



FAMILY INDEPENDENCE ADMINISTRATION

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POLICY DIRECTIVE #15-23-ELI *(This Policy Directive Replaces PD #08-43-ELI)*

EMERGENCY ASSISTANCE TO NEEDY FAMILIES WITH CHILDREN (EAF)

Date: September 8, 2015	Subtopic(s): Emergency Assistance
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AUDIENCE The instructions in this policy directive are for Job Center staff and are informational for all other staff.

REVISIONS TO THE PRIOR DIRECTIVE

This policy directive is being revised to inform staff that:

- For Emergency Assistance to Needy Families (EAF), shelter arrears payment is limited to a total period of six months, once every five years. Utility arrears assistance may be granted more than once in a 12-month period.
- Households with one member in receipt of Social Security Income (SSI) and/or State Supplement Program (SSP) at the time of EAF determination do not have to meet the gross income standards.
- The EAF Agreement to Repay Excess Shelter Arrears (**W-147KK**) form was updated to include property tax as a shelter expense, and no longer requires an applicant signature.
- The Information About Repaying the Department of Social Services For Rental Arrears (**W-147PP**) form is given to the applicant to understand the repayment billing process.
- The Utility Arrears/Emergency Heating (**M-858M**) form is completed for every utility arrears request.
- The Utility Arrears Repayment Agreement Worksheet (**W-147XX**) helps determine if the applicant is required to repay the utility arrears assistance.
- The Utility Arrears Repayment Agreement (**W-147X**) form has been updated with a new mailing address for HRA Division of Accounts Receivable and Billing.
- The applicant will receive Notice to Report to Center (**M-3g**) form, if applicable, to return to Job Center to sign the **W-147X**.

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 Information About Repaying the Department of Social Services For Utility Arrears (**W-147NN**) form is given to the applicant to understand the repayment billing process.
- The mailing address for the Human Resources Administration (HRA) Division of Accounts Receivable and Billing (DARB) has been updated.
- The Single Issuance (SI) Grant Requests and Issuance Task List window in POS is used to determine eligibility for EAF.
- The Determination of Eligibility for EAF (**W-145TT**) form and the Shelter Arrears Repayment Agreement Worksheet (**W-147F**) are pre-filled in POS, and automatically saved into the HRA OneViewer.
- The Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance [For Applicants Only] (**W-145HH**) form will be mailed by MIS to the applicant to inform him/her of the Agency's decision on the request for shelter arrears.
- The Notice of Determination Regarding Your Request for a Utility Grant (**FIA-1104**) form is used to notify the applicant of the outcome of their request for emergency utility assistance.
- The Investigation, Revenue and Enforcement Administration (IREA) Repayment Transmittal (**W-113B**) is used to submit a list of cases to IREA, when the request decision is processed manually.
- **Attachment A** (List of EAF-Eligible Issuance Codes) has been updated.

POLICY

EAF is a federally funded program dedicated to meeting the emergency needs of families with children. The emergency situation must be a result of a sudden occurrence or set of circumstances requiring immediate attention. In addition, the emergency assistance is necessary to avoid destitution of the child. Individuals claiming an emergency need must have a same-day interview.

Applicants who need emergency assistance with shelter arrears or utility arrears may be eligible for a payment to prevent eviction/foreclosure or utility disconnect.

BACKGROUND

Applicants Applying for One Shot Deals

To be categorically eligible for EAF, the household must contain either an individual with a medically verified pregnancy, or a child under the age of 18, or age 18 and attending full-time secondary school or the equivalent level of vocational or technical training.

In addition, the following criteria must be met:

Categorical Eligibility for EAF

- The child must be currently living with an adult related by blood, marriage or adoption;
- The child, parents or other eligible relatives must be without immediately accessible resources necessary for meeting their needs, and those needs cannot be met by an advance allowance;
- The child must be facing destitution or requiring emergency assistance to provide living arrangements for him/her in a home; and
- The emergency could not have been foreseen by the applicant, and was not under his/her control.

Note: Utility payments are not subject to the “sudden and unforeseen” EAF requirement.

Financial Eligibility for EAF

Financial eligibility for EAF is not based on financial eligibility for Cash Assistance (CA), but rather on actual income and resources available on the date of the application to meet the emergency need.

See Federal Poverty Level Guidelines for Emergency Assistance to Families (EAF) and Emergency Safety Net Assistance (ESNA) Categories of Assistance form (**EXP-76D**)

In order to be financially eligible for EAF, the gross available income of the applicant on the date of application must be at or below 200% of the federal poverty level for that household size. In addition, the applicant must be without the resources to meet the emergency need (income, money on hand, bank accounts, etc.).

If the applicant’s available gross income on the date of application is above the 200% federal poverty level guideline for the applicant’s family size, and the income is sufficient, assistance under EAF cannot be granted.

To be eligible for EAF, the applicant’s available resources must not exceed the Resource Limits. Refer to the CA and SNAP Resource Limits/Exemptions Desk Guide form (**W-204X**) for the current Resource Limits. A resource must be easily converted to available cash, even if it results in a penalty for liquidating the resource, such as in the case of stocks, bonds, etc. The family must be without resources immediately available to meet the emergency need.

Revised

The gross available income standards do not apply to households receiving child protective, child preventative, or any other child welfare services paid for under EAF. Such households must, however, include one member in receipt of CA or Supplemental Security Income (SSI) and/or State Supplement Program (SSP) at the time of the EAF determination.

EAF cannot be granted in the following instances:

- When the emergency is the result of a refusal to accept employment or training for employment without good cause;
- When the emergency is the result of mismanagement of the CA grant; or
- When the grant replaces or duplicates assistance for which a person would otherwise be eligible, were it not for an employment or other program sanction.

Note: When mismanagement of a CA grant exists, the household is not eligible for EAF payment, but must still be evaluated for emergency assistance under the current case category.

Note: Emergency assistance cannot be requested to cover the share of an individual person in “sanction” status. The amount of assistance for which the remaining household members are deemed eligible must be sufficient to overcome the household’s emergency need. However, the sanction policy does not apply to households requesting emergency utility assistance.

An EAF grant may be a cash grant, a direct vendor check payment, and/or supplies necessary to meet the identified emergency need. All payments for shelter arrears will be made in the form of a check made payable to the landlord or managing agency.

When a household falls behind paying their rent, mortgage, or property tax due to an unforeseen event(s), they may be eligible for a shelter arrears grant. When a household falls behind in paying utilities or are facing a utility disconnect, they may be eligible for a utility arrears grant.

For EAF, the following rules apply:

Shelter Arrears

New
Refer to [PD #15-21-ELI](#).
The amount of the shelter arrears payment is limited to a total period of six months, once every five years. However, the Rental Assistance Unit (RAU) may determine, on a case-by-case basis, whether an exception to policy should be made for additional shelter arrears payment, if necessary.

The payment of shelter arrears above the Agency maximum monthly shelter allowance is subject to recovery. Applicants applying for an EAF grant that exceeds the Agency monthly shelter allowance must repay the excess portion of the EAF grant.

New
The **W-147KK** informs the applicant that he/she will receive a monthly bill from the HRA Division of Accounts Receivable and Billing (DARB), until the full amount of the excess portion of the EAF grant is paid in full. The **W-147PP** form contains information about the repayment billing process, and must be given to the applicant along with the **W-147KK** form.

Refer to [PB #15-55-SYS](#)
Note: Previously, the **W-147KK** required a signature from the applicant. The form was revised and no longer requires an applicant signature. When required, the **W-147KK** and **W-147PP** are mailed by the Management Information Systems (MIS) to the applicant via Print-to-Mail (PTM).

Utility Arrears

New
Utility arrears assistance may be granted more than once in a 12-month period, if the applicant has met or is making his/her repayment obligations for prior utility arrears assistance.

New
Refer to [PD #14-12-ELI](#).
The Utility Arrears/Emergency Heating (**M-858m**) form must be filled out for every utility arrears request.

New
Refer to [PB #13-73-OPE](#)
When an applicant requests emergency assistance to pay utility arrears, and he/she has exhausted all of his/her available resources, the JOS/Worker must complete form **W-147XX** to determine if the applicant is required to repay the utility arrears assistance. Utility arrears may be recoverable if the household's gross monthly income on the date of application is greater than the CA monthly standard of need.

Revised

Refer to
[PD #14-12-ELI](#).

If the applicant is required to repay the utility grant, the JOS/Worker must have the applicant sign the completed **W-147X** form as a condition of eligibility for utility assistance. If the approval is not received from the utility liaison on the same day as the request, the applicant will be required to return to sign form **W-147X** prior to payment of the grant. The **W-147X** must be signed by the applicant after the amount to be repaid is entered on the form. Under no circumstance should an applicant be required to sign a blank **W-147X** form in advance. If necessary, the applicant will receive the Notice to Report to Center (**M-3g**) form to return to the Job Center to sign the **W-147X**. The **W-147X** must be scanned and indexed into the HRA OneViewer.

New

New

The **W-147NN** must be given to the applicant along with a copy of the signed **W-147X**. The **W-147NN** notice contains information that will help the applicant understand the repayment billing process.

Revised

Form **W-147X** includes an agreement that the household will repay the amount of the utility arrears grant in twenty-four monthly installments. DARB will send a monthly bill with an addressed postage-free return envelope.

The household is responsible for mailing payments in the return envelope provided to:

Revised

Human Resources Administration
Division of Accounts Receivable and Billing
150 Greenwich Street, 34th Floor
New York, NY 10007

Households receiving utility arrears assistance will not be eligible for future assistance unless all prior utility arrears payments have been fully paid, or are currently being repaid in accordance with the repayment agreement (has not defaulted on the current repayment agreement and is not in arrears). If the household fails to repay the utility arrears assistance within twenty-four months, HRA will enforce the repayment agreement by any method available to a creditor, including referring the matter to a collection agency, obtaining a judgment from a court, obtaining a lien on real property, or garnishing wages, where appropriate.

Note: See **Attachment A** for a list of all of the issuance codes that may be issued under EAF if all other EAF eligibility criteria are met.

REQUIRED ACTION

One Shot Deal

If the applicant is applying for a One Shot Deal (OSD), and the household contains either an individual with a medically verified pregnancy, or a child under the age of 18, or age 18 and attending full-time secondary school or the equivalent level of vocational or technical training, the JOS/Worker must:

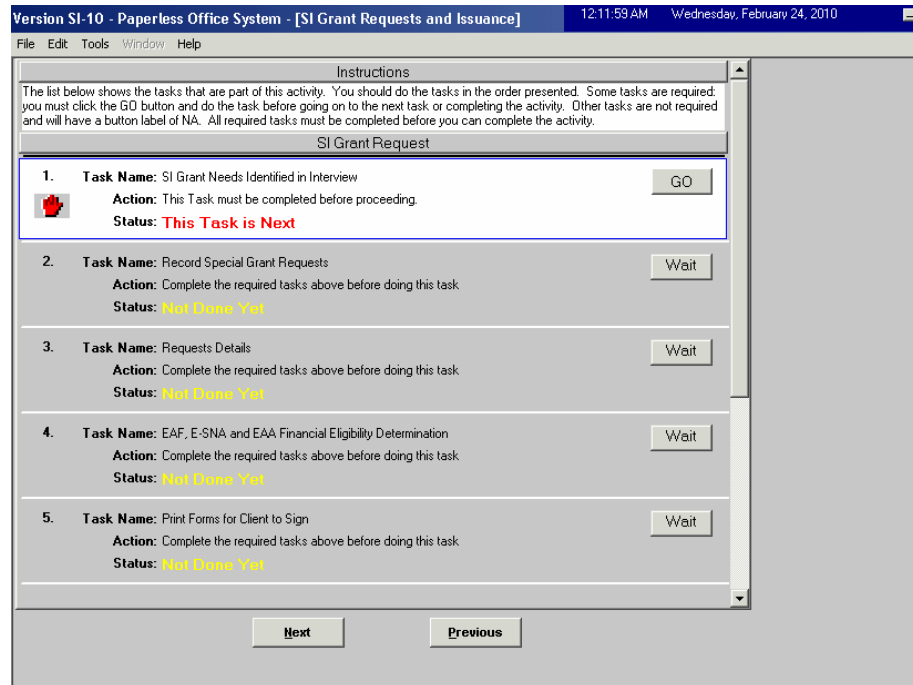
- Select the “**One Shot Deal**” check box from the Site Determination window in POS.
- Select the EAF category in the Case Log-in window of the **POS Application Intake**.
 - Once “**One Shot Deal**” is selected, a check mark will automatically appear in the “**CA**” check box.

Revised

During the POS Application Interview, POS will prompt the JOS/Worker to complete the **SI Grant Requests and Issuance Task List** window.

