Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING

James K. Whelan, Executive Deputy Commissioner

Stephen Fisher, Assistant Deputy Commissioner
Office of Procedures

POLICY DIRECTIVE #16-25-ELI

(This Policy Directive Replaces PD #14-30-ELI and PB #15-114-ELI)

JANUARY 2017 RSDI/SSI COLA INCREASES

Date:	**Subtopic(s):**
December 21, 2016	Budgeting

AUDIENCE

The instructions in this policy directive are for Job Center and Non Cash Assistance (NCA) Supplemental Nutrition Assistance Program (SNAP) Center staff, and are informational for all others.

POLICY

Social Security and Supplemental Security Income (SSI) benefits are adjusted to reflect the increase, if any, in the cost-of-living adjustment (COLA), as measured by the federal Consumer Price Index (CPI) for Urban Wage Earners and Clerical Workers (CPI-W).

The average CPI-W for the third quarter of the last year that a COLA was determined is compared to the average CPI-W for the third quarter of the current year. The resulting percentage increase, if any, represents the percentage that will be used to increase Social Security and SSI benefits for the following year.

The increase in Social Security and SSI, if any, must be reflected in the budgets for Cash Assistance (CA) and SNAP participants, as required.

BACKGROUND

Effective January 1, 2017, all individuals in receipt of Social Security Retirement, Survivors, and Disability Insurance (RSDI) and/or SSI will receive a COLA of 0.3 percent. This 0.3 percent COLA results in an average increase of $2 per month for SSI recipients.

See PB #14-124-ELI for information on State Supplement Program benefits.

Note: Updated RSDI amounts can be obtained from the State Online Query (SOLQ) System. However, since SOLQ no longer contains the State Supplement Program (SSP) benefits that were previously included in the federal portion of SSI benefits, the updated combined amounts of SSI and SSP benefits (budgeted with Income Source Code **31**), must be obtained from the SDX Inquiry screen (**NQSDX1**) in the Welfare Management System (WMS).

The SSI and SSP Benefit Levels Chart effective January 1, 2017 (**Attachment A**) reflects the 0.3 percent federal COLA and increases in the Personal Needs Allowance (PNA) for individuals residing in Congregate Care facilities. The new semi-monthly (s/m) PNA amounts effective January 2017 are as follows:

Congregate Care Level 1 = $70.50 s/m
Congregate Care Level 2 = $81.50 s/m
Congregate Care Level 3 = $97.00 s/m

In addition to the increases in the PNA, the new CA shelter amounts used to budget Congregate Care cases effective January 2017 are as follows:

Shelter Type Code	Semi-monthly shelter rate
28	$411.00
15	$430.00
29, **32**	$488.50
16, **31**, **43**	$503.50
42	$617.50

Revised **W-200G** and **W-648J**

The Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (**W-200G**) and the Congregate Care Budget Worksheet (**W-648J**) have been revised to reflect the changes in the PNA and the Shelter amounts for Congregate Care cases.

A Notice of Intent to Change Benefits: NYC PA COLA (**Attachment B**) was sent to all participants whose CA grants will be reduced effective January 2017 because of the RSDI/SSI increase.

A Notice of Mass Change (**Attachment C**) was sent to all participants whose SNAP benefits will be reduced effective January 2017 because of the RSDI/SSI increase.

The changes in the New York State Nutrition Improvement Project (NYSNIP) standardized benefit levels and the shelter cost thresholds will be announced in a separate procedure.

A mass re-budget (MRB) was run in WMS on December 17, 2016 to update the cases with individuals in receipt of RSDI/SSI or Veterans Benefits. The MRB included the automatic recalculation of all pending budgets affected by the RSDI/SSI COLA. Cases included in the MRB can be identified by the unique authorization number **33333238**, and can be seen on the WMS Case Action History screen. The following cases were excluded from the MRB:

- Cases requiring bottom-line budgeting
- Cases with invalid financial involvement codes
- Cases in error status

A list of all the CA cases that were excluded from the MRB will be forwarded to the Regional Offices for distribution to the appropriate Centers for re-budgeting. A list of all NCA SNAP cases that were excluded from the MRB will be forwarded to SNAP Center 25 for re-budgeting.

REQUIRED ACTION

CA Budgeting

When the list of cases not included in the MRB is received by the JOS/Worker, he/she must determine if any of the individuals on the case are in receipt of SSI benefits. For individuals in receipt of SSI benefits, the updated amount must be obtained from the SDX Inquiry screen. For individuals in receipt of RSDI, a referral to the SOLQ Liaison must be done to obtain the new amount of benefits. After the new amounts are received, the JOS/Worker must take all required actions to budget the income appropriately.

- If the household remains eligible for CA and SNAP benefits, authorize a budget that reflects the change in income. The Client Notices System (CNS) will generate the appropriate reduction notice.
- If the household is no longer eligible for CA, close the CA case using closing code **E39** (Excess Income – COLA). WMS will process an automated SNAP separate determination. CNS will generate the appropriate closing notice.
- If the household remains eligible for CA but is no longer eligible for SNAP benefits, close the SNAP portion of the CA/SNAP case using closing code **E39** (Excess Income – COLA). CNS will generate the appropriate SNAP closing notice.

NCA SNAP Budgeting	For SNAP participants, the Worker at SNAP Center 25 must determine if any of the individuals on the case are in receipt of SSI benefits. For individuals in receipt of SSI benefits, the updated amount must be obtained from the SDX Inquiry screen. For individuals in receipt of RSDI, a referral to the SOLQ Liaison must be done to obtain the new amount of benefits. After obtaining the new amount of benefits, the Worker must take all required actions to budget the income appropriately. • If the household remains eligible for SNAP benefits, authorize a budget that reflects the change in income. CNS will generate the appropriate reduction notice. • If the household is no longer eligible for SNAP benefits, close the SNAP case using closing code **E39** (Excess Income – COLA). CNS will generate the appropriate closing notice.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications	Cases that were excluded from the MRB must be re-budgeted in POS.
SNAP Implications	A separate SNAP benefit determination is required for CA cases that will be closed as a result of the COLA increase.
Medicaid Implications	A separate Medicaid determination is required for CA cases that are closed as a result of the COLA increase.

