guide Dog Food Program  
150 Greenwich Street, 36th Floor  
New York, NY 10007  
Attn: Coordinator

Notice Date: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Center: \_\_\_\_\_  
FH&C Telephone: \_\_\_\_\_

### Notice of Determination on Application for Guide Dog Food Assistance Program

After careful consideration of your application for the Guide Dog Food Assistance Program, we find that you are:

eligible for assistance from the program and will receive, on or about the first day of each month, a check for \$35. Payments will be issued retroactive from \_\_\_\_\_ (date) .

ineligible for assistance from the program due to the following reason(s):

**Our clearance indicates:**

- You are not eligible for, or in receipt of, Supplemental Security Income (SSI) benefits.
- You are not blind, deaf, or disabled.

**Your application indicates:**

- You do not own a guide dog.
- You are employed. SSA exempts some earnings for the maintenance of a guide, hearing or service dog from consideration when determining your SSI benefit.
- Other (specify): \_\_\_\_\_

The law(s) and/or regulation(s) that allow(s) us to do this is/are 18 NYCRR § 397.10.

\_\_\_\_\_  
Signature of Guide Dog Coordinator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

**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 Information

### CONFERENCE

If you think our decision is wrong, or if you do not understand our decision, please call us to set up a conference (a conference is an informal meeting with us). To do this, call the Fair Hearing and Conference (FH&C) unit phone 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.

### STATE FAIR HEARING

**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 (and keep a copy for yourself) 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**

**(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>

**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. To help explain your case, you can bring a lawyer and/or witnesses such as a relative or a friend to the hearing, and/or give the Hearing Officer any written documentation related to your case such as: pay stubs, leases, receipts, bills and/or doctor's statements, etc. 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 that person a letter to show the Hearing Officer that you want that person to represent you. At the hearing, you, your lawyer or your representative can also ask questions of witnesses whom we bring, or you bring, to explain the case.

**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.

**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 phone number/address listed on **page 1** of this notice.

**FAIR HEARING REQUEST**

**Continuing Your Benefit(s):** If our decision affects your benefits and you ask for a Fair Hearing within ten (10) days of the date of this notice, we will restore your benefits to the level that they were at before this notice, until a Fair Hearing decision is issued. If you ask for a conference only, and not a State Fair Hearing, your benefits will not be restored to the level that they were at before this notice.

If you lose the Fair Hearing, you will have to pay back any benefits that you received, but should not have received, while you were waiting for the Fair Hearing decision. If you ask for a Fair Hearing and you do not want your benefits to be restored while you wait for the decision to be issued, you must tell the State when you call for a Fair Hearing, OR check the box below and send back this notice.

**I do not want my benefits restored while I wait for the Fair Hearing decision to be issued.**

**Deadline:** If you want the State to review our decision, you must ask for a Fair Hearing within sixty (60) days from the date of the notice for Cash Assistance, medical assistance, or social services issues; and you must ask within ninety (90) days for Supplemental Nutrition Assistance Program (SNAP) issues.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, in person or online, please write to ask for a Fair Hearing before the deadline.

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

SAMPLE

Print Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

Name M.I. Last Name

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Of Project Support  
Guide Dog Food Program  
150 Greenwich Street, 36th Floor  
New York, NY 10007  
Attn: Coordinator**

Fecha del Aviso: \_\_\_\_\_  
Número del Caso: \_\_\_\_\_  
Nombre del Caso: \_\_\_\_\_  
Centro: \_\_\_\_\_  
Teléfono de FH&C: \_\_\_\_\_

### **Aviso de Determinación sobre la Solicitud para el Programa de Asistencia para Comida de Perros Guía**

Tras revisar cuidadosamente su solicitud del Programa de Asistencia para Comida de Perros Guía, concluimos que usted:

es elegible para asistencia del programa y recibirá un cheque de \$35 el o cerca del primer día de cada mes. Se emitirán retroactivamente los pagos a partir del \_\_\_\_\_ .  
(fecha)

es inelegible para asistencia del programa a raíz del/los siguiente(s) motivo(s):

**Nuestra autorización indica que:**

- Usted no reúne los requisitos para beneficios de Ingreso de Seguridad Suplemental (SSI), ni recibe los mismos.
- Usted no es ni ciego, ni sordo, ni discapacitado.

**Su solicitud indica que:**

- Usted no posee un perro guía.
- Usted está empleado. La Administración de Seguridad Social (SSA) exime algunos ingresos para la manutención de perros guía, para sordos, o para servicios, respecto a la determinación de sus beneficios de Ingreso de Seguridad Suplemental (SSI).
- Otro caso (especifique): \_\_\_\_\_

La(s) ley(es) y/o regulación(es) que nos permite(n) obrar de este modo es/son 18 NYCRR § 397.10.