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

Task 1 of the **SI Grant Requests and Issuance Task List** window displays the needs identified during the interview, for which a grant is requested (i.e., rent arrears, utility arrears, pregnancy allowance, back rent, etc.). The JOS/Worker must indicate the needs in **Task 1**.



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

Based on the response to questions, **Task 4** of the **SI Grant Requests and Issuance Task List** window is used to determine eligibility for benefits under the EAF category. If the household does not qualify under the EAF category, eligibility for benefits under E-SNA category is determined.

Revised

When **Task 4** is completed, POS will pre-fill and automatically save the Determination of Eligibility for EAF (**W-145TT**) and Shelter Arrears Repayment Agreement Worksheet (**W-147F**) forms into the HRA OneViewer.

Refer to [PD #15-21-ELI](#).

Note: If POS is down, the JOS/Worker must ensure that forms **W-145TT** and **W-147F** are completed, scanned, and indexed as part of an EAF eligibility determination.

The **EAF/E-SNA Eligibility Determination** window outlines eligibility for EAF/E-SNA. This window also determines whether a repayment agreement is required for utility and/or rent arrear requests.

EAF/E-SNA Eligibility Determination window:

Revised

Instructions
 This window shows a batch of grant requests made on a particular date for which the client may be eligible to receive under EAF or E-SNA. Unlike the SNA 125% income test, the EAF test is only applicable to income that is actually available to the EAF household on the date of application, not the household's anticipated or past income. Income guidelines are updated annually. For example, an applying household may have received income exceeding 200% but on the day of EAF application has less than 200% of that income available, therefore passing the income test and any available income is applied to the emergency need.

Request Date: 03/09/2010
 Crisis is Due to: Emergency medical expenses required all available resources to be diverted from rent
 Other Crisis Details: ee
 Emergency Type: ee
 Cause: ee

Qualifying child or pregnant individual in household? No
 Does the household have income available on the day of application? Yes No Available monthly gross income amount:
 Resources available to meet needs? Yes No Total PA resources (from interview): \$0.00
 Emergency is result of refusal without good cause of employment or work activities/community service by employable relative or child? Yes No View Client Infraction History
 Emergency is result of sudden occurrence/situation, unforeseen and beyond the individual's control? Yes No

Utility Arrears Only
 Is the applicant/participant the client of record? Yes No
 Is the client of record receiving CA or SSI (or additional State payments) on the date of application or request? Yes No

Grant Request	Does this Grant Represent PA Duplication?	Financially Eligible For	Repayment Agreement
	Yes No	EAF? E-SNA?	Required?
Disaster Shelter	<input type="radio"/> Yes <input checked="" type="radio"/> No	No Yes	NA

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Task 5 of the **SI Grant Requests and Issuance Task List** window is used to print required forms, capture required signatures, and save eligibility worksheets.

New POS will save the following agency forms directly in the HRA OneViewer, without printing:

Refer to PD #10-22-SYS.

- **W-145TT** – This form will be pre-filled and saved when an EAF determination is made.
- **W-147F** – This form will be saved when a special grant request for shelter arrears is made.
- **W-147XX** – This form will be saved when a special grant request for utility arrears is made.

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

Task 8 of the **SI Grant Requests and Issuance Task List** window is used to print repayment agreements and capture required signatures of applicants/participants.

Revised

Task 8 allows the JOS/Worker to print and capture the applicant/participant’s signature on the Utility Arrears Repayment Agreement (**W-147X**).

New

Note: The **W-147KK** form no longer requires an applicant signature.

Task 8 also allows the Supervisor to print the following forms:

- Action Taken on your Request for Emergency Assistance or Additional Allowance (for participants only) (Form **W-137B**);
- Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (for applicants only) (Form **W-145HH**).

Shelter Arrears

EAF Applying for a One Shot Deal

Refer to [PD #15-21-ELI](#).

When a household is applying for a one-shot deal, and requests emergency assistance for shelter arrears, the JOS/Worker must register the case in the appropriate category. He/she should then initiate and refer the shelter request to the Homelessness Diversion Unit (HDU). HDU will process the request, and then refer the case to the Rental Assistance Unit (RAU). RAU will determine if the household is eligible for the emergency grant, and will relay the determination back to HDU staff in POS.

If the request is for shelter arrears, the JOS/Worker must determine:

- If the shelter grant is being duplicated. A shelter payment can be issued as long as the household meets the criteria for EAF, and the arrears are not used to duplicate or replace recurring shelter payments already issued.

- If an individual receives a one-time-only shelter arrears payment under EAF, any amount above the Agency monthly shelter allowance is an overpayment and is subject to recovery.
- If the arrears are caused by a sanctioned household member. Arrears caused by a sanctioned household member cannot be authorized.

If the applicant is eligible for a shelter arrears payment under the EAF category, the JOS/Worker must:

New

Refer to [PD #15-21-ELI](#).

- Provide the applicant with the POS prefilled **W-147KK** form and **W-147PP** form, if the shelter allowance is recoverable.
 - Form **W-147KK** informs the applicant that he/she will receive a monthly bill from DARB until the full amount of the excess portion of the EAF grant is paid in full.
 - The **W-147PP** contains complete information about the repayment billing process of the shelter arrears to the Department of Social Services.
- Single-Issue (**SI**) the case using Opening Code **Y38** (Case accepted only for emergency shelter arrears and/or emergency utility arrears which the applicant agrees to repay) on the POS Turn-Around Document (TAD).
- Enter Code **F** (Current EAF Authorization on a FA, SNFP, SNCA, SNNC, or EAF Case) in the **Emergency Indicator** in the **POS TAD** window, if the household is deemed eligible for the EAF grant based on the outcome on the **W-145TT**.
- Complete the **Single Issue Data Entry** window and enter the appropriate issuance code, as follows:
 - Special Grant Code **31** (Pre PA Rent Arrears) to issue the arrears payment equal to or below Agency maximum monthly shelter allowance for the household size.
 - If the rent/mortgage exceeds the Agency maximum for the household size, Special Grant Code **30** (Rent Payments in Excess of Maximum) must be used to cover the excess portion of the rent.
 - Special Grant Code **09** (Rent Only) must be used to pay rent, property taxes, and/or mortgage arrears.

The **W-145HH** form will be mailed by MIS to the applicant to inform him/her of the Agency's decision on the request for shelter arrears.

New

Refer to [PB #15-55-SYS](#)

Note: The **W-145HH** form was converted to the PTM process, and is now mailed by MIS on the day after the decision is recorded in POS and approved by the appropriate supervisor(s).

Once the emergency need has been met and the emergency authorization period ends, the JOS/Worker will:

- Change case status from “single issue” (SI) to “closed” (CL) using closing code **Y95** (Case Closed After Being Accepted for Emergency Assistance [Manual Notice]);
- Enter code **P** (Prior Emergency Authorization [Enter This Code When the Emergency Authorization Period Ends]) in the **Emergency Indicator** in the **POS TAD** window.

Applicants for Ongoing CA with an Emergency Need

EAF Applicants for Ongoing CA

When an applicant who applies for ongoing CA has an emergency need for shelter arrears, the case must be referred to HDU, then RAU.

Refer to
[PD #15-21-ELI](#).

Note: If POS is down, the JOS/Worker must ensure that Forms **W-145TT** and **W-147F** are completed to determine EAF eligibility. Forms **W-145TT** and **W-147F** must also be scanned and indexed into the HRA OneViewer.

If the amount requested exceeds the Agency monthly shelter allowance, the applicant must repay the excess portion of the grant.

The JOS/Worker must:

- Inform the applicant that if the case is not accepted for ongoing CA, the emergency shelter arrears payment becomes repayable.
- Provide the applicant with the POS prefilled **W-147KK** form and **W-147PP** form, if the shelter allowance is recoverable.
 - Form **W-147KK** informs the applicant that he/she will receive a monthly bill from DARB until the amount of the excess portion of the EAF grant is paid in full.
 - The **W-147PP** contains complete information about the repayment billing process of the shelter arrears to the Department of Social Services.

Upon receipt of the RAU approval, the JOS/Worker must:

- Single-Issue (**SI**) the case using Opening Code **Y41** (Case accepted for immediate needs) on the POS Turn-Around Document (TAD).

- Enter Code **F** (Current EAF Authorization on a FA, SNFP, SNCA, SNNC, or EAF Case) in the **Emergency Indicator** in the **POS TAD** window, if the household is deemed eligible for the EAF grant based on the outcome on the **W-145TT**.
- Complete the **LDSS- 3575** on the **Single Issue Data Entry** window and enter the appropriate issuance code, as follows:
 - Special Grant Code **31** (Pre PA Rent Arrears) to issue the arrears payment equal to or below the Agency maximum monthly shelter allowance for the household size.
 - If the rent/mortgage exceeds the Agency maximum monthly shelter allowance for the household size, Special Grant Code **30** (Rent Payments in Excess of Maximum) must be used to cover the excess portion of the rent.

Note: If the case is subsequently accepted for CA, the **W-147KK** is null and void. A recoupment for the Code 30 issuance must be initiated.

Refer to [PB #15-55-SYS](#)

The **W-145HH** form will be mailed by MIS to the applicant to inform him/her of the Agency's decision on the request for shelter arrears.

Additional Allowances for Participants

Participants requesting an additional allowance for emergency shelter assistance must complete the Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137A**) form.

The JOS/Worker must refer the case to HDU, who will then refer the case to RAU.

Upon receipt of RAU approval, the JOS/Worker must:

- Complete the **Single Issue Data Entry** window and enter Special Grant Code depending on circumstances in the Shelter/Recoupment field of the **LDSS-3575**.
- Enter Code **F** (Current EAF Authorization on a FA, SNFP, SNCA, SNNC, or EAF Case) in the **Emergency Indicator** in the **POS TAD** window, if the household is deemed eligible for the EAF grant based on the outcome on the **W-145TT**.
- Complete 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**) form advising the participant of the Agency's decision.

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

Utility Arrears

EAF Applying for a One Shot Deal

Refer to
[PD #14-12-ELI](#).

The decision on the application for utility arrears is made at the Job Center level. The JOS/Worker must follow the instructions outlined in [PD #14-12-ELI](#) (Revisions to the Utility Process).

The JOS/Worker must:

New

Refer to
[PD #14-12-ELI](#).

- Complete the Notice of Determination Regarding Your Request for a Utility Grant (**FIA-1104**) to inform the applicant of the outcome of his/her request for emergency utility assistance.
- Determine whether or not the household is eligible for a recoupable or non-recoupable utility grant.
 - If the household can verify that the benefits issued were not mismanaged, the household will receive a non-recoupable grant. The JOS/Worker will issue the utility grant using Issuance Code **50** (Non-Recoupable Utility Grant [No Mismanagement]).
 - If the household does not meet the non-recoupable criteria, the utility grant must be recouped. The JOS/Worker will issue the utility grant using Issuance Code **41** (Utility Grant to Prevent Turn Off or Restore Utility Services [Mismanagement]).

To assist applicants requesting emergency assistance to pay utility arrears, the JOS/Worker must:

- Complete the **W-147XX** form to determine if the applicant is required to repay the utility grant.
- If it is determined that the applicant is required to repay the utility grant, and the Utility Liaison determines the household eligible for the grant, the **W-147X** form must be signed by the applicant after the amount to be repaid is entered on the form.
- If necessary, the applicant will receive the **M-3g** form to return to the Job Center to sign the **W-147X** form.

New

Refer to [PB #13-73-OPE](#)

Note: Form **W-147X** and the Investigation, Revenue and Enforcement Administration (IREA) Repayment Transmittal (**W-113B**) are available in POS for automatic processing and placement in the HRA OneViewer. The **W-113B** is used to submit a list of cases to IREA, where the request decision is processed manually.

Note: If POS is unavailable, and the repayment agreement forms are completed manually, the forms must be scanned and indexed into the HRA OneViewer.

If the household is eligible for a utility grant, the JOS/Worker must:

- Put the case in SI status using Opening Code **Y38** (Case accepted only for emergency shelter arrears and/or emergency utility arrears which the applicant agrees to repay) on the POS Turn-Around Document (TAD).
- Issue the payment to vendor as a Direct Vendor payment.

Additional Allowance for Participants

If an individual with an active CA case is making a request for a one-time payment for a special grant or an additional allowance that can be issued under the EAF category, the JOS/Worker must:

- Record the individual's request using the **SI Grant Requests and Issuance Task List** window in POS.
- Prepare a Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137A**).

If the household is eligible for EAF, the JOS/Worker will:

- Enter code **F** (Current EAF Authorization on a FA, SNFP, SNCA, SNNC, or EAF Case) in the **Emergency Indicator** field in the **POS Turn-Around Document (TAD)** window;
- Inform the applicant about the decision on their grant request using 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**).