LIMITED ENGLISH PROFICIENT AND DEAF/HARD-OF-HEARING IMPLICATIONS

For Limited English Proficient (LEP) and Deaf/Hard-of-Hearing applicants/participants, make sure to obtain appropriate interpreter services in accordance with PD #16-14-OPE and PD #16-16-OPE.

FAIR HEARING IMPLICATIONS

Avoidance/ Resolution	Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up-to-date. Remember that participants must receive either adequate or timely and adequate notification of all actions taken on their case.
Conferences at Job Centers	A participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If a participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the participant is waiting to be seen. In Model Centers, the Receptionist at Main Reception will issue an FH&C ticket to the participant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff. The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the participant, review the case file, and explain the reason for the Agency's action(s) to the participant. If the participant has shown that the outstanding adverse action related to the January 2017 COLA needs to be withdrawn, the FH&C AJOS/Supervisor I will Settle in Conference (SIC), enter detailed case notes in NYCWAY and forward all documentation submitted by the participant to the appropriate JOS/Worker for corrective action to be taken. If the determination is that the Agency action was correct, the FH&C AJOS/Supervisor I will explain the reason for the determination to the participant. If the explanation is accepted, no further action is necessary. The AJOS/Supervisor I must complete a Conference Report (**M-186a**). Should the participant elect to continue his/her appeal by requesting or proceeding to a Fair Hearing, already requested, the FH&C AJOS/Supervisor I is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.
Conferences at SNAP Centers	If a participant comes to the SNAP Center requesting a conference, the Receptionist must alert the SNAP Center Director's Designee that the participant is to be seen. If the participant contacts the Worker directly, advise the participant to call the Designee.

The Designee will listen to and evaluate any material presented by the participant, and explain the reason for the Agency's action to the participant. If the participant has shown that the Agency's action needs to be withdrawn, the Designee will SIC the adverse action. If the determination is that the Agency action is correct, the Designee will explain the reason for the determination to the participant. If the explanation is accepted, no further action is necessary.

Should the participant elect to continue his/her appeal by requesting or proceeding to a Fair Hearing, already requested the Designee is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Evidence Packets

For Fair Hearing purposes, all complete and relevant evidence packages must include a copy of the state mass re-budgeting notice.

REFERENCES

ABEL Transmittal 16-4
18 NYCRR 352.8, 352.29, 387.10, 387.12, 387.15
Chapter 54 of the Laws of 2016

RELATED ITEMS

PB #14-124-ELI	State Supplement Program Benefits
PB #14-133-SYS	State Online Query (SOLQ) System
PB #10-102-OPE	Introduction to the Congregate Care Budget Worksheet (W-648J)
PD #09-31-ELI	Revision to Processing of Cases Referred by the Division of Voluntary and Proprietary Homes for Adults (DVPHA)

ATTACHMENTS

Please use Print on Demand to obtain copies of forms.

Attachment A	SSI and SSP Benefit Levels Chart effective January 1, 2017
Attachment B	Notice of Intent to Change Benefits: NYC PA COLA
Attachment C	Notice of Mass Change
W-200G	Shelter Rates and Personal Needs Allowance for Congregate Care Facilities Desk Aid (Rev. 12/21/16)
W-648J	Congregate Care Budget Worksheet (Rev. 12/21/2016)
W-648J (S)	Congregate Care Budget Worksheet (Spanish) (Rev. 12/21/2016)

Attachment A

SSI and SSP Benefit Levels Chart effective January 1, 2017 (reflects the 0.3% federal COLA for January 2017)

Fed L/A Code	State Supp Code	New York State Living Arrangement	Individual			Couple		
			Federal	State	Total[1]	Federal	State	Total
A	**A**	**Living Alone**	$735	$87	**$822**	$1,103	$104	**$1,207**
A, C	**B**	**Living With Others**	$735	$23	**$758**	$1,103	$46	**$1,149**
(B)	(F)	(Living in the Household of Another) [2]	($490)		**($513)**	($735.33)		**($781.33)**
A	**C**	**Congregate Care Level 1 - *Family Care*** OCFS certified Family Type Homes for Adults; and OMH or OPWDD certified Family Care Homes						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	$735	$266.48	**$1,001.48**	$1,103	$899.96	**$2,002.96**
		Rest of State	$735	$228.48	**$963.48**	$1,103	$823.96	**$1,926.96**
A	**D**	**Congregate Care Level 2 - *Residential Care*** OMH or OPWDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	$735	$435	**$1,170**	$1,103	$1,237	**$2,340**
		Rest of State	$735	$405	**$1,140**	$1,103	$1,177	**$2,280**
A	**E**	**Congregate Care Level 3 – *Enhanced Residential Care*** DOH certified Adult Homes and Enriched Housing programs; and OPWDD certified Schools for the Developmentally Disabled	$735	$694	**$1,429**	$1,103	$1,755	**$2,858**
D	**Z**	**Title XIX (Medicaid certified) Institutions** [3]	$30	0[4]	**$30**	N/A		
A	**Z**	(see below) [5]	$735	0	**$735**	$1,103	0	**$1,103**

Minimum Personal Needs Allowances

Congregate Care Level 1	-	$ 141
Congregate Care Level 2	-	$ 163
Congregate Care Level 3	-	$ 194

Limits on Countable Resources

Individuals	$2,000
Couples	$3,000

Revised 24 Oct 2016

Statutory References: Chap. 54 of L. 2016

[1] The combined federal and State SSI benefit provided to eligible individuals and eligible couples with no countable income.
[2] The *Living With Others* category includes recipients whose federal benefit has been reduced by the "value of the 1/3 reduction" (VTR) due to the federal determination that they are both: *a)* Living in someone else's household, *and b)* receiving some amount of free or subsidized food and shelter (room and board).
[3] Applies when an SSI recipient is residing in a medical facility, is not expected to return home within 90 days, and Medicaid is paying for at least 50% of the cost of care.
[4] Recipients in nursing homes licensed by DOH receive an additional monthly grant of $25 issued by OTDA called a State Supplemental Personal Needs Allowance (SSPNA). Residents of other medical facilities receive an SSPNA of $5.
[5] No State supplement is provided: a) when an SSI recipient is residing in a private medical facility and Medicaid is paying for less than 50% of the cost of care, or b) when a recipient resides in certain publicly operated residential facilities serving 16 or fewer residents, or c) while a recipient resides in a public emergency shelter for 6 calendar months during a 9 month period.