\_\_\_\_\_  
Firma del Coordinador de Perros Guía

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Supervisor

\_\_\_\_\_  
Fecha

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

## Información sobre Conferencias y Audiencias Imparciales

### CONFERENCIA

Si usted considera que nuestra decisión ha sido errónea, o si no la entiende, por favor llámenos para programar una conferencia (reunión informal con nosotros). Para ello, llame al número de teléfono de la unidad de Audiencias Imparciales y Conferencias (Fair Hearing and Conference – FH&C) en la **página 1** de este aviso, o escríbanos a la dirección en la **página 1** de este aviso. A veces éste resulta el modo más rápido de solucionar algún problema que pueda tener. Le recomendamos que así lo haga, aun si ha solicitado una Audiencia Imparcial. En el caso de solicitar una conferencia, usted seguirá teniendo derecho a una Audiencia Imparcial.

### AUDIENCIA IMPARCIAL ESTATAL

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

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

**(2) POR ESCRITO:** Envíe una copia (y guarde una copia para sí) de todo este 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**

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

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

**(5) POR INTERNET:** Llene un formulario de petición electrónica en: <http://www.otda.state.ny.us/oah/forms.asp>

**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. Para ayudarle a presentar su caso, usted puede traer a la audiencia a un abogado y/o testigos como familiares o amigos, y/o entregarle al Funcionario de la Audiencia cualquier documento escrito relacionado con su caso tal como: talones de paga, contratos de arrendamiento, recibos, cuentas y/o declaraciones médicas, etc. Si no puede acudir a la audiencia, puede enviar a alguien que le represente. Si tal representante no es abogado, usted debe proporcionarle una carta para que el Funcionario de la Audiencia sepa que usted desea que esa persona le represente. Durante la audiencia, usted, su abogado o su representante también pueden interrogar a los testigos por parte nuestra o suya, para aclarar el caso.

**Si usted padece una discapacidad, y no puede trasladarse,** puede comparecer mediante un representante, o un amigo, pariente o abogado. Si su representante no es abogado, ni es empleado de abogado, su representante debe traerle al funcionario de audiencias una carta escrita y firmada.

**ASISTENCIA LEGAL:** Si usted necesita asistencia legal gratuita, puede obtener tal asistencia al comunicarse con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede ubicar la Sociedad de Ayuda Legal o grupo de abogacía más cercana al buscar 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 como 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. Éstas 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 usted desea más información sobre su caso, cómo solicitar 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**

**Continuación de Su(s) Beneficio(s):** Si nuestra decisión afecta sus beneficios y usted solicita una Audiencia Imparcial dentro de diez (10) días a partir de la fecha de este aviso, nosotros restauraremos sus beneficios al nivel anterior a este aviso, hasta que la decisión de la Audiencia Imparcial sea emitida. Si usted solicita sólo una conferencia, en vez de una Audiencia Imparcial Estatal, sus beneficios no se restaurarán al nivel de beneficios anterior a este aviso.

Si usted pierde la Audiencia Imparcial, tendrá que devolver cualquier beneficio que haya recibido sin derecho a ello, mientras esperaba la emisión de la decisión. Si solicita una Audiencia Imparcial y no desea que sus beneficios se restauren mientras espera la decisión de la Audiencia Imparcial, usted debe informar al Estado al llamar para una Audiencia Imparcial, O marcar la casilla más abajo y devolver este aviso.

**No deseo que se restauren mis beneficios mientras espero que se emita la decisión de la Audiencia Imparcial.**

**Fecha Límite:** Si usted desea que el Estado revise nuestra decisión, tiene que solicitar una Audiencia Imparcial dentro de sesenta (60) días a partir de la fecha de este aviso para asuntos de Asistencia en Efectivo, asistencia médica, o de servicios sociales; y tiene que presentar solicitud dentro de noventa (90) días para asuntos del Programa de Asistencia de Nutrición Suplementaria (SNAP).

Si usted no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporal y para Discapacitados (New York State Office of Temporary and Disability Assistance) por teléfono, por fax, en persona o por Internet, favor de solicitar por escrito una Audiencia Imparcial antes de la fecha límite.

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

SAMPLE

En Letras de Molde: \_\_\_\_\_ Núm. del Caso: \_\_\_\_\_  
Nombre I. Apellido

Dirección: \_\_\_\_\_ Teléfono: \_\_\_\_\_  
\_\_\_\_\_

Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_