Once the emergency need has been met and the emergency authorization period ends, the JOS/Worker will:

- Change case status from **SI** to **CL** using closing code **Y95** (Case Closed After Being Accepted for Emergency Assistance [Manual Notice]);
- Enter code **P** (Prior Emergency Authorization [Enter This Code When the Emergency Authorization Period Ends]) in the **Emergency Indicator** in the **POS TAD** window.

Refer to
[PD #14-02-SYS](#).

When the JOS/Worker enters actions on the TAD, a notice is generated in the Client Notices System (CNS) to notify an applicant of an action that has been taken on their case.

If the applicant cannot be informed through a notice issued via CNS, a manual notice is required. POS will alert the JOS/Worker that he/she must complete the Action Taken on Your Application: Public Assistance, Supplemental Nutrition Assistance Program (SNAP) and Medical Assistance Coverage (NYC), Part A form (**LDSS-4013A NYC**) and the Action Taken on Your Application: Public Assistance, Supplemental Nutrition Assistance Program (SNAP) and Medical Assistance Coverage (NYC), Part B form (**LDSS-4013B NYC**).

The Supervisor must review the **Approve Eligibility Decision** activity and print forms **LDSS-4013A NYC** and **LDSS-4013B NYC** if the manual forms are required.

Refer to
[PB #07-19-ELI](#).

JOS/Workers are reminded that EAF applicants must be finger-imaged and referred to the Bureau of Eligibility Verification (BEV).

PROGRAM IMPLICATIONS

Paperless Office
System (POS)
Implications

Whenever an applicant/participant requests emergency assistance, additional allowance, or to add a person to the budget in the course of an interview activity, POS will prompt the JOS/Worker to complete the **SI Grant Requests and Issuance Task List** window as per PD#10-22-SYS. The **SI Grant Requests and Issuance Task List** will record the request and the decision and ensure that established time frames are met.

Forms **M-3g**, **W-137A**, **W-137B**, **W-145HH**, **W-145TT**, **W-147F**, **W-147KK**, **W-147NN**, **W-147PP**, **W-147X**, and **W-147XX** are available in POS.

Supplemental
Nutrition Assistance
Program (SNAP)
Implications

The JOS/Worker must ask all individuals applying for emergency assistance only (One-Shot Deal), who are not in receipt of SNAP and who have not indicated on the application that they have a food emergency or wish to apply for SNAP benefits, whether they wish to apply for SNAP.

If the answer is “no,” the JOS/Worker must make a case entry that clearly indicates the individual was offered this option.

If the answer is “yes,” an application for SNAP must be filed. The JOS/Worker must also ensure that the household has been screened for expedited processing of the SNAP application and that the SNAP benefits are made available within the required time frame.

Medicaid
Implications

There are no Medicaid implications.

**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 #14-24-OPE](#) and [PD #14-18-OPE](#).

**FAIR HEARING
IMPLICATIONS**

Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up to date. Remember that applicants/participants must receive either adequate or timely and adequate notification of all actions taken on their case.

Avoidance/
Resolution
Conferences

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 individual is waiting to be seen. In Model Offices, the Receptionist at Main Reception 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 listen to and evaluate any material presented by the participant, review the case file, and discuss the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker's Supervisor. The AJOS/Supervisor I will explain the reason for the Agency's action(s) to the participant.

If the participant has in fact presented good cause for the infraction, or shown that the outstanding Notice of Intent needs to be withdrawn for other reasons, 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 applicant/participant to the appropriate JOS/Worker for corrective action to be taken. In addition, if the adverse case action still shows on the "Pending" (08) screen in WMS, the AJOS/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (LDSS-3722), change the 02 to a 01 if the case has been granted aid continuing (ATC), or prepare and submit a PA Recoupment Data Entry Form – WMS (LDSS-3573) to delete a recoupment. The AJOS/Supervisor I must complete a Conference Report (M-186a).

If the participant fails to show good cause for the infraction or if it is determined that the Agency's action(s) should stand, the AJOS/Supervisor I will explain to the applicant/participant why s/he cannot settle the issue(s) in conference (SIC). The AJOS/Supervisor I must complete an **M-186a**.

Evidence Packets

Should the participant 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.

All Evidence Packets must contain a detailed history (e.g., copies of POS "Case Comments" and/or NYCWAY "Case Notes" screens, History Sheet [**W-25**]), copies of relevant WMS screen printouts, notices sent, and other documentation relevant to the action taken.

REFERENCES

[GIS #15 TA/DC013](#)

[14 ADM 07](#)

[09 ADM-17](#)

[02 ADM 2](#)

[03 ADM 11](#)

[03 INF-35](#)

[04-INF-03](#)

[04-INF-21](#)

[TASB Chapter 2, Section C, page 2](#)

[18 NYCRR 372](#)

[SSL § 350-j](#)

RELATED ITEMS

[PB #07-19-ELI](#)

[PB #13-73-OPE](#)

[PB #15-55-SYS](#)


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

[PD #14-02-SYS](#)

[PD #14-12-ELI](#)

[PD #15-21-ELI](#)

ATTACHMENTS

 Please use Print on Demand to obtain copies of forms.

Attachment A EXP-76D	EAF - Eligible Issuance Codes Federal Poverty Level Guidelines for Emergency Assistance to Families (EAF) and Emergency Safety Net Assistance (ESNA) Categories of Assistance (Rev. 3/26/15)
FIA-1104	Notice of Determination Regarding Your Request for a Utility Grant (Rev. 6/4/14)
FIA-1104 (S)	Notice of Determination Regarding Your Request for a Utility Grant (Spanish) (Rev. 6/4/14)
M-3g	Notice to Report to Center (Rev. 7/22/14)
M-3g (S)	Notice to Report to Center (Spanish) (Rev. 7/22/14)
M-858M	Utility Arrears/Emergency Heating (Rev. 2/5/13)
W-113B	IREA Repayment Transmittal Form (Rev. 12/8/09)
W-137A	Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Rev. 7/1/14)
W-137A (S)	Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 7/1/14)
W-137B	Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Rev. 7/1/14)
W-137B (S)	Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 7/1/14)
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)
W-145TT	Determination of Eligibility for Emergency Assistance to Needy Families (EAF) (Rev. 3/12/14)
W-147F	Shelter Arrears Repayment Agreement Worksheet (Rev. 8/12/15)

W-147KK	Emergency Assistance to Needy Families (EAF) Agreement to Repay Excess Shelter Arrears (Rev. 9/8/15)
W-147KK (S)	Emergency Assistance to Needy Families (EAF) Agreement to Repay Excess Shelter Arrears (Spanish) (Rev. 9/8/15)
W-147NN	Information About Repaying the Department of Social Services For Utility Arrears (Rev. 12/8/09)
W-147NN (S)	Information About Repaying the Department of Social Services For Utility Arrears (Spanish) (Rev. 12/8/09)
W-147PP	Information About Repaying the Department of Social Services For Rental Arrears (Rev. 8/12/15)
W-147PP (S)	Information About Repaying the Department of Social Services For Rental Arrears (Spanish) (Rev. 8/12/15)
W-147X	Utility Arrears Repayment Agreement (Rev. 9/8/15)
W-147X (S)	Utility Arrears Repayment Agreement (Spanish) (Rev. 9/8/15)
W-147XX	Utility Arrears Repayment Agreement Worksheet (Rev. 7/30/09)

EAF – Eligible Issuance Codes*

07	Replacement of lost/stolen undelivered check	39	Rent in advance to secure an apartment
08	Replacement of cancelled check	40	Rent in advance to avoid eviction
09	Rent only	41	Utility grant to prevent turn-off/restore utility services (Mismanagement)
10	Utility grant to prevent turn-off/restore services (Prior to CA)	42	Broker's and Finder's fees
14	Replacement of lost/stolen cash	44	Immediate needs grant
16	Transportation to points outside of NYC – Waverly JC (Transportation Unit only)	45	Disaster sustenance
18	Expenses connected with maintaining housing	46	Disaster clothing
19	Replacement of heating equipment, stove, or refrigerator	47	Disaster household furnishings and replacements
21	Storage fees	48	Disaster shelter – temporary housing
22	Moving expenses	49	Disaster transportation to home of friend/relative or to a shelter
30	Rent payment in excess of maximum	50	Non-recoupable utility grant (No Mismanagement)
31	Pre-CA rent arrears	58	Emergency childcare fees
38	Security deposit private housing	60	Establishment of a home
		99	Other

* Form **W-145TT** must be completed to determine EAF eligibility.

**Federal Poverty Level Guidelines for Emergency Assistance to Families (EAF)
and Emergency Safety Net Assistance (ESNA) Categories of Assistance**
(Effective April 1, 2015)

Size of Household	Federal Poverty Level		EAF – 200% of Poverty Level		ESNA – 125% of Poverty Level	
	Annual	Monthly (Rounded)	Annual	Monthly (Rounded)	Annual	Monthly (Rounded)
1	\$11,770	\$981	\$23,540	\$1,962	\$14,713	\$1,226
2	\$15,930	\$1,328	\$31,860	\$2,655	\$19,913	\$1,659
3	\$20,090	\$1,674	\$40,180	\$3,348	\$25,113	\$2,093
4	\$24,250	\$2,021	\$48,500	\$4,042	\$30,313	\$2,526
5	\$28,410	\$2,368	\$56,820	\$4,735	\$35,513	\$2,959
6	\$32,570	\$2,714	\$65,140	\$5,428	\$40,713	\$3,393
7	\$36,730	\$3,061	\$73,460	\$6,122	\$45,913	\$3,826
8	\$40,890	\$3,408	\$81,780	\$6,815	\$51,113	\$4,259
9	\$45,050	\$3,754	\$90,100	\$7,508	\$56,313	\$4,693
10	\$49,210	\$4,101	\$98,420	\$8,202	\$61,513	\$5,126
For each additional member:	\$4,160	\$347	\$8,320	\$693	\$5,200	\$433

Date: _____
Case Number: _____
Case Name: _____
Center _____
Telephone Number: _____

Notice of Determination Regarding Your Request for a Utility Grant

Based on your request for a utility grant to prevent a shut-off or to restore a utility service that you made on _____, it has been determined that:

- Your utility arrears will be paid by the Home Energy Assistance Program (HEAP). A HEAP application has been initiated for you and HEAP has determined that your household is eligible for either a regular HEAP or an Emergency HEAP Grant. This grant will be applied directly to your utility arrears. You will receive a notice from HEAP indicating the amount of the payment.
- We have made a payment in the amount of _____ to your service provider who is Acct. No. _____.

Based on the information used to make this payment, we have determined that:

Recoupment Determination:

- You are eligible to receive a nonrecoupable utility grant.
- You are not eligible to receive a nonrecoupable utility grant because you failed to meet the criteria. We will therefore be required to recoup the utility grant issued to meet this request from future Cash Assistance benefits.

We will send you a Notice of Intent to Recoup this utility grant, which will specify the amount to be recouped and the rate of recoupment. This notice will also explain how you can appeal this decision by requesting a Fair Hearing, at which you will be able to challenge (1) our decision that you failed to meet the criteria on page 1 of this form, requiring us to recoup the utility grant, (2) the intended amount of recoupment, and (3) the intended rate of recoupment.

(Continued on next page)

Restriction Determination:

- We will not restrict the Home Energy Allowance portion of your grant in the future. Because you have demonstrated that your failure to pay your utility and/or rent bills in amounts equal to or greater than the utility and shelter allowances in your grant was because you spent such amounts appropriately for some emergency or extraordinary need. You must continue to pay your utility bills from your grant.
- Your Home Energy Allowance will not be restricted at this time.
- We intend to restrict the Home Energy Allowance portion of your grant and pay your utility bills directly to the utility company. Since your failure to pay your utility and/or rent bills in amounts equal to or greater than the utility and shelter allowances in your grant threatened the health and safety of your household. We will deduct the amount of your Home Energy Allowance from your grant to pay these bills.

We will send you a Notice of Intent to Restrict, which will specify the amount to be restricted. This notice will also explain how you can appeal the restriction decision by requesting a Fair Hearing.

Utility Guarantee Determination:

- You are not eligible for a utility guarantee because your entire outstanding balance has been paid by HRA.
- You are not eligible for a utility guarantee because the agency is restricting your home energy allowance (see box checked above).
- You are eligible for a six-month utility guarantee. HRA will guarantee the above service provider payment of all bills during the six-month period beginning on _____ or until you are no longer in receipt of Cash Assistance or SSI, whichever comes first. You will continue to be billed for services rendered and are required to pay these bills. Your service provider will proceed with normal collection efforts for all future bills and will notify HRA when payments are overdue. All outstanding monies owed to your service provider in excess of the above payment shall be exempt from collection for as long as you continue to receive Cash Assistance.