Attachment B

NOTICE OF INTENT TO CHANGE BENEFITS:
NYC PA COLA

Notice Date: **December 6, 2016**

Case Number:
Loc. Off./Unit/Worker: **//**

General Telephone No. for
Questions or Help: **- -**

This Notice is to tell you that this agency intends to change your benefits as follows:

PUBLIC ASSISTANCE GRANT YOUR PUBLIC ASSISTANCE GRANT WILL BE **REDUCED FROM $0.00 TO $0.00**

EFFECTIVE JANUARY 1, **2017**.

The reason for this action is that according to our records you and/or your dependent(s) are receiving Social Security and/or SSI payments and/or Veteran's Benefits from the Federal Government and a Family Assistance (FA) or Safety Net Assistance (SNA) grant from this Department. As you probably know, Congress has passed a Law (Public, 93-233) providing for an automatic cost of living adjustment in Social Security and/or SSI benefits and/or Veteran's Benefits. This has resulted in an **increase of 0.3** percent which will take effect in December **2016** and be contained in payments received in **January 2017**. Under Law these increases must be counted in determining the amount of the grant you receive from this Department. However, SSI grants are never used to calculate FA payments. SSI can only be counted in SNA cases when the SSI recipient is also receiving SNA.

INCREASE TO SOCIAL SECURITY/SSI/VETERAN'S BENEFITS

WE CALCULATE THAT STARTING **JANUARY 2017** THE MONTHLY FEDERAL BENEFIT(S) OF YOU AND/OR YOUR DEPENDENTS WILL BE INCREASED BY A TOTAL OF $

Because of this increase, your FA or SNA grant must be reduced by an equal amount.

This decision is based on Department Regulation 352.29.

MEDICAL ASSISTANCE: Your Medical Assistance will continue unchanged. This decision is based on Department Regulation 360-3.3.

Supplemental Nutrition Assistance Program (SNAP): Even though your public assistance grant will change, your SNAP benefits will not change unless you get a separate notice telling you that your SNAP benefits will change. This decision is based on Department Regulation(s) 387.10 and 387.15.

If you do not understand this notice or are in disagreement with the action we are taking, you may request a conference. To do so, visit your center or call on the telephone as soon as possible.

THE TELEPHONE NUMBER TO CALL FOR A CONFERENCE IS - - .

BY REQUESTING A CONFERENCE YOU ARE NOT GIVING UP YOUR RIGHTS TO A FAIR HEARING PROVIDED THAT YOU REQUEST A HEARING WITHIN THE TIME LIMITS DESCRIBED ON THE ENCLOSED PAGE. SEE THE ENCLOSED PAGE FOR APPEAL PROCESS INFORMATION.

SEE BELOW FOR EXPLANATION OF YOUR NEW PA GRANT.

PRE-ADD CONCESIÓN PRE-SUMADA		SSA INCOME INGRESO DE SEGURO SOCIAL	
SHELTER VIVIENDA		SSI INCOME INGRESO DE SSI	
ENERGY ENERGÍA		OTHER INCOME OTRO INGRESO	
ENERGY SUPPLEMENT SUPLEMENTO DE ENERGÍA		TOTAL INCOME INGRESO TOTAL	
OTHER NEEDS OTRAS NECESIDASES			
TOTAL NEEDS TOTAL DE NECESIDADES		PA GRANT CONCESIÓN DE PA	

Sincerely,
Matthew Brune, Executive Deputy Commissioner
Family Independence Administration

XL0074 (11/16)

Attachment B Notice of Intent To Change Public Assistance Benefits Due To An Increase In Social Security, SSI and/or Veteran's Benefits

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

If you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2:

1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer.

The Office of Temporary and Disability Assistance (OTDA) policy issuances and manuals are posted on the OTDA website at otda.ny.gov/legal. These issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. In addition, upon request to your local social services district, specific OTDA policy issuances and manuals will also be available to assist you or your representative.

1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

   If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See "Keeping Your Benefits The Same" below.)

2. **STATE FAIR HEARING -** You have **60 days** from the date of this notice to ask for a fair hearing:

   KEEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any Public Assistance benefits you got, but should not have gotten, while you were waiting for the decision.

   If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a fair hearing or, if you send back this notice, check the box below:

   ☐ I do not want to keep my Public Assistance benefits the same until the Fair Hearing decision is issued.

   If at the hearing, the hearing officer determines that you are not complaining about an incorrect computation of your benefits or that there has been a misapplication or misinterpretation of Federal Law or regulations, the hearing officer may determine that you were not entitled to have your Public Assistance benefits continue unchanged until the fair hearing decision is issued, and order that the reduction take effect immediately.

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

Mail: Send a copy of the notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.) _____

Phone: **800-342-3334** (Please have this notice with you when you call.)

Fax: Fax a copy of the front and reverse of this notice to: **(518) 473-6735**.

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn.

Online: Complete an online request form at: **http://www.otda.ny.gov/oah/forms.asp**.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, fax, walk-in or on-line, please write to ask for a fair hearing before the deadline.

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice that tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing. At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong. To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements. At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

LEGAL ASSISTANCE: If you think you need a lawyer to help you with this problem, you may be able to get a lawyer at no cost to you by contacting your local Legal Aid Society or other legal advocate group. For the names of other lawyers, check your Yellow Pages under "Lawyers".

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

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

Notice Date: December 6, 2016 **Effective Date: January 1, 2017** **NYC PA COLA '17**

Attachment B

PREAVISO DE CAMBIOS EN LOS BENEFICIOS:
Asistencia Pública / Ajuste de costo de vida *(NYC PA COLA)*

Fecha del aviso: **6 de diciembre de 2016**
N° de caso:

Oficina Local / Unidad / Trabajador(a): ***//***

N° de teléfono general para
preguntas o ayuda: **- -**

Por medio de esta notificación le comunicamos que esta agencia tiene el propósito de modificar sus beneficios, tal como lo explicamos a continuación.

SUBVENCIÓN DE ASISTENCIA PÚBLICA: SU SUBVENCIÓN DE ASISTENCIA PÚBLICA SE **REDUCIRÁ** DE **$0.00** A **$0.00** A PARTIR DEL 1º DE ENERO DE **2017**.