Worker's Signature/Date

Supervisor's Signature/Date

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Número de Teléfono del Centro: _____

Aviso de Determinación Respecto a Su Petición de Concesión de Servicios Públicos

Según su petición de concesión de servicios públicos para prevenir la desconexión o para restablecer servicios públicos presentada el _____, se ha determinado que:

- Sus atrasos de servicios públicos se pagarán por el Programa de Asistencia de Energía Doméstica (Home Energy Assistance Program – HEAP). La solicitud de HEAP ha sido iniciada por usted y HEAP ha determinado que su hogar es elegible para HEAP normal o una Concesión de Emergencia de HEAP. Esta concesión se destinará directamente a sus atrasos de servicios públicos. Usted recibirá un aviso de parte de HEAP que indicará la cantidad del pago.
- Se ha determinado que: nosotros efectuamos un pago por la cantidad de _____ a su proveedor de servicios que tiene la Cuenta Número _____.

Según la información utilizada para efectuar este pago, hemos determinado que:

Determinación de Recuperación:

- Usted es elegible para recibir una concesión no reembolsable de servicios públicos.
- Usted no es elegible para recibir una concesión no recuperable de servicios públicos porque no reunió los requisitos como debido. Por lo tanto nosotros tendremos que recuperar la concesión de servicios públicos emitida para cumplir esta petición de beneficios futuros de Asistencia en Efectivo (Cash Assistance).

Nosotros le enviaremos a usted un Aviso de la Intención de Recuperación (Notice of Intent to Recoup) esta concesión de servicios públicos, que indicará la cantidad a ser recuperada, así como la tasa de la recuperación. Este aviso también explicará cómo usted puede apelar esta decisión solicitando una Audiencia Imparcial (Fair Hearing), en la cual usted podrá cuestionar (1) nuestra decisión de que usted no reunió los criterios en la página 1 de este formulario, lo que nos obligará a recuperar la concesión de servicios públicos, (2) la cantidad establecida de la recuperación, y (3) la tasa establecida de la recuperación.

(Continúa en la próxima página)

Determinación de Restricción:

- Nosotros no restringiremos la porción de la Concesión de Energía Doméstica (Home Energy Allowance) de su concesión en el futuro. Puesto que usted no ha demostrado que el impago de sus facturas de servicios públicos y/o alquiler en cantidades iguales a o superiores a las asignaciones de servicios públicos y albergue de su concesión se debió a que usted gastó tales cantidades de manera apropiada en alguna emergencia o necesidad extraordinaria. Usted debe continuar pagando sus facturas de servicios públicos de su concesión.

- Su Asignación de Energía Doméstica (Home Energy Allowance) no será restringida en este momento.

- Nosotros tenemos la intención de restringir la porción de la Asignación de Energía Doméstica (Home Energy Allowance) de su concesión y de pagar sus facturas de servicios públicos directamente a la compañía de servicios públicos. Puesto que el impago de sus facturas de servicios públicos y/o alquiler en cantidades iguales a superiores a las asignaciones de servicios públicos y albergue en su concesión ponen en peligro la salud y seguridad de su hogar. Nosotros deduciremos la cantidad de la Asignación de Energía Doméstica de su concesión para pagar estas facturas.

Nosotros le enviaremos a usted un Aviso de la Intención de Restringir (Notice of Intent to Restrict), el cual indicará la cantidad a ser restringida. Este aviso también explicará cómo usted puede apelar la decisión de restricción solicitando una Audiencia Imparcial (Fair Hearing).

Determinación de Garantía de Servicios Públicos:

- Usted no es elegible para una garantía de servicios públicos debido a que su balance total remanente ha sido pagado por la HRA.

- Usted no es elegible para una garantía de servicios públicos debido a que la agencia está restringiendo su asignación de energía doméstica (vea la casilla marcada más arriba).

- Usted es elegible para una garantía de seis meses. La HRA garantizará el pago al proveedor de servicios de todas las facturas durante el periodo de seis meses que comienza el _____ o hasta que usted ya no reciba Asistencia en Efectivo (Cash Assistance) o SSI, el primero de dichos beneficios que venga primero. A usted se le seguirán cobrando los servicios brindados y tiene que pagar estas facturas. Su proveedor de servicios procederá con el trámite normal de cobro de todas las facturas futuras y notificará a la HRA cuando los pagos estén atrasados. Todo dinero pagadero adeudado a su proveedor de servicios en exceso del pago más arriba estará exento de cobro por el tiempo que usted continúe recibiendo Asistencia en Efectivo.

Firma del Trabajador/Fecha

Firma del Supervisor/Fecha

Date: _____
Case Number: _____
Case Name: _____
Telephone Number: _____
Center: _____

Notice to Report to Center

Please report to:

Location Name: _____

Address: _____

City: _____ State: _____ Zip: _____
On: Appointment Date: _____ Time: _____ Telephone: _____

SAMPLE

To discuss:

Other:

If any required documentation is listed below, it must be brought into the center **with this letter**.

Required documentation:

If you have any questions or are unable to keep this appointment, please call the telephone number above.
You must contact us prior to your reporting time to arrange a new appointment.

This is a mandatory eligibility appointment. Failure to keep this appointment or contact us may make you ineligible for public assistance or may reduce your benefits for a specific period of time.

This is a nonmandatory eligibility appointment.

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Número de Teléfono: _____
Centro: _____

Aviso de Presentarse al Centro

Favor de presentarse a:

Local: _____
Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

El: _____ Fecha de la Cita: _____ Hora: _____ Teléfono: _____

Para tratar:

Otro:

Si se indica alguna documentación necesaria más abajo, usted tiene que traerla al centro **con esta carta**.

Documentación necesaria:

Si tiene alguna pregunta o si no puede cumplir esta cita, favor de llamar al número de teléfono más arriba. **Usted tiene que comunicarse con nosotros antes de la hora programada para fijar una nueva cita.**

Ésta es una cita obligatoria de elegibilidad. El incumplimiento de esta cita o el no comunicarse con nosotros puede hacerle inelegible para asistencia pública o puede que se le reduzcan sus beneficios por un período de tiempo específico.

Ésta es una cita de elegibilidad no obligatoria.

Date: _____
Case Number: _____
Case Name: _____
Job Center: _____

UTILITY ARREARS/EMERGENCY HEATING

APPLICANT/PARTICIPANT INFORMATION

Case Name: _____ Case Number: _____ Caseload: _____
Social Security Number: _____ Telephone Number: _____
Address: _____ Program Type (check one):
_____ CA NCA SNAP SSI
City: _____ State: _____ Zip: _____

UTILITY ARREARS

Utility Company: _____ Account Number: _____
Name on Account: _____ Service is: On Off Date: _____
HEAP payment received? Yes No Utility guarantee/restriction in effect – code:* _____
Is the utility service required to provide heat or operate heating equipment? Yes No
Additional Information: _____

JOS/Worker's Signature Date

EMERGENCY HEATING

Type of Heating Equipment: Boiler/Furnace Other: _____
 Oil: Vendor's Name: _____ Account Number: _____
HEAP payment received? Yes, amount: \$ _____
 No Pending: HEAP Application Date: _____
Emergency HEAP payment received? Yes, amount: \$ _____
 No Pending: HEAP Application Date: _____
Resource Amount Available: _____ **Other Household Income:†** _____

Does the applicant/participant own the home? Yes No
Is the applicant/participant the tenant of record? Yes No

* Enter code from Element 044 of the TAD
† Verification required

EMERGENCY HEATING (continued)

Vendor Status (check one) (Refer to Participating Vendor List):

- Participating Vendor Non-Participation Vendor

Non-Participating Vendor Payment Plan Type (check the type of plan in which the applicant/participant is currently enrolled.)

- Pre-Payment Purchase Plan Price Per Gallon Capped or Locked in Plan Monthly Budget Plan
 Annual Service Contract Plan Other Type of Contract Plan

If applicant/participant is **NOT ENROLLED** in a Price Protection Plan, Budget Plan or Service Contract with a Non-Participating Vendor, ask the applicant/participant to switch to a participating vendor.

Is the applicant/participant willing to select a new vendor? Yes No If Yes, complete vendor information below:

New Vendor Name: _____ Old Vendor Name: _____
 Address: _____ Address: _____
 Telephone Number: _____ Telephone Number: _____

Additional Information:

SAMPLE

Worker's Signature _____

Date _____

UTILITY LIAISON RECOMMENDATION
(Breakdown)

Amount	From	To
\$		
\$		
\$		
\$		

Service is: On Off Date of termination: _____
 Turn-off notice: Yes No Heating Heat-Related

If applicant/participant has a payment plan with a non-participating vendor, obtain verification from vendor and indicate how plan was verified:

If applicant/participant has chosen a participating vendor, obtain verification that the new vendor will accept the applicant/participant as a customer.

Refer applicant/participant to HEAP Central? Yes Application initiated on _____ No
 (date)

***If yes**, do not request an extension from the utility company; an extension will be obtained at HEAP Central. If the emergency is imminent, obtain the extension and notify HEAP Central. If **no**, provide reason and additional information.

UTILITY LIAISON RECOMMENDATION (continued)

Extension Granted at Center: Yes Expiration date: _____
Reason Requested: _____

No Reason: _____

PAYMENT RECOMMENDED: Code: _____ Amount: \$ _____ Period Covered: _____
Abeyance amount: \$ _____ Forms/letters required: _____

HEATING EQUIPMENT: Replacement amount: \$ _____ Repair Amount: \$ _____

Additional Information: _____

UTILITY LIAISON INFORMATION

Name: _____ Telephone No: _____
Fax No: _____ E-mail Address: _____

Group Supervisor's Name: _____

Group Supervisor's Telephone No: _____

Group Supervisor's E-mail Address: _____

Utility Liaison's Signature _____ Date _____

HEAP REFERRAL OUTCOME

Date HC Sent to Job Center: _____ Time: _____
(HEAP comp. sys. populates in real time) (HEAP comp. sys. populates in real time)

Regular Approved: _____

Primary (Heating) Emergency Approved: _____

Heat-Related Emergency Approved: _____

Regular HEAP Case Pended: Reason: _____

Case Denied: Reason: _____

SUPERVISORY REVIEW

Applicant/participant eligible for HEAP? Yes If Yes, amount: _____ Code: _____

No **If No, is a payment authorized by Center?**
 Yes No

Is verification of HEAP evaluation in the case record? Yes No

Additional Information: _____

Supervisor's Signature _____ E-Mail Address _____ Date _____

MANAGERIAL REVIEW

- Evidence of emergency HEAP evaluation in case record* Case action correct
- Issuance code is correct

REMINDER

***DO NOT** provide authorization for payment of a heat-related emergency unless there is verification that the household was **first** evaluated and has been determined **ineligible** for emergency HEAP benefits.

Approved

Signature of Assistant to the Deputy Director

Date

- Not Approved** (HEAP evaluation required) **Not Approved** – Inappropriate issuance code

Signature of Assistant to the Deputy Director

Date

SAMPLE

Date: _____

Job Center: _____

Number of Referrals Attached: _____

IREA Repayment Transmittal Form

No.	Case Number/ Suffix	Last Name/First Name	Payment Date	Payment Amount	Reason Code
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					
13)					
14)					
15)					
16)					

SAMPLE

Signature of Deputy Director for Intake Unit: _____

Date: _____
Case Name: _____
Case Number: _____
Caseload: _____
Center: _____
Worker Telephone No.: _____
FH&C Telephone No.: _____

Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only)

Please fill out this form if you need emergency assistance, additional allowances, or to add a person to the case.

Remember:

- (1) You may be asked for proof of what you tell us. If you have trouble obtaining proof, your Worker must help you.
- (2) You may still need to see your Worker. If you do, you will be given an appointment.

SECTION I: EMERGENCY ASSISTANCE

The type of emergency assistance I am requesting is:

SAMPLE

The reason I need emergency assistance is:

SECTION II: ADDITIONAL ALLOWANCES

I am requesting the following allowance(s) for special need(s):

- | | |
|---|--|
| <input type="checkbox"/> Back rent | <input type="checkbox"/> Additional allowance for fuel |
| <input type="checkbox"/> Repair of essential household items | <input type="checkbox"/> Additional allowance to maintain or restore utility service |
| <input type="checkbox"/> Back mortgage and/or taxes | <input type="checkbox"/> Property repairs |
| <input type="checkbox"/> Pregnancy allowance | <input type="checkbox"/> Replacement of clothing lost as a result of a disaster such as homelessness or fire |
| <input type="checkbox"/> Restaurant allowance because I cannot prepare meals where I am living | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Burial allowance – you or your duly authorized representative must apply for this allowance at the Burial Claims Unit
25 Chapel Street, Room 606
Brooklyn, NY 11201
Telephone: (718) 473-8310 | |

(Worker: Scan and Index this completed form and give the signed original back to the participant.)

SECTION II: ADDITIONAL ALLOWANCES (Continued)

I am requesting the following allowance(s) for special need(s):

<p>Expenses related to moving:</p> <p><input type="checkbox"/> Moving expenses</p> <p><input type="checkbox"/> Security deposit/agreement</p> <p><input type="checkbox"/> Broker's/finder's fee/voucher</p> <p><input type="checkbox"/> Furniture and other household items</p> <p><input type="checkbox"/> Storage of furniture and personal belongings</p>	<p>New Address: _____ (include apt. no.)</p> <p>_____ City _____ State _____ Zip Code</p> <p>When did you move? _____ New rent: \$ _____</p> <p>Landlord's name: _____</p> <p>Primary tenant's name: _____</p> <p>Address: _____ (include apt. no.)</p> <p>_____ City _____ State _____ Zip Code</p>
---	--

SECTION III: WORK ACTIVITY-RELATED SUPPORTIVE SERVICES

I am requesting the following supportive services:

- | | |
|--|---|
| <p><input type="checkbox"/> Clothing for participants in job search activities who have exceptional circumstances, such as homelessness or a recent fire and lack of appropriate clothing</p> <p><input type="checkbox"/> Activity/engagement-related licensing, uniform or durable goods fee within approved limits, upon submission of documentation certifying the need for such items</p> | <p><input type="checkbox"/> Child care allowance within approved limits, if needed</p> <p><input type="checkbox"/> Necessary public transportation</p> <p><input type="checkbox"/> Other work activity-related supportive services: _____</p> |
|--|---|

WEP agencies and/or contractors are responsible for providing necessary safety equipment or job-related clothing for their participants.

Necessary supportive services will be provided when you begin a work activity. If your needs change or if you are not receiving a needed service, you should apply for an additional allowance.

SECTION IV: ADD PERSON TO CASE

If you do not have all this information, you can still submit this form to your Worker.

I want to add the following person(s) to my cash assistance case:

<p><input type="checkbox"/> New Baby</p> <p><input type="checkbox"/> Child entered home</p> <p><input type="checkbox"/> Child under 18 years of age (whose immigrant status has changed since my last application/recertification)</p> <p><input type="checkbox"/> Spouse/Adult living with me who has not previously applied (this person must complete an application to receive assistance)</p> <p><input type="checkbox"/> Spouse who previously applied and was denied because immigration status and his/hers status have changed now (this person does not need to complete another application/recertification)</p> <p><input type="checkbox"/> Myself/Adult payee to the case</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p>	<p>Name: _____</p> <p>Date moved in/returned: _____</p> <p>Date of Birth: _____</p> <p>Social Security Number (if known): _____</p> <hr/> <p>Name: _____</p> <p>Date moved in/returned: _____</p> <p>Date of Birth: _____</p> <p>Social Security Number (if known): _____</p> <hr/> <p>Name: _____</p> <p>Date moved in/returned: _____</p> <p>Date of Birth: _____</p> <p>Social Security Number (if known): _____</p>
---	---

 Participant's Signature

 Date of Request

 Time of Request AM PM

 Worker's Signature

 Date

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

Petición para Asistencia de Emergencia, Asignaciones Adicionales, o para Añadir a una Persona al Caso de Asistencia en Efectivo (Sólo para Participantes)

Favor de llenar este formulario si necesita asistencia de emergencia, asignaciones adicionales, o para añadir una persona al caso.

Recuerde:

- (1) Puede que se le pida prueba de los datos que usted nos proporcione. Si tiene problemas en obtener pruebas, su Trabajador tiene que ayudarlo.
- (2) Puede que usted aún necesite reunirse con su Trabajador. En tal caso, se le programará una cita.

SECCIÓN I: ASISTENCIA DE EMERGENCIA

El tipo de asistencia de emergencia que estoy solicitando es:

SAMPLE

La razón por la cual necesito asistencia de emergencia es la siguiente:

SECCIÓN II: ASIGNACIONES ADICIONALES

Estoy solicitando la(s) siguiente(s) asignación(es) para necesidad(es) especial(es):

- | | |
|--|--|
| <input type="checkbox"/> Alquiler atrasado | <input type="checkbox"/> Asignación adicional para combustible |
| <input type="checkbox"/> Reparación de artículos del hogar de primera necesidad | <input type="checkbox"/> Asignación adicional para mantener o restaurar servicios públicos |
| <input type="checkbox"/> Hipoteca y/o impuestos atrasados | <input type="checkbox"/> Reparaciones a la propiedad |
| <input type="checkbox"/> Asignación para embarazo | <input type="checkbox"/> Reemplazo de ropa perdida a raíz de desastres tal como desamparo o incendio |
| <input type="checkbox"/> Asignación para restaurante porque no puedo preparar comidas donde estoy viviendo | <input type="checkbox"/> Otras asignaciones: |
| <input type="checkbox"/> Asignación para entierros – usted o su representante debidamente autorizado debe solicitar esta asignación en la Unidad de Reclamos de Entierro
25 Chapel Street, Sala 606
Brooklyn, NY 11201
Teléfono: (718) 473-8310 | |

(Worker: Scan and Index this completed form and give the signed original back to the participant.)

SECCIÓN II: ASIGNACIONES ADICIONALES (continuación)

Estoy solicitando la(s) siguiente(s) asignación(es) para necesidad(es) especial(es):

<p>Gastos relacionados con la mudanza::</p> <p><input type="checkbox"/> Gastos de mudanza</p> <p><input type="checkbox"/> Depósito/acuerdo de garantía</p> <p><input type="checkbox"/> Pago de comisión/comprobante de agente</p> <p><input type="checkbox"/> Muebles y otros artículos del hogar</p> <p><input type="checkbox"/> Almacenamiento de muebles y artículos personales</p>	<p>Nueva Dirección: _____ (con núm. de apt.)</p> <p>_____ Ciudad _____ Estado _____ Código Postal</p> <p>¿Cuándo se mudó? _____ Nuevo alquiler: \$ _____</p> <p>Nombre del casero: _____</p> <p>Nombre del inquilino principal: _____</p> <p>Dirección: _____ (con núm. de apt.)</p> <p>_____ Ciudad _____ Estado _____ Código Postal</p>
---	---

SECCIÓN III: SERVICIOS DE APOYO RELACIONADOS CON ACTIVIDADES DE TRABAJO

Estoy solicitando los siguientes servicios de apoyo:

- | | |
|--|--|
| <p><input type="checkbox"/> Ropa para participantes que realicen actividades relacionadas con la búsqueda de trabajo, que se encuentren en situaciones fuera de lo común, tales como desahucio o incendio reciente y no tener la vestimenta adecuada.</p> <p><input type="checkbox"/> Cuota de autorización, relacionada con actividad/participación, de uniformes o bienes duraderos dentro de los límites aprobados, a la hora de presentar la documentación que compruebe la necesidad de dichos artículos</p> | <p><input type="checkbox"/> Asignación de cuidado infantil dentro de los límites aprobados, de ser necesario</p> <p><input type="checkbox"/> Transporte público necesario</p> <p><input type="checkbox"/> Otros servicios de apoyo relativos a actividades de trabajo: _____</p> |
|--|--|

Las agencias de WEP y/o los contratistas tienen la responsabilidad de proporcionar a sus participantes la ropa o el equipo de seguridad necesarios para el trabajo.

Se brindarán los servicios necesarios cuando usted empiece una actividad de trabajo. Si se produce algún cambio en sus necesidades, o si usted no está recibiendo un servicio necesario, debería solicitar una asignación adicional.

SECCIÓN IV: AÑADA A UNA PERSONA AL CASO

Si usted no tiene toda esta información, aún puede presentar este formulario a su Trabajador.

Deseo añadir a la(s) siguientes personas a mi caso de asistencia en efectivo:

<p><input type="checkbox"/> Recién nacido</p> <p><input type="checkbox"/> Niño ingresó al hogar</p> <p><input type="checkbox"/> Niño menor de 18 años de edad (cuyo estado de inmigración haya cambiado desde mi última solicitud/recertificación)</p> <p><input type="checkbox"/> Cónyuge/Adulto que viva conmigo quien no haya presentado solicitud anteriormente (para recibir asistencia dicha persona debe llenar una solicitud)</p> <p><input type="checkbox"/> Cónyuge quien anteriormente haya presentado solicitado y haya sido rechazado por su estado de inmigración y cuyo estado haya cambiado (dicha persona no necesita llenar otra solicitud/recertificación)</p> <p><input type="checkbox"/> Yo mismo(a)/Beneficiario adulto al caso</p> <p><input type="checkbox"/> Otra Persona _____</p> <p><input type="checkbox"/> Otra Persona _____</p> <p><input type="checkbox"/> Otra Persona _____</p>	<p>Nombre: _____</p> <p>Fecha de mudanza/regreso: _____</p> <p>Fecha de Nacimiento: _____</p> <p>Número de Seguro Social (si lo sabe): _____</p> <hr/> <p>Nombre: _____</p> <p>Fecha de mudanza/regreso: _____</p> <p>Fecha de Nacimiento: _____</p> <p>Número de Seguro Social (si lo sabe): _____</p> <hr/> <p>Nombre: _____</p> <p>Fecha de mudanza/regreso: _____</p> <p>Fecha de Nacimiento: _____</p> <p>Número de Seguro Social (si lo sabe): _____</p>
--	--

Firma del Participante

Fecha de la Petición

Hora de la Petición AM PM

Worker's Signature

Fecha

Date: _____
Case Number: _____
Case Name: _____
Center: _____
Caseload: _____
Worker Telephone No.: _____
FH&C Telephone No.: _____

**Action Taken on Your Request for Emergency Assistance, Additional Allowances,
or to Add a Person to the Cash Assistance Case
(For Participants Only)**

The Agency's decision(s) regarding your benefit program(s) is/are explained below, next to the checked box(es) .

This Notice applies only to your request for an additional allowance to meet a special need, a change in grant, or an application for emergency assistance. If your request for additional assistance is denied, your ongoing Cash Assistance case will not be affected.

On _____, you requested Emergency Assistance Additional Allowance for:
(Date)

SAMPLE

- Your request for _____ has been accepted. You will receive:
 - One payment in the amount of \$ _____ . Period covered, if applicable: _____

Method of payment:

- Broker's or finder's fee/voucher
- Check to be picked up by you at your Job Center
- Check mailed to your home
- As an addition to your regular public grant, which can be obtained through the EBT system
- Security deposit agreement
- Direct vendor check
- Other action: _____
- You will receive a second notice informing you as to how your ongoing benefits will be affected.

On _____, you were referred to the Burial Claims Unit at 25 Chapel Street, Room 606, Brooklyn, NY 11201, (718) 473-8310, to apply for a burial allowance.

Your request for _____ has been denied because:

The law(s) and/or regulation(s) that allow(s) us to do this is/are 18 NYCRR (please see the section numbers below):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Addition to Household § 352.30 | <input type="checkbox"/> Additional Allowance for Fuel § 352.5 | <input type="checkbox"/> Back Mortgage and/or Taxes § 352.7(g) | <input type="checkbox"/> Back Rent § 352.7(g) |
| <input type="checkbox"/> Broker's or Finder's Fee/Voucher § 352.6(a) | <input type="checkbox"/> Catastrophic Loss (replacement of clothing and furniture lost in fire, flood or other disaster) § 352.7(d) | <input type="checkbox"/> Furniture and Other Household Items § 352.7(a) | <input type="checkbox"/> Moving Expenses § 352.6(a) |
| <input type="checkbox"/> Payment to Maintain or Restore Utility Services § 352.5 | <input type="checkbox"/> Pregnancy Allowance § 352.7(k) | <input type="checkbox"/> Property Repairs § 352.4(d), § 352.6(e) | <input type="checkbox"/> Rent Security Deposit/ Letter of Guarantee § 352.6(a) |
| <input type="checkbox"/> Repair of Essential Household Items § 352.7(b) | <input type="checkbox"/> Restaurant Allowance § 352.7(c) | <input type="checkbox"/> Semimonthly Fuel for Heating Allowance § 352.5(b) | <input type="checkbox"/> Storage of Furniture and Personal Belongings § 352.6(f) |
| <input type="checkbox"/> Work Activity Related Supportive Services § 385.4 | | | |
- Other (specify): _____

JOS/Worker's Signature

Date

Supervisor's 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 (informal meeting with us). To do this, call the Fair Hearing and Conference (FH&C) unit phone number on **page one (1)** of this notice or write to us at the address on **page one (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, 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.ctda.ny.gov/eah/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 disability you 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 one (1)** of this notice.

FAIR HEARING REQUEST

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 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. **Note:** If your situation is extremely serious please explain your situation; 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 phone.