La razón de esta decisión es que, según nuestros registros, usted y/o su(s) dependiente(s) recibe(n) pagos del Seguro Social y/o pagos de SSI y/o beneficios para Veteranos de parte del gobierno federal, y una subvención de Asistencia para Familias (FA) o Asistencia de Seguridad (SNA) de este departamento. Como usted probablemente sabe, el Congreso aprobó una Ley (Public, 93-233) que contempla un ajuste automático de costo de vida a los beneficios del Seguro Social y/o de SSI, y/o beneficios para Veteranos. Dicha acción tendrá como resultado un **incremento del 0.3 por ciento**, el cual entrará en vigor en **diciembre de 2016** y se reflejará en los pagos que se reciban en **enero de 2017**. Según la ley, estos aumentos deben tomarse en cuenta al determinar el monto de la subvención que usted reciba de este departamento. Sin embargo, las subvenciones de SSI nunca se usan para calcular los pagos de Asistencia para Familias (FA). La subvención de SSI sólo puede ser considerada en los casos de Asistencia de Seguridad (SNA) cuando el beneficiario de SSI también recibe Asistencia de Seguridad (SNA).

AUMENTO EN LOS BENEFICIOS DE SEGURO SOCIAL / SSI / VETERANOS

CALCULAMOS QUE A PARTIR DE **ENERO DE 2017**, EL/LOS BENEFICIO(S) FEDERAL(ES) MENSUAL(ES) RECIBIDO(S) POR USTED Y/O SUS DEPENDIENTES AUMENTARÁ(N) POR UN TOTAL DE $

Debido a este aumento, a su subvención de FA o de SNA se le debe restar el mismo monto.

Esta decisión se basa en Reglamentación Departamental 352.29.

ASISTENCIA MÉDICA: sus beneficios de Asistencia Médica continuarán sin modificaciones. Esta decisión se basa en Reglamentación Departamental 360-3.3.

Asistencia Nutricional Suplementaria (SNAP): si bien su subvención de asistencia pública se modificará, su subsidio de SNAP no se modificará a no ser que usted reciba un aviso por separado informándole que su subsidio SNAP se modificará. Esta decisión se basa en Reglamentación Departamental 387.10 y 387.15.

Si usted no entiende de qué trata esta notificación o no está de acuerdo con la decisión que hemos tomado, puede solicitar una conferencia. Para hacerlo, visite su centro o llame al número de teléfono lo antes posible.

EL NÚMERO DE TELÉFONO PARA SOLICITAR UNA CONFERENCIA ES EL - - .

EL SOLICITAR UNA CONFERENCIA NO IMPLICA QUE USTED RENUNCIE SU DERECHO A UNA AUDIENCIA IMPARCIAL, SIMPRE Y CUANDO USTED SOLICITE UNA AUDIENCIA DENTRO DEL PLAZO DESCRITO EN LA PÁGINA ADJUNTA. VEA LA PÁGINA ADJUNTA PARA INFORMARSE SOBRE EL PROCESO DE APELACIÓN.

VEA A CONTINUACIÓN UN DETALLE DE SU NUEVO SUBSIDIO DE ASISTENCIA PÚBLICA:

PRE-ADD CONCESIÓN PRE-SUMADA		SSA INCOME INGRESO DE SEGURO SOCIAL	
SHELTER VIVIENDA		SSI INCOME INGRESO DE SSI	
ENERGY ENERGÍA		OTHER INCOME OTRO INGRESO	
ENERGY SUPPLEMENT SUPLEMENTO DE ENERGÍA		TOTAL INCOME INGRESO TOTAL	
OTHER NEEDS OTRAS NECESIDASES			
TOTAL NEEDS TOTAL DE NECESIDADES		PA GRANT CONCESIÓN DE PA	

Sincerely,
Matthew Brune, Subcomisionado Ejecutivo
Family Independence Administration

XL074C (**11/16**)

Attachment B

Preaviso de cambios en los beneficios de Asistencia Pública debido a un aumento en los beneficios del Seguro Social, SSI y/o beneficios a Veteranos

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

Si cree que nuestra decisión es incorrecta, puede solicitar una revisión de nuestra decisión. Corregiremos nuestro error. Usted puede tomar ambas acciones, 1 y 2:
1. Solicitar una reunión (conferencia) con un supervisor; 2. Solicitarle al Estado una audiencia imparcial con un funcionario estatal de audiencias.

1. **CONFERENCIA** (reunión informal con nosotros): si usted cree que nuestra decisión es incorrecta o si no comprende nuestra decisión, sírvase llamarnos para solicitar una reunión. Llame al número de teléfono para conferencias que aparece en el **anverso** de esta notificación o escríbanos a la dirección que aparece en el **anverso** de esta notificación. En algunos casos, ésta es la forma más rápida de resolver problemas. Le recomendamos hacerlo, aunque haya solicitado una audiencia imparcial. Si solamente solicita una reunión con nosotros, no mantendremos sus beneficios al mismo nivel mientras dure el proceso de apelación. Sus beneficios se mantendrán sin cambios solamente si usted solicita una audiencia imparcial estatal. (Vea la sección abajo titulada «Mantener sus Beneficios sin Cambios»).

2. **AUDIENCIA IMPARCIAL ESTATAL:** usted tiene **60 días**, contados a partir de la fecha de esta notificación, para solicitar una audiencia imparcial:

MANTENER SUS BENEFICIOS SIN CAMBIOS: reanudaremos sus beneficios de Asistencia Pública al mismo nivel en que estaban antes de esta notificación si usted solicita una audiencia imparcial antes de la fecha de vigencia señalada en esta notificación. However, if you lose the fair hearing, you will have to pay back any Public Assistance benefits you got, but should not have gotten, while you were waiting for the decision.

Si usted no quiere que sus beneficios continúen al mismo nivel hasta que se remita la decisión, deberá informárselo al Estado cuando llame para solicitar una audiencia imparcial o si usted devuelve esta notificación, marque la casilla a continuación:

☐ No deseo que mis beneficios de Asistencia Pública continúen al mismo nivel hasta que se remita la decisión de la audiencia imparcial.

Si en la audiencia, el oficial de audiencias determina que su queja no tiene que ver con un cálculo incorrecto de sus beneficios o que hubo una aplicación o interpretación incorrecta de la ley federal o reglamento, el oficial de audiencias puede dictaminar que usted no tenía derecho a continuar recibiendo los beneficios de Asistencia Pública sin cambios mientras esperaba por la decisión de la audiencia imparcial, y como resultado ordenar que la reducción entre en vigor inmediatamente.

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

Por correo: envíe una copia de esta notificación rellenada a: *Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201*. Favor de quedarse con una copia.

☐ Deseo una audiencia imparcial. No estoy de acuerdo con la decisión de la agencia. (Puede explicar a continuación por qué no está de acuerdo, aunque no tiene que incluir una explicación por separado). _____

Por teléfono: **800-342-3334** (Favor de tener a mano este aviso cuando llame).
Por fax: envíe por fax una copia del anverso y reverso de esta notificación al: **(518) 473-6735**.
En persona: traiga una copia de todas las partes de este aviso a la oficina de *New York State Office of Temporary and Disability Assistance* ubicada en: 14 Boerum Place, Brooklyn.
Por internet: rellene una solicitud en línea en: **http://www.otda.ny.gov/oah/forms.asp**.

Si no puede comunicarse con la Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York por teléfono, por fax, en persona o por Internet, favor de solicitar por escrito una audiencia imparcial antes del vencimiento del plazo.

LO QUE SUCEDE EN UNA AUDIENCIA IMPARCIAL: el Estado le enviará un aviso informándole cuándo y dónde se realizará la audiencia imparcial. En la audiencia, usted tendrá la oportunidad de explicar por qué cree que nuestra decisión es incorrecta. Puede traer consigo a un abogado, a un familiar o a un(a) amigo(a), o a alguien más que pueda ayudarle a exponer su caso. Si usted no puede presentarse, puede enviar a otra persona en su representación. Si la persona que lo representará no es un abogado, debe entregarle a esta persona una carta, dirigida al funcionario de audiencias, en la cual usted declara que desea que dicha persona lo represente en la audiencia.

En la audiencia, usted y su abogado u otro representante, tendrán la oportunidad de explicar por qué creen que nuestra decisión es incorrecta, como también la oportunidad de presentar, ante el funcionario de audiencias, documentos que demuestren nuestra equivocación.

Con el fin de ayudarle a exponer el motivo de nuestra equivocación, le sugerimos presentar testigos que puedan avalar su caso. También, le sugerimos presentar documentos tales como: comprobantes de pagos salariales, contrato de alquiler, recibos, cuentas médicas, etc.

En la audiencia, usted y su abogado o representante, podrán interrogar a los testigos que nosotros presentemos o los que usted presente con motivo de avalar su caso.

ASISTENCIA LEGAL: si cree que necesita representación legal en la resolución de este problema, puede obtener los servicios de un abogado, sin costo alguno, comunicándose con la Sociedad de Ayuda Legal *(Legal Aid Society)* u otra asociación de defensa legal de su localidad. Puede encontrar los nombres de otros abogados en las páginas amarillas, bajo «Abogados» *("Lawyers").*

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: en preparación para la audiencia imparcial, usted tiene derecho a revisar el archivo de su caso. Si nos llama, nos escribe o nos envía un fax, le enviaremos copias gratis de documentos en su archivo; los mismos que entregaremos al funcionario de audiencias en la audiencia imparcial. Además, si nos llama o nos escribe o nos manda un fax, le enviaremos copias gratis de documentos específicos en su archivo y los cuales usted considere necesarios en preparación para la audiencia imparcial. Si desea solicitar documentos o averiguar la modalidad a seguir para consultar su archivo, llámenos al **(718) 722-5012,** fax **(718) 722-5018** o mande una carta a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201.**
Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Se le proporcionarán dentro de un lapso de tiempo razonable antes de la fecha fijada de la audiencia. Los documentos se le enviarán por correo sólo si usted específicamente los solicita.

INFORMACIÓN: si desea información adicional sobre su caso, cómo solicitar una audiencia imparcial, cómo consultar su archivo o cómo obtener copias adicionales de documentos, sírvase llamarnos al número de teléfono señalado en el **anverso** de este aviso o mande una carta a la dirección que figura en el **anverso** de esta notificación.

Attachment B

Important notice

Important notice enclosed. If you need help reading the notice, contact your worker.

Aviso importante adjunto. Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a).

إخطار هام طيّه. إذا احتجت إلى مساعدة في قراءة الإخطار خاطب مسؤول ملفك.

內附重要通告. 如需幫助閱讀此通告, 請與您的個案負責人接洽。

Avis important ci-joint. Si vous avez besoin d'aide pour lire cet avis, veuillez contacter votre collaborateur.

Gen yon avi enpòtan nan anvlòp la. Si ou bezwen èd pou li avi a, kontakte travayè sosyal ou.

중요한 통지서가 동봉되어 있습니다. 이 통지서를 읽는데 도움이 필요하시면, 담당 직원에게 연락하십시오.

Содержит важную информацию. Если при чтении этого извещения у Вас возникнут трудности, обратитесь к сотруднику, ведущему Ваше дело.

Có đính kèm thông báo quan trọng. Nếu cần đùọc giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

א וויכטיגע מעלדונג איז בייגעלייגט. אויב איר דארפט הילף צו ליינען די מעלדונג, רופט אייער ארבעטער.

Importante avviso allegato. Se occorre aiuto per leggere l'avviso, rivolgersi al proprio operatore di riferimento.

Attachment C

P.O. BOX 02-9121
Brooklyn GPO
Brooklyn, N.Y. 11202-9121

The City Of New York
HUMAN RESOURCES ADMINISTRATION
Family Independence Administration

CONFERENCE PHONE: - -
NÚMERO PARA CONFERENCIA

Center:
CASE No:
:

FAM SIZE:
DATE: December 6, 2016
FECHA: 6 de diciembre de 2016

NOTICE OF MASS CHANGE
PREAVISO DE REDUCCIÓN EN SU SUBSIDIO SNAP

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

THIS IS TO INFORM YOU THAT YOUR SNAP BENEFITS MAY BE REDUCED EFFECTIVE **JANUARY 1, 2017** FOR THE FOLLOWING REASON:

BEGINNING JANUARY **2017**, SOCIAL SECURITY, SSI AND/OR VETERAN'S BENEFITS WILL INCREASE **BY 0.3%.** IF YOU ARE IN RECEIPT OF ANY OF THESE FEDERAL BENEFITS, THIS INCREASE IN INCOME TO YOUR HOUSEHOLD MUST BE CONSIDERED IN DETERMINING YOUR **SNAP** BENEFIT LEVEL. ***IF YOU ARE IN RECEIPT OF BOTH SOCIAL SECURITY BENEFITS AND SSI, YOUR JANUARY SSI BENEFITS WILL BE REDUCED BY THE AMOUNT OF YOUR SOCIAL SECURITY BENEFIT INCREASE. THESE INCOME CHANGES MUST ALSO BE CONSIDERED IN DETERMINING YOUR*** **SNAP** ***BENEFITS***.