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

SAMPLE

Print Name: _____
Name M.I. Last Name

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Centro: _____
Unidad de Casos: _____
Núm. de Teléfono del Trabajador: _____
Núm. de Teléfono de FH&C: _____

Medidas Tomadas con Respecto a su Petición de Asistencia de Emergencia, Asignaciones Adicionales, o Añadidura de una Persona al Caso (Sólo para Participantes)

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

Este Aviso sólo se refiere a su petición de una asignación adicional para satisfacer una necesidad específica, un cambio en la concesión o una solicitud de asistencia de emergencia. Si su petición de asistencia adicional es rechazada, su caso actual de Asistencia en Efectivo no será afectado.

El _____, usted solicitó Asistencia de Emergencia Asignación Adicional para:
(Fecha)

SAMPLE

Su solicitud de _____, ha sido aceptada. Usted recibirá:

Un pago por la cantidad de \$ _____. Período de cobertura, si corresponde: _____.

Método de pago:

Pago/comprobante de agente o intermediario Cheque que debe ser recogido por usted en su Centro de Trabajo Cheque enviado por correo a su hogar

Un suplemento a su concesión pública usual, que se puede obtener a través del sistema de EBT Acuerdo de depósito de garantía Cheque directo al contratista

Otra medida: _____

Usted recibirá un segundo aviso informándole de cómo serán afectados sus beneficios actuales.

NOTA: A partir del 29 de agosto, toda referencia al Programa de Cupones para Alimentos en este aviso se denominará el Programa de Asistencia de Nutrición Suplementaria (SNAP), y toda referencia a Cupones para Alimentos se denominará beneficios de SNAP.

El _____, usted fue enviado a la Unidad de Reclamos de Sepultura (Burial Claims Unit) en 25 Chapel Street, Sala 606, Brooklyn, NY 11201, (718) 473-8310, para solicitar una asignación de sepultura.

Su petición de _____ ha sido rechazada debido a que:

La(s) ley(es) y/o reglamento(s) que nos permite(n) hacer esto es/son 18 NYCRR (favor de ver la sección a continuación):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Agregar una Persona al Hogar § 352.30 | <input type="checkbox"/> Asignación Adicional para Combustible § 352.5 | <input type="checkbox"/> Pagos Atrasados de Hipoteca y/o Impuestos § 352.7(g) | <input type="checkbox"/> Alquiler Atrasado § 352.7(g) |
| <input type="checkbox"/> Pago/Comprobante de Agente o Intermediario de Bienes Raíces §352.6(a) | <input type="checkbox"/> Pérdida Catastrófica (reemplazo de ropa y muebles perdidos por un fuego, inundación u otro desastre) § 352.7(d) | <input type="checkbox"/> Muebles y Otros Artículos Domésticos § 352.7(a) | <input type="checkbox"/> Gastos de Mudanza § 352.6(a) |
| <input type="checkbox"/> Pagos para Mantener o Restaurar Servicios de Electricidad y Gas § 352.5 | <input type="checkbox"/> Asignación para Embarazo §352.7(k) | <input type="checkbox"/> Reparaciones a la Propiedad § 352.4(d), § 352.6(e) | <input type="checkbox"/> Depósito de Garantía de Alquiler/Carta de Garantía § 352.6(a) |
| <input type="checkbox"/> Reparaciones de Artículos Domésticos Indispensables §352.7(b) | <input type="checkbox"/> Asignación para Restaurante § 352.7(c) | <input type="checkbox"/> Asignación Quincenal de Combustible para Calefacción § 352.5(b) | <input type="checkbox"/> Almacenamiento de Muebles y Pertenencias Personales § 352.6(f) |
| <input type="checkbox"/> Actividad de Trabajo Relacionada con Servicios de Apoyo § 385.4 | | | |

SAMPLE

Otros (datos específicos): _____

Firma del JOS/Trabajador

Fecha

Firma del Supervisor

Fecha

**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.**

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 arreglar 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) que aparece en la **página uno (1)** de este aviso, o escríbanos a la dirección que también aparece en la **página uno (1)** de este aviso. A veces este resulta el modo más rápido de solucionar algún problema que pueda tener. Le recomendamos que así lo haga, aun si ha pedido 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 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 número: **(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) en:
14 Boerum Place, Brooklyn, NY 11201.
- (5) POR INTERNET:** Complete una solicitud de formulario electrónico conectándose a:
<http://www.otda.ny.gov/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 tal 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 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.

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 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 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 **primera página** de este aviso.

PETICIÓN DE 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 servicios sociales y noventa (90) días para asuntos del Programa de Asistencia de Nutrición Suplementaria (SNAP).

Si no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporal y para Incapacitados (New York State Office of Temporary and Disability Assistance) por teléfono, por fax, en persona o por Internet, favor de enviar por escrito su solicitud de Audiencia Imparcial antes de la fecha límite. **Nota:** Si su circunstancia es sumamente urgente, favor de explicarlo en detalle; el Estado hará todo esfuerzo de procesar su solicitud para una Audiencia Imparcial lo más pronto posible. Si usted llama para solicitar una Audiencia Imparcial, por favor esté preparado para explicar su situación a la persona que conteste el teléfono.

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

SAMPLE

Nombre en
Letras de
Molde: _____
Nombre I. Apellido

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____

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: _____

Determination of Eligibility for Emergency Assistance to Needy Families (EAF)

Case Name:	Case Composition:
Case Number/Suffix:	
Caseload:	
Center:	
Type of Emergency:	
Cause of Emergency:	

As set forth in 18 NYCRR § 372.1 and 97 ADM-20, EAF may be authorized more than once in any 12 consecutive months as long as the eligibility criteria are met.

I. This Crisis Situation is Due to the Following Circumstance(s):

SAMPLE

<input type="checkbox"/> Fire or other disaster <input type="checkbox"/> Asked to leave shared apartment by relative or friend who is primary tenant <input type="checkbox"/> Emergency medical expenses required all available recourses to be diverted from rent <input type="checkbox"/> Sudden loss of employment due to layoff or other reason not brought about by voluntary quit <input type="checkbox"/> Landlord refused late or partial rent payment	<input type="checkbox"/> Utility shutoff/termination <input type="checkbox"/> Eviction by landlord for reasons other than nonpayment of rent (specify): _____ <input type="checkbox"/> Eviction by landlord due to nonpayment of rent as part of a complex set of problems, which constitutes an emergency for the family <input type="checkbox"/> Victim of domestic violence (adult and/or child) <input type="checkbox"/> Other (specify): _____
--	---

II. EAF Eligibility Determination Checklist:

In order to determine participant's eligibility for EAF, respond to each of the following items:

1. Does the caretaker relative or non-parent caretaker receive SSI? If "Yes," determine eligibility for Emergency Assistance of Adults (EAA) first, if "No" or not EAA eligible, proceed to question 2. Yes No

2. Is there at least one child under the age of 18, or age 18 and attending full-time secondary school, who is currently residing with an adult caretaker who is related by blood, marriage or adoption? * Yes No

* The term "caretaker who is related by blood, marriage or adoption" shall include the following:

- (1) the child's father, mother, brother, sister, grandfather, great-grandfather, great-great-grandfather, grandmother, great-grandmother, great-great-grandmother, uncle, great-uncle, great-great-uncle, aunt, great-aunt, great-great aunt, of whole or half blood;
- (2) the child's first cousin, nephew and niece, of whole or half blood;
- (3) the child's stepfather, stepmother, stepbrother, stepsister, but no other step relative;
- (4) in the case of a child who has been surrendered to an authorized agency or who has been adopted:
 - (i) any of the blood or step relatives included in the preceding paragraphs of this subdivision; and
 - (ii) the child's adoptive parents and:
 - (a) the other children of the adoptive parents and the children of such children;
 - (b) the parents, grandparents and great-grandparents of the adoptive parents;
 - (c) the brothers and sisters of the adoptive parents and the children of such brothers and sisters; and
 - (d) the aunts, uncles, great-aunts and great-uncles of the adoptive parents.

- (5) the spouse of any person described in the preceding paragraphs, even though the marriage may have been terminated by death, divorce or annulment; and
- (6) in the case of a child born out of wedlock, any relative in the maternal line included in the preceding paragraphs of this subdivision and, if paternity has been adjudicated or acknowledged in writing, any relative in the maternal and paternal lines included in the preceding paragraphs.

- 3. Is there a woman of any age with a medically verified pregnancy?
If you checked "Yes" to either question 2 or 3 above, proceed. If not, the case is ineligible for EAF. Yes No
- 4. Does the family have resources to meet their needs or available income at or above 200% of the most recently published Federal poverty guidelines, as transmitted by the State Office of Temporary and Disability Assistance, on the date of application for the family size? (See **EXP-76D**) Yes No
- 5. Did the emergency arise because an employable child or relative refused without good cause to accept employment or participate in work activities or community services? Yes No
- 6. Will the emergency grant being applied for duplicate or replace a Cash Assistance grant already made under **18 NYCRR § 352.2(a)(b)(c)? (See **W-203K**)
(Do not answer "Yes" if the duplication will replace lost or stolen Cash Assistance.) Yes No

** Each social services district shall utilize the applicable schedules of monthly grants and allowances as found in subdivision (d) of Section 352.2 to provide for all items of need, exclusive of:

- (1) shelter;
- (2) fuel for heating;
- (3) additional cost of meals for persons who are unable to prepare meals at home;
- (4) purchase of necessary and essential furniture required for the establishment of a home;
- (5) replacement of necessary and essential furniture for persons in need of Cash Assistance who have suffered the loss of such items as the result of fire, flood or other like catastrophe;
- (6) essential repairs of heating equipment, cooking stoves and refrigerators;
- (7) allowances for occupational training.

If you checked "No" to questions 4, 5, and 6, proceed.
If you checked "Yes" to any of questions 4, 5, and 6, the applicant is ineligible for EAF.

- 7. Is the necessary payment a diversion payment or a utility emergency payment?
If you checked "Yes" to Number 7, **Stop** — EAF eligible.
If you checked "No" to Number 7, go to Number 8. Yes No
- 8. Is the emergency the result of a sudden occurrence or situation, unforeseen and beyond the individual's control?
If you checked "Yes" to Number 8, **Stop** — EAF eligible.
If you checked "No" to Number 8, ineligible for EAF. Yes No

III. Is This Case Eligible for EAF? Yes No

In accordance with 18 NYCRR § 372.4(d), services which can be determined as necessary to cope with the emergency situation include counseling, securing family shelter, if available, and any other services which meet needs attributable to the emergency situation.

JOS/Worker Signature	Date
Supervisor Signature	Date

IMPORTANT: If you have determined that this case is eligible for EAF, HAVE YOU:

- Completed all questions on this form?
- Signed and date this form, and obtained your Supervisor's signature?
- Entered an "F" in element 270 of POS TAD?

All POS case entries must be descriptive and indicate the nature of the emergency. Please ensure that all related materials are scanned and available on the HRA One Viewer. Complete the POS TAD and annotate the EAF indicator.

(File copy in case record)

**For CIS/OCP Use Only
EAF Indicator Data Entry**

Case Name _____

Case Number

0	0								
---	---	--	--	--	--	--	--	--	--

Suffix

--	--	--	--

Center

0		
---	--	--

Item 270

F

SAMPLE

OCP Control Clerk Date Control Clerk Date

OCP CRT Operator Date Error

Resubmit Date

Control Clerk Date

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

Shelter Arrears Repayment Agreement Worksheet (Use for EAF and SNA Applicants Only)

APPLICANT INFORMATION (To be completed by the JOS/Worker.)

A. Print Name: _____
Last Name First Name M.I.

Address: _____

City: _____ State: _____ Zip Code: _____

- B. 1. Is the household eligible for EAF? (Refer to Determination of Eligibility for Emergency Assistance to Needy Families, form **W-145TT**). Yes No
If Yes, a repayment agreement is not required (see exception in the Note below).
If No, go to Question 2.
2. Is the household applying for recurring SNA? Yes No
If Yes, see the asterisk (*) below and proceed to Section C.
If No, proceed to question 3.
3. Is the household applying for ESNA assistance? Yes No
If Yes, proceed to Section C.
If No, reevaluate category of assistance. Return to question 1.

Note: If shelter arrears are paid under Emergency Assistance to Needy Families (EAF), any amount that exceeds the maximum monthly shelter allowance is to be recovered. Complete the Emergency Assistance to Needy Families (EAF) Agreement to Repay Excess Shelter Arrears (**W-147KK**).

For applicants found eligible under recurring Family Assistance (FA) or Safety Net Assistance (SNA), any amount that exceeds the maximum monthly shelter allowance is to be recouped. Complete the PA Recoupment Data Entry Form – WMS (**LDSS-3573**) and enter the recoupment in the Welfare Management System (WMS).