BEGINNING IN **JANUARY 2017**, IF YOU ARE AN SSI RECIPIENT LIVING ALONE IN THE COMMUNITY WHO IS PARTICIPATING IN THE NEW YORK STATE NUTRITION IMPROVEMENT PROJECT (NYSNIP) AND YOUR RENT IS ABOVE or below **$247.00 and you either incur a separate bill or charge for heating or air conditioning costs or you have received Home Energy Assistance (HEAP) benefits of more than $20 during the month this letter is dated or the during the immediately preceding twelve (12) months ,** YOUR MONTHLY SNAP BENEFIT OF $194.00 WILL NOT CHANGE. HOWEVER, IF YOUR RENT IS above **$247.00 and you do not incur a separate bill or charge for heating or air conditioning costs or have not received Home Energy Assistance (HEAP) benefits of more than $20 during the month this letter is dated or the during the immediately preceding twelve (12) months,** BEGINNING IN **JANUARY 2017,** YOU WILL RECEIVE **$26** IN SNAP BENEFITS and if you receive income in addition to SSI, you will receive $17 in SNAP benefits.

IF YOU ARE A NYSNIP PARTICIPANT WHO WAS RECEIVING **$16** PER MONTH IN **SNAP** BENEFITS, BEGINNING IN JANUARY **2017** YOU WILL continue to RECEIVE **$16** PER MONTH.

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

COMENZANDO EN ENERO DE **2017**, LOS SUBSIDIOS DE SEGURO SOCIAL, SSI Y SUBSIDIOS PARA VETERANOS, AUMENTARÁN POR UN **0.3 %.** SI USTED RECIBE ALGUNO DE LOS SUBSIDIOS FEDERALES ANTES MENCIONADOS, ESTE AUMENTO EN EL INGRESO DE SU GRUPO FAMILIAR DEBERÁ TOMARSE EN CUENTA EN EL CÁLCULO DEL MONTO DEL SUBSIDIO **SNAP** QUE USTED RECIBE. **SI USTED ACTUALMENTE RECIBE AMBOS SUBSIDIOS: SEGURO SOCIAL Y SSI, EL MONTO DEL SUBSIDIO DE SSI PARA EL MES DE ENERO SERÁ REDUCIDO POR EL MONTO DEL AUMENTO EN SU SUBSIDIO DE SEGURO SOCIAL.*ESTOS CAMBIOS EN INGRESO TAMBIÉN DEBEN TOMARSE EN CUENTA EN EL CÁLCULO DE SU SUBSIDIO SNAP.***

COMENZANDO EN **ENERO DE 2017**, SI USTED ES UN BENEFICIARIO DE SSI QUE VIVE SOLO(A) EN LA COMUNIDAD Y PARTICIPA EN EL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP) Y SU ALQUILER ES SUPERIOR o inferior a los **$247.00 y usted ya sea: recibe facturas o cargos por separado de calefacción o aire acondicionado, o ha recibido el Subsidio de Energía para el Hogar (HEAP) por un monto mayor de $20 en el mes de la fecha de esta carta o en los últimos 12 meses;** EL MONTO MENSUAL DE SU SUBSIDIO SNAP DE$194.00 NO CAMBIARÁ. SIN EMBARGO, SI SU ALQUILER ES superior a los **$247.00 y usted no incurre facturas o cargos por separado de calefacción o aire acondicionado o no ha recibido el Subsidio de Energía para el Hogar (HEAP) por un monto mayor a los $20 en el mes de la fecha de esta carta o en los últimos 12 meses;** COMENZANDO EN **ENERO DE 2017**, USTED RECIBIRÁ **$26** EN SUBSIDIO SNAP y si usted recibe ingreso adicional al SSI, usted recibirá $17 en subsidio SNAP.

SI USTED ES UN PARTICIPANTE DEL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP) QUE RECIBÍA $16 AL MES EN **SUBSIDIO SNAP**, COMENZANDO EN ENERO DE **2017**, USTED CONTINUARÁ recibiendo **$16** AL MES.

LA PÁGINA 2 DE ESTE AVISO ES UNA HOJA DE DATOS FINANCIEROS LA CUAL MUESTRA SU NUEVO MONTO DE SUBSIDIO **SNAP** COMO TAMBIÉN TODOS LOS DATOS SOBRE INGRESOS REGISTRADOS EN NUESTRO ARCHIVO COMPUTARIZADO Y EL CUAL FUE UTILIZADO EN EL CÁLCULO DE SU NUEVO MONTO DE SUBSIDIO **SNAP**.HEMOS ADJUNTADO HOJAS DE CÁLCULO DE PRESUPUESTO LAS CUALES USTED PUEDE UTILIZAR PARA DETERMINAR SI HEMOS CALCULADO CORRECTAMENTE SU INGRESO NETO EN RELACIÓN CON LA SUBVENCIÓN **SNAP.** CONSULTE 18 NYCRR 387.10, 387.12 Y 387.15

ATENTAMENTE,
MATTHEW BRUNE,EXECUTIVE DEPUTY COMMISSIONER / SUBCOMISIONADO
EJECUTIVO FAMILY INDEPENDENCE ADMINISTRATION

XL0263 (**11/16**)

Attachment C

YOUR FINANCIAL FACTS CURRENTLY ON FILE
SUS DATOS FINANCIEROS ACTUALMENTE EN ARCHIVO

Previous Net Supplemental Nutrition Assistance Program (SNAP)
Ingreso anterior del subsidio de Asistencia Nutritional Suplementaria (SNAP)

New Net SNAP Income
Nuevo Ingreso neto del subsidio SNAP

Previous Monthly **Benefit** Amount
Monto anterior mensual del subsidio

New Monthly **Benefit** Amount
Nuevo monto mensual del subsidio

A. A. MONTHLY INCOME
Ingreso Mensual

1a.	**Monthly Gross Income from Employment or Training.** Ingreso bruto mensual por empleo o entrenamiento	
b.	**Monthly Net Income from Self Employment** Ingreso neto mensual por trabajo por cuenta propia.	
2a.	**Net Monthly Income from Boarder/Lodger.** Ingreso neto mensual que recibe del huésped/inquilino	
b.	**Net Monthly Income from Lodger** Ingreso neto mensual que recibe del inquilino	
3.	**Total of lines 1 and 2.** Total de las lineas 1 y 2.	
4a.	**Monthly Gross Unearned Income** Ingreso bruto mensual no devengado	
	b.	
	c.	
5.	**Monthly Income from Educational Loans, Scholarships** Ingreso mensual por préstamos y becas educacionales.	
6.	**Total of Lines 3, 4 and 5** Total de lÌneas 3, 4 y 5 **A.**	$

B. DEDUCTIONS
Deducciones

7.	**% of Line 3.** % de línea 3	
8.	**Standard Deduction Monthly** Deducción mensual estándar	
9.	**Monthly Child Care/Dependent Care Costs.** Gastos mensuales por cuidado de niños / dedependientes **(Maximum** (Máximo)	
10.	**Monthly Automatic Recoupment (from Public Assistance Grant)** RecuperaciOn mensual automática(de subsidio de Asistencia Pûblica)	
11.	**Monthly Tuition and Mandatory Fees** Gastos mensuales de colegiatura y cuotas obligatorias	
12a.	**Monthly Medical Expense (less $35 Deductible)** Gasto médicos mensuales (menos $35 de deducible)	
b.		
13.	**Total Lines 7, 8, 9, 10, 11, and 12** Total de líneas 7, 8, 9, 10, 11, y 12 **B.**	$

C. ADJUSTED INCOME
Ingreso ajustado

14.	**Subtract B from A.(Line 13 from Line 6.)** Reste B de A. (Línea 13 de línea 6.) **C.**	

D. SHELTER COSTS
Gastos de Vivienda

15.	**Monthly Rent or Mortgage actually paid.** Renta o hipoteca actualmente pagada cada mes.	
16.	**Monthly Heating Expense** Gasto mensual por calefacción.	
17.	**Monthly Utility Expense** Gasto mensual por utilidades.	
18.	**Monthly Telephone Expense** Gasto mensual por teléfono.	
19.	**Other Monthly Shelter Expense. (Real Estate Taxes, Insurance, Installation of Utilities, etc.)** Otros gastos mensuales de vivienda. (Impuestos inmobiliarios, seguro, conexión de servicios públicos etc.)	
20.	**Total of Lines 15, 16, 17, 18, and 19.** Total de líneas 15, 16, 17, 18, y 19 **D.**	$

E. SNAP NET INCOME
Ingreso neto por subsidio SNAP

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

MINUS RECOUPMENT OF
MENOS EL REEMBOLSO DE

ADJUSTED SNAP AMOUNT
MONTO AJUSTADO DEL SUBSIDIO SNAP

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

If you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2:

1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer.

The Office of Temporary and Disability Assistance (OTDA) policy issuances and manuals are posted on the OTDA website at otda.ny.gov/legal. These issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. In addition, upon request to your local social services district, specific OTDA policy issuances and manuals will also be available to assist you or your representative.

1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

   If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See "Keeping Your Benefits The Same" below.)

2. **STATE FAIR HEARING -** You have **90 days** from the date of this notice to ask for a fair hearing:

   KEEPING YOUR BENEFITS THE SAME: We will restore your SNAP Benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any SNAP Benefits you got, but should not have gotten, while you were waiting for the decision.

   If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a fair hearing or, if you send back this notice, check the box below:

   ☐ I do not want to keep my SNAP Benefits the same until the Fair Hearing decision is issued.

   If at the hearing, the hearing officer determines that you are not complaining about an incorrect computation of your benefits or that there has been a misapplication or misinterpretation of Federal Law or regulations, the hearing officer may determine that you were not entitled to have your SNAP Benefits continue unchanged until the fair hearing decision is issued, and order that the reduction take effect immediately.

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

Mail: Send a copy of the notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.) _____

Phone: **800-342-3334** (Please have this notice with you when you call.)

Fax: Fax a copy of the front and reverse of this notice to: **(518) 473-6735**.

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn.

Online: Complete an online request form at: **http://www.otda.ny.gov/oah/forms.asp**.

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, fax, walk-in or on-line, please write to ask for a fair hearing before the deadline.

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice that tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing. At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong. To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements. At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

LEGAL ASSISTANCE: If you think you need a lawyer to help you with this problem, you may be able to get a lawyer at no cost to you by contacting your local Legal Aid Society or other legal advocate group. For the names of other lawyers, check your Yellow Pages under "Lawyers".

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

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

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

Si cree que nuestra decisión es incorrecta, puede solicitar una revisión de nuestra decisión. Corregiremos nuestro error. Usted puede tomar ambas acciones, 1 y 2:
1. Solicitar una reunión (conferencia) con un supervisor; 2. Solicitarle al Estado una audiencia imparcial con un funcionario estatal de audiencias.

Los manuales y publicaciones sobre políticas de la Oficina de Asistencia Temporal y Asistencia para Incapacitados (OTDA) se encuentran publicadas en el sitio web de OTDA: otda.ny.gov/legal. Estas publicaciones y manuales están a su disposición o la disposición de su representante con el fin de ayudarle a determinar si debería o no solicitar una audiencia imparcial o con el fin de ayudarle a prepararse para una audiencia imparcial. Además, si lo solicita de su oficina de servicios sociales de distrito, publicaciones específicas de OTDA sobre políticas y manuales también estarán a su disposición o a la disposición de su representante con el fin de asistirle.

1. **CONFERENCIA** (reunión informal con nosotros): si usted cree que nuestra decisión es incorrecta o si no comprende nuestra decisión, sírvase llamarnos para solicitar una reunión. Llame al número de teléfono para conferencias que aparece en el **anverso** de esta notificación o escríbanos a la dirección que aparece en el **anverso** de esta notificación. En algunos casos, ésta es la forma más rápida de resolver problemas. Le recomendamos hacerlo, aunque haya solicitado una audiencia imparcial. Si solamente solicita una reunión con nosotros, no mantendremos sus beneficios al mismo nivel mientras dure el proceso de apelación. Sus beneficios se mantendrán sin cambios solamente si usted solicita una audiencia imparcial estatal. (Vea la sección abajo titulada «Mantener sus Beneficios sin Cambios»).