* If the applicant is applying for recurring SNA but eligibility has not yet been established for recurring assistance, the Repayment Agreement should be signed in the event that the recurring case is not opened. If the recurring case is opened, the Repayment Agreement is null and void and the arrears should be claimed under the recurring SNA. In this situation, any arrears that exceed the maximum shelter standards for the month of application and/or for any prior months must be recouped from future SNA grants.

Shelter Arrears Repayment Agreement Worksheet (continued)

C. Household size: _____ (Include all persons residing in the applicant's house or apartment.)

D. The household's gross monthly income at the time of application: \$ _____
(Include all earned and unearned income [including SSI] for all persons residing in the applicant's household.)

125% of the 2015 Federal Poverty Level Guidelines

Size of Household	1	2	3	4	5	6	7	8	9	10	For Each Additional Household Member:
Monthly Amount (Rounded)	\$1,226	\$1,659	\$2,093	\$2,526	\$2,959	\$3,393	\$3,826	\$4,259	\$4,693	\$5,126	\$433

E. 125% of the Federal poverty level for the household size in Section C: \$ _____

F. Does the amount in Section E exceed the amount in Section D?

- Yes. Applicant is eligible for ESNA shelter arrears payment. Complete the Emergency Safety Net Assistance (ESNA) Shelter Arrears Repayment Agreement (W-147H) form.
- No. Applicant is ineligible for an ESNA shelter arrears payment.

G. Total arrears requested: \$ _____

H. Estimated monthly repayment amount: \$ _____ (The amount in Section G divided by 12.)

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

Emergency Assistance to Needy Families (EAF) Agreement to Repay Excess Shelter Arrears

You have applied for Emergency Assistance to help pay your current shelter expense arrears. Your current actual monthly shelter expense (rent/mortgage/property tax) is \$_____. You are currently _____ months behind in paying your rent/mortgage/property tax. These arrears total \$_____.

The Human Resources Administration (HRA) allows \$_____ per month as the maximum monthly shelter allowance for your household size of _____. HRA will pay the maximum monthly allowance for _____ months which totals \$_____.

You are required to repay HRA any amount paid that is greater than the maximum monthly shelter allowance for your household size.

HRA may approve a payment up to the total arrears indicated above. Of this amount, the maximum monthly amount that you will be required to repay to HRA is \$_____. If HRA approves a lesser amount, your monthly payment will be reduced, and you will be advised of the reduced amount.

You will receive a bill each month from the HRA/Division of Accounts Receivable and Billing (DARB), and you will be billed each month until the total amount is paid in full. You have the option at any time of repaying the total balance due in one lump-sum payment.

If you are found eligible under recurring Family Assistance (FA) or Safety Net Assistance (SNA), the amount that exceeds the maximum monthly shelter allowance for your household size will be recouped from your future Cash Assistance grant.

DO NOT SEND IF PROCESSED IN POS

For Office Use Only

**For Use by Division of Accounts Receivable
and Billing (DARB) Only**

Billing Information

Refund Item Class Description: **One-Time Shelter**

MGMT Unit: **0707**

Code: **RES**

Billing: **Yes**

Number of Payments: **12**

Mail Receipt: **Yes**

SAMPLE

Copies: (1) file (1) applicant

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Nombre del Centro: _____

Asistencia de Emergencia a las Familias Necesitadas (EAF) Acuerdo para Reembolsar Atrasos de Albergue Excedentes

Usted ha solicitado Asistencia de Emergencia para pagar sus atrasos actuales de gastos de albergue. Su gasto mensual actual y efectivo de albergue (alquiler/hipoteca/impuesto sobre la propiedad) suma \$ _____. Actualmente usted está _____ meses atrasado(a) con el pago de su alquiler/hipoteca/impuesto sobre la propiedad. Estos pagos atrasados suman \$ _____.

La máxima concesión mensual de albergue para el número de integrantes de su hogar de _____ integrantes permitida por la Administración de Recursos Humanos (HRA) es de \$ _____. La HRA pagará la máxima concesión mensual por _____ meses, la cual suma \$ _____.

Se requiere que usted reembolse a la HRA cualquier cantidad pagada superior a la máxima concesión mensual de albergue para el número de integrantes de su hogar.

La HRA puede aprobar un pago de hasta el total de los atrasos indicados más arriba. De ese pago, la máxima cantidad mensual que se requiere que usted reembolse a la HRA suma \$ _____. Si la HRA aprueba una cantidad inferior, se reducirá su pago mensual y le informará de la cantidad reducida.

Usted recibirá una factura mensual del Departamento de Cuentas por Cobrar y Facturación (DARB) de la HRA, y se le facturará mensualmente hasta que la cantidad debida se reembolse en total. Usted tiene la opción en cualquier momento de pagar la cantidad total en un pago único global.

Si se determina que usted reúne los requisitos conforme a Asistencia Familiar (FA) o Asistencia de Red de Seguridad (SNA) recurrentes, se recuperará de su futura concesión de Asistencia en Efectivo la cantidad excedente de la máxima concesión mensual de albergue para el número de integrantes de su hogar.

DO NOT SEND IF PROCESSED IN POS

For Office Use Only

**For Use by Division of Accounts Receivable
and Billing (DARB) Only**

Billing Information

Refund Item Class Description: **One-Time Shelter**

MGMT Unit: **0707**

Code: **RES**

Billing: **Yes**

Number of Payments: **12**

Mail Receipt: **Yes**

SAMPLE

Copies: (1) file (1) applicant

Information About Repaying the Department of Social Services For Utility Arrears

You have just signed an agreement to repay the Department of Social Services (DSS) the money you received for assistance with your utility arrears. The Human Resources Administration (HRA) has arranged with its Division of Accounts Receivable and Billing to enroll you in its automated billing process.

How does the automated billing process work?

Once your signed repayment agreement is received and the HRA check to the utility company is cashed, HRA will enter the full amount into the HRA billing system as a billable account. The amount will be divided into the 24 monthly installments required by New York State Social Services law. Each month you will receive a bill from the HRA Division of Accounts Receivable and Billing and a postage pre-paid business reply envelope. Each bill will show payments received since the prior bill and the remaining balance.

How can I change the amount of the bill due each month?

If you want to change the monthly amount due, you can contact the HRA Division of Claims and Collections. The Division will work with you to create a different payment plan based on changes to your finances or other circumstances. You can ask to reduce or increase the monthly bill amount at any time during the 24-month repayment period. You can also repay the outstanding amount in full at any time during the billing process.

When will the monthly billing begin?

The monthly billing begins after your repayment agreement is given to HRA and the check HRA issued to pay your utility arrears is cashed. If the check is not cashed, you will not be enrolled in the monthly billing process and no money will be due to the DSS.

When will the billing end?

The billing will end when the amount is paid in full. If you become an active Cash Assistance recipient before the amount has been paid in full, billing will be stopped until your case closes. If you are sanctioned on your case, we will start billing you again until the total amount is repaid.

Who do I contact with my questions or concerns?

You can contact the HRA Division of Claims and Collections at (212) 274-4943. Tell the representative you want to discuss your repayment agreement. You will be given an appointment to talk about your repayment agreement with Division staff.

Where is the Division of Claims and Collections located?

The address is 250 Church St. New York, N.Y. 10013.

What happens if I stop paying the bills sent to me?

You are responsible for repaying your utility assistance on the assigned schedule unless you ask for a different payment plan and HRA agrees. If you do not contact the HRA Division of Claims and Collections to change your payment schedule or ask for a suspension, you might have a civil action taken against you. This means you could have your credit score negatively affected, your paycheck garnished, and legal fees plus interest added to the original amount owed.

Información sobre el Reembolso al Departamento de Servicio Social Por Pagos Atrasados en los Servicios de Electricidad y Gas

Usted ha firmado un acuerdo para reembolsar al Departamento de Servicio Social (Department of Social Services -DSS) el dinero que recibió para la asistencia de sus pagos atrasados de los servicios de electricidad y gas. La Administración de Recursos Humanos (The Human Resources Administration - HRA) ha acordado con la División de Cuentas y Pagos (Division of Accounts Receivable and Billing) inscribirle en el proceso automático de pago.

¿Cómo trabaja el proceso automático de pagos?

Una vez se reciba su acuerdo de reembolso firmado y el cheque que la HRA envíe a la compañía de electricidad y gas se haya cobrado, la HRA ingresará la cantidad total en el sistema de pago como una cuenta por cobrar. La cantidad será dividida entre los 24 plazos mensuales que requiere la Ley Estatal de Servicios Sociales de Nueva York. Cada mes usted recibirá una factura de la División de Cuentas y Pagos de HRA y un sobre de retorno con estampilla. Cada factura indicará los pagos recibidos desde la factura anterior y el balance restante.

¿Cómo puedo cambiar la cantidad de la factura que se debe cada mes?

Si desea cambiar la cantidad que se debe cada mes, puede comunicarse con la División de Reclamos y Cobros de la HRA. Esa unidad coordinará con usted para crear un plan diferente basado en los cambios en sus finanzas u otras circunstancias. Usted puede solicitar que se disminuya o aumente la factura mensual en cualquier momento durante el período de reembolso de 24 meses. Usted además puede reembolsar en total el balance restante en cualquier momento durante el proceso de pago.

¿Cuándo se iniciará el pago mensual?

El pago mensual se iniciará después de que su acuerdo de reembolso haya sido entregado a la HRA y el cheque que la HRA envió para cancelar los pagos atrasados de los servicios de electricidad y gas se cobra. Si el cheque no ha sido cobrado, usted no estará inscrito en el proceso mensual de pago y no se deberá dinero al DSS.

¿Cuándo finalizará el pago?

El pago finalizará cuando la cantidad sea totalmente pagada. Si usted se hace beneficiario(a) activo de la Asistencia en Efectivo antes de que la cantidad en total se pague, no recibirá facturas de pago hasta que se cierre su caso. Si es sancionado(a) en su caso, empezaremos a enviarle las facturas nuevamente hasta que la cantidad en total se reembolse.

¿Con quién me comunico si tengo preguntas o dudas?

Puede comunicarse con la División de Reclamos y Cobros de la HRA llamando al (212) 274-4943. Dígame al representante que quiere hablar con alguien sobre su acuerdo de reembolso. Se programará una cita para que hable con un empleado de la División sobre el acuerdo de reembolso.

¿Dónde está ubicada la División de Reclamos y Cobros?

La dirección es 250 Church St. New York, N.Y. 10013.

¿Qué pasa si dejo de pagar las facturas que me envían?

Usted es responsable de reembolsar su asistencia de los servicios de electricidad y gas en las fechas indicadas, a menos que solicite un plan de reembolso diferente y la HRA esté de acuerdo. Si no se comunica con la División de Quejas y Cobros de la HRA para cambiar las fechas de pago de su reembolso o solicitar que se suspendan los pagos, podría entablarse un proceso civil en contra suya. Esto significa que su estado de crédito podría verse afectado, y su salario ser embargado, y se podrían agregar tarifas legales y más intereses a la cantidad que se debe.

Information About Repaying the Department of Social Services For Rental Arrears

You have agreed to repay the Department of Social Services (DSS) the money you received for assistance for your rental arrears. The Human Resources Administration (HRA) has arranged with its Division of Accounts Receivable and Billing to enroll you in its automated billing process.

How does the automated billing process work?

Once your signed repayment agreement is received and the HRA check to the landlord is cashed, HRA will enter the full amount into the HRA billing system as a billable account. The amount will be divided into the 12 monthly installments required by New York State Social Services law. Each month you will receive a bill from the HRA Division of Accounts Receivable and Billing and a postage pre-paid business reply envelope. Each bill will show payments received since the prior bill and the remaining balance.

How can I change the amount of the bill due each month?

If you want to change the monthly amount due, you can contact the HRA Division of Claims and Collections. The Division will work with you to create a different payment plan based on changes to your finances or other circumstances. You can ask to reduce or increase the monthly bill amount at any time during the 12-month repayment period. You can also repay the outstanding amount in full at any time during the billing process.

When will the monthly billing begin?

The monthly billing begins after your repayment agreement is given to HRA and the check HRA issued to pay your rental arrears is cashed. If the check is not cashed, you will not be enrolled in the monthly billing process and no money will be due to the DSS.

When will the billing end?

The billing will end when the amount is paid in full. If you become an active Cash Assistance recipient before the amount has been paid in full, billing will be stopped until your case closes. If you are sanctioned on your case, we will start billing you again until the total amount is repaid.

Who do I contact with my questions or concerns?

You can contact the HRA Division of Claims and Collections at (212) 274 - 4943. Tell the representative you want to discuss your repayment agreement. You will be given an appointment to talk about your repayment agreement with Division staff.

Where is the Division of Claims and Collections located?

The address is 250 Church Street, 8th Floor, New York, N.Y. 10013.

What happens if I stop paying the bills sent to me?

You are responsible for repaying your rental assistance on the assigned schedule unless you ask for a different payment plan and HRA agrees. If you do not contact the HRA Division of Claims and Collections to change your payment schedule or ask for a suspension, you might have a civil action taken against you. This means you could have your credit score negatively affected, your paycheck garnished, and legal fees plus interest added to the original amount owed.

Información sobre el Reembolso al Departamento de Servicios Sociales Por Pagos Atrasados de Alquiler

Usted ha acordado reembolsar al Departamento de Servicios Sociales (DSS) el dinero que recibió de asistencia para sus pagos atrasados de alquiler. La Administración de Recursos Humanos (HRA) ha acordado con la División de Cuentas por Cobrar y Facturación inscribirle en el trámite automático de facturación.

¿Cómo funciona el trámite automático de facturación?

Una vez se reciba su acuerdo de reembolso firmado y se haya cobrado el cheque de la HRA a nombre del casero, la HRA ingresará la cantidad total en el sistema de facturación como cuenta por cobrar. La cantidad se dividirá entre los 12 plazos mensuales que estipula la Ley Estatal de Servicios Sociales de Nueva York. Cada mes usted recibirá una factura de la División de Cuentas por Cobrar y Facturación de la HRA y un sobre con franqueo pagado y con dirección del remitente. Cada factura indicará los pagos recibidos desde la factura anterior y el saldo remanente.

¿Cómo puedo cambiar la cantidad de la factura que se debe cada mes?

Si usted desea cambiar la cantidad debida mensualmente, puede comunicarse con la División de Reclamaciones y Cobros de la HRA. Esa unidad coordinará con usted para crear un diferente plan de pagos, basado en cambios a sus finanzas u otras circunstancias. En cualquier momento durante el período de reembolso de 12 meses, usted puede solicitar que se disminuya o aumente la factura mensual. Además, usted puede reembolsar la cantidad total debida en cualquier momento durante el trámite de facturación.

¿Cuándo se iniciará la facturación mensual?

La facturación mensual se iniciará después de que se haya proporcionado su acuerdo de reembolso a la HRA y que se cobre el cheque que la HRA expidió para pagar sus atrasos de alquiler. Si no se cobra el cheque, usted no estará inscrito(a) en el trámite de facturación mensual y no se deberá ningún dinero al DSS.

¿Cuándo se terminará la facturación?

La facturación se terminará cuando se salde la cantidad total. Si posteriormente usted pasa a ser beneficiario(a) activo de Asistencia en Efectivo antes de que se salde la cantidad total, no recibirá facturas de pago hasta el cierre de su caso. Si usted es sancionado(a) en su caso, empezaremos nuevamente a enviarle las facturas hasta que se salde la cantidad total.

¿Con quién me comunico si tengo preguntas o dudas?

Puede comunicarse con la División de Reclamaciones y Cobros de la HRA al llamar al (212) 274 - 4943. Infórmele al representante que quiere hablar con alguien sobre su acuerdo de reembolso. Se le programará una cita para que hable con un empleado de la División sobre el acuerdo de reembolso.

¿Dónde está ubicada la División de Reclamaciones y Cobros?

La dirección es 250 Church Street, 8vo piso, New York, N.Y. 10013.

¿Qué tal si dejo de pagar las facturas que se me envían?

Usted es responsable de reembolsar su asistencia de alquiler en las fechas indicadas, a menos que solicite un plan de reembolso diferente y la HRA esté de acuerdo. Si no se comunica con la División de Reclamaciones y Cobros de la HRA para cambiar las fechas de pago de su reembolso, o no solicita que se suspendan las facturas, se puede entablar un proceso civil en contra suya. Esto significa que su puntaje de crédito puede verse afectado, puede embargarse su salario, y pueden agregarse tarifas legales más intereses a la cantidad debida.

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

Utility Arrears Repayment Agreement

REPAYMENT AGREEMENT

Case Address (at time of arrears): _____

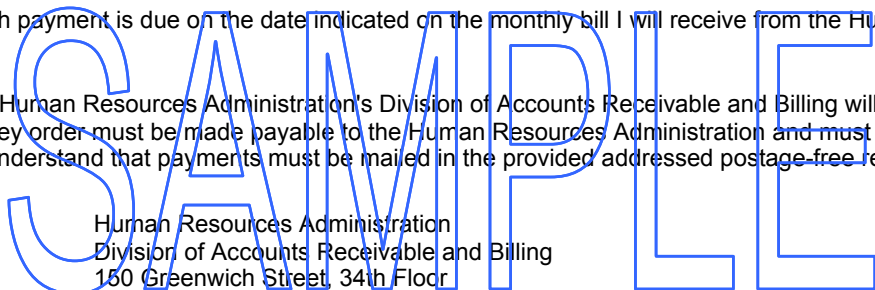
As a condition of eligibility for receiving this utility arrears assistance to restore or to prevent termination of service, I agree to repay the Human Resources Administration \$ _____.

I agree to repay this amount in twenty-four (24) monthly installments of \$ _____.

I understand that each payment is due on the date indicated on the monthly bill I will receive from the Human Resources Administration.

I understand that the Human Resources Administration's Division of Accounts Receivable and Billing will send me a monthly bill. My check or money order must be made payable to the Human Resources Administration and must include my address and case number. I understand that payments must be mailed in the provided addressed postage-free return envelope to:

Human Resources Administration
Division of Accounts Receivable and Billing
150 Greenwich Street, 34th Floor
New York, NY 10007



I understand that I will not be eligible for subsequent utility arrears assistance to restore or prevent termination of service unless I have fully repaid any prior utility arrears payments that were subject to repayment; or I am repaying this assistance in accordance with the terms of any Repayment Agreement(s); or my household's income is below the temporary assistance standard of need for my household size as of the date of application for such subsequent assistance. I also understand that if I fail to repay this assistance within the twenty-four (24) month period, the Human Resources Administration will enforce this Repayment Agreement by any method available to a creditor. This includes, but is not limited to, referring the matter to a collection agency, obtaining a judgment from a court, obtaining a lien on real property or garnishing wages, in appropriate cases.

I understand that the Human Resources Administration also has the right to require that I sign a lien on my real property for receiving a utility arrears payment authorized under Emergency Safety Net Assistance or Emergency Assistance to Needy Families. If a lien is taken, that portion which represents this arrears payment will be reduced by payments made under this agreement.

If I later become eligible for recurring temporary assistance, any unpaid balance of this utility arrears payment will be suspended until I am no longer receiving recurring temporary assistance. At that time, the unpaid balance will become due to the Human Resources Administration under the terms of this agreement.

I understand that by signing this form, I agree to all of the above conditions.

Applicant's Signature

Date

Authorized by

Date

Note: This form is not valid unless the Applicant's signature and the authorized Human Resources Administration staff signature are present.

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Número del Centro: _____

Acuerdo de Reembolso de Pagos Atrasados de Servicios Públicos

ACUERDO DE REEMBOLSO

Dirección del caso (en el momento del atraso): _____

Como condición de elegibilidad para recibir asistencia de pagos atrasados de servicios públicos, para restaurar o prevenir la terminación de mi servicio, acepto reembolsar a la Administración de Recursos Humanos (HRA) \$ _____.

Estoy de acuerdo en reembolsar esta cantidad en veinticuatro (24) plazos mensuales de \$ _____.

Entiendo que la fecha límite de cada pago se indica en la factura mensual que obtendré de la Administración de Recursos Humanos.

Entiendo que la División de Cuentas por Cobrar y Facturación de la HRA me enviará una factura mensual. Mi cheque o giro postal tiene que ser pagadero a la Administración de Recursos Humanos y debe incluir mi dirección y número del caso. Entiendo que se deben enviar por correo los pagos en el sobre con franqueo pagado y con dirección del remitente a:

Human Resources Administration
Division of Accounts Receivable and Billing
150 Greenwich Street, 34th Floor
New York, NY 10007

Entiendo que no seré elegible para asistencia adicional de atrasos de servicios públicos para restablecer o evitar la terminación de servicio, a menos que yo haya reembolsado por completo cualquier pago debido de atrasos anteriores de servicios públicos; o estoy reembolsando esta asistencia conforme a las condiciones de cualquier Acuerdo(s) de Reembolso; o el ingreso de mi hogar es inferior al de la norma de necesidad de asistencia temporal para el número de integrantes de mi hogar, a partir de la fecha de solicitud de dicha asistencia adicional. Entiendo además que si no reembolso como debido esta asistencia dentro del plazo de veinticuatro (24) meses, la HRA hará cumplir este Acuerdo de Reembolso por cualquier método del que disponga un acreedor. Esto incluye, pero no se limita a remitir el asunto a una agencia de cobros, obtener una orden judicial, obtener un gravamen de bienes inmuebles o embargar mi sueldo, en caso apropiado.

Entiendo que la HRA también tiene el derecho de estipular que yo firme un gravamen de mis bienes inmuebles para recibir un pago de atrasos de servicios públicos conforme a Asistencia de Red de Seguridad de Emergencia (Emergency Safety Net Assistance) o Asistencia de Emergencia a Familias Necesitadas (Emergency Assistance to Needy Families). Si se acepta el gravamen, la porción que representa este pago de atrasos se reducirá por los pagos efectuados conforme a este acuerdo.

Si posteriormente resulto elegible para asistencia temporal recurrente, se suspenderá cualquier saldo no pagado de esta deuda atrasada de servicios públicos, hasta que yo deje de recibir asistencia temporal recurrente. En ese momento, el saldo por pagar se deberá a la HRA conforme a las estipulaciones de este acuerdo.

Entiendo que al firmar este formulario, accedo a todas las condiciones anteriores.

Firma del Solicitante

Fecha

Autorizado por

Fecha

Nota: Este Formulario no es válido a menos que esté firmado por el solicitante y por un miembro autorizado del personal de la Administración de Recursos Humanos.

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

Utility Arrears Repayment Agreement Worksheet

A. Applicant's Information (To be completed by the JOS/Worker.)

Print Name: _____
First Name M.I. Last Name
 Address: _____

 City: _____ State: _____ Zip Code: _____
 Utility arrears owed: \$ _____

Category: ESN EAF

B. Is the applicant the customer of record? Yes. Proceed. No. The customer of record must come in to apply.

C. Household size (Include all persons residing in the applicant's house or apartment and their Social Security numbers):

(1) Name	(2) Relationship	(3) Social Security Number	(4) Type/Verification	(5) Monthly Gross
Total				\$

D. Is the customer of record in receipt of CA or SSI (or additional State payments) on the date of application?

Yes. Repayment Agreement is **not** required (regardless of category of assistance under which the arrears are paid). No. Proceed to Section "E."

E. Household's gross monthly income on the date of application is \$ _____.

(Include all earned and unearned income for all persons residing in the house or apartment.)

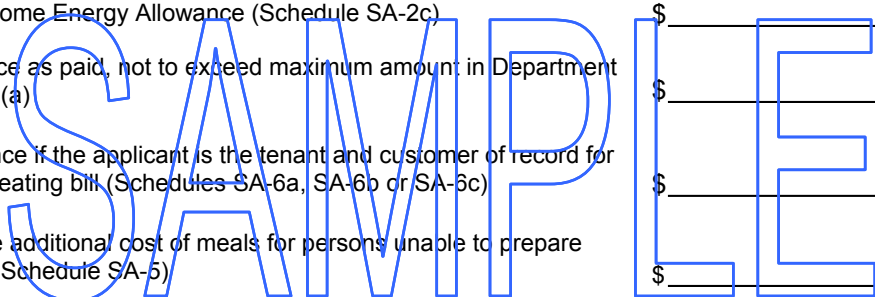
For employed persons, include the name, address, and telephone number of the employer(s) beside the person's name.

Employer's Name: _____ Telephone: _____
First Name M.I. Last Name
Address: _____
City: _____ State: _____ Zip Code: _____

F. CA standard of need for household size in Section "C" \$ _____.

This is the sum of the following 6 items:

- 1. Basic Allowance (Schedule SA-2a) \$ _____
- 2. Home Energy Allowance (Schedule SA-2b) \$ _____
- 3. Supplemental Home Energy Allowance (Schedule SA-2c) \$ _____
- 4. Shelter Allowance as paid, not to exceed maximum amount in Department regulation 352.3(a) \$ _____
- 5. Heating Allowance if the applicant is the tenant and customer of record for the residential heating bill (Schedules SA-6a, SA-6b or SA-6c) \$ _____
- 6. If applicable, the additional cost of meals for persons unable to prepare meals at home (Schedule SA-5) \$ _____



G. Is Section "E" (gross monthly income) greater than Section "F" (Temporary Assistance) monthly standard of need?

- Yes. Repayment Agreement is required. Complete the Utility Arrears Repayment Agreement (**W-147X**) form.
- No. Repayment Agreement is **not** required.