2. **AUDIENCIA IMPARCIAL ESTATAL:** usted tiene **90 días**, contados a partir de la fecha de esta notificación, para solicitar una audiencia imparcial:

MANTENER SUS BENEFICIOS SIN CAMBIOS: reanudaremos sus beneficios de Asistencia Pública al mismo nivel en que estaban antes de esta notificación si usted solicita una audiencia imparcial antes de la fecha de vigencia señalada en esta notificación. However, if you lose the fair hearing, you will have to pay back any Public Assistance benefits you got, but should not have gotten, while you were waiting for the decision.

Si usted no quiere que sus beneficios continúen al mismo nivel hasta que se remita la decisión, deberá informárselo al Estado cuando llame para solicitar una audiencia imparcial o si usted devuelve esta notificación, marque la casilla a continuación:

☐ No deseo que mis beneficios de Asistencia Pública continúen al mismo nivel hasta que se remita la decisión de la audiencia imparcial.

Si en la audiencia, el oficial de audiencias determina que su queja no tiene que ver con un cálculo incorrecto de sus beneficios o que hubo una aplicación o interpretación incorrecta de la ley federal o reglamento, el oficial de audiencias puede dictaminar que usted no tenía derecho a continuar recibiendo los beneficios de Asistencia Pública sin cambios mientras esperaba por la decisión de la audiencia imparcial, y como resultado ordenar que la reducción entre en vigor inmediatamente.

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

Por correo: envíe una copia de esta notificación rellenada a: *Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.* Favor de quedarse con una copia.

☐ Deseo una audiencia imparcial. No estoy de acuerdo con la decisión de la agencia. (Puede explicar a continuación por qué no está de acuerdo, aunque no tiene que incluir una explicación por separado) _____

_____

Por teléfono: **800-342-3334** (Favor de tener a mano este aviso cuando llame).
Por fax: envíe por fax una copia del anverso y reverso de esta notificación al **(518) 473-6735**.
En persona: traiga una copia de todas las partes de este aviso a la oficina de *New York State Office of Temporary and Disability Assistance* ubicada en: 14 Boerum Place, Brooklyn.
Por internet: rellene una solicitud en línea en: **http://www.otda.ny.gov/oah/forms.asp**.

Si no puede comunicarse con la Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York por teléfono, por fax, en persona o por Internet, favor de solicitar por escrito una audiencia imparcial antes del vencimiento del plazo.

LO QUE SUCEDE EN UNA AUDIENCIA IMPARCIAL: el Estado le enviará un aviso informándole cuándo y dónde se realizará la audiencia imparcial. En la audiencia, usted tendrá la oportunidad de explicar por qué cree que nuestra decisión es incorrecta. Puede traer consigo a un abogado, a un familiar o a un(a) amigo(a), o a alguien más que pueda ayudarle a exponer su caso. Si usted no puede presentarse, puede enviar a otra persona en su representación. Si la persona que lo representará no es un abogado, debe entregarle a esta persona una carta, dirigida al funcionario de audiencias, en la cual usted declara que desea que dicha persona lo represente en la audiencia.

En la audiencia, usted y su abogado u otro representante, tendrán la oportunidad de explicar por qué creen que nuestra decisión es incorrecta, como también la oportunidad de presentar, ante el funcionario de audiencias, documentos que demuestren nuestra equivocación.

Con el fin de ayudarle a exponer el motivo de nuestra equivocación, le sugerimos presentar testigos que puedan avalar su caso. También, le sugerimos presentar documentos tales como: comprobantes de pagos salariales, contrato de alquiler, recibos, cuentas médicas, etc.

En la audiencia, usted y su abogado u otro representante, podrán interrogar a los testigos que nosotros presentemos o los que usted presente con motivo de avalar su caso.

ASISTENCIA LEGAL: si cree que necesita representación legal en la resolución de este problema, puede obtener los servicios de un abogado, sin costo alguno, comunicándose con la Sociedad de Ayuda Legal *(Legal Aid Society)* u otra asociación de defensa legal de su localidad. Puede encontrar los nombres de otros abogados en las páginas amarillas, bajo «Abogados»*("Lawyers").*

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: en preparación para la audiencia imparcial, usted tiene derecho a revisar el archivo de su caso. Si nos llama, nos escribe o nos envía un fax, le enviaremos copias gratis de documentos en su archivo; los mismos que entregaremos al funcionario de audiencias en la audiencia imparcial. Además, si nos llama o nos escribe o nos manda un fax, le enviaremos copias gratis de documentos específicos en su archivo y los cuales usted considere necesarios en preparación para la audiencia imparcial. Si desea solicitar documentos o averiguar la modalidad a seguir para consultar su archivo, llámenos al **(718) 722-5012,** fax **(718) 722-5018** o mande una carta a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201.**
Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Se le proporcionarán dentro de un lapso de tiempo razonable antes de la fecha fijada de la audiencia. Los documentos se le enviarán por correo sólo si usted específicamente los solicita.

INFORMACIÓN: si desea información adicional sobre su caso, cómo solicitar una audiencia imparcial, cómo consultar su archivo o cómo obtener copias adicionales de documentos, sírvase llamarnos al número de teléfono señalado en el **anverso** de este aviso o mande una carta a la dirección que figura en el **anverso** de esta notificación.

Important notice

Important notice enclosed. If you need help reading the notice, contact your worker.

Aviso importante adjunto. Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a).

إخطار هام طيّه. إذا احتجت إلى مساعدة في قراءة الإخطار خاطب مسؤول ملفك.

內附重要通告. 如需幫助閱讀此通告, 請與您的個案負責人接洽。

Avis important ci-joint. Si vous avez besoin d'aide pour lire cet avis, veuillez contacter votre collaborateur.

Gen yon avi enpòtan nan anvlòp la. Si ou bezwen èd pou li avi a, kontakte travayè sosyal ou.

중요한 통지서가 동봉되어 있습니다. 이 통지서를 읽는데 도움이 필요하시면, 담당 직원에게 연락하십시오.

Содержит важную информацию. Если при чтении этого извещения у Вас возникнут трудности, обратитесь к сотруднику, ведущему Ваше дело.

Có đính kèm thông báo quan trọng. Nếu cần đùọc giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

א וויכטיגע מעלדונג איז בייגעלייגט. אויב איר דארפט הילף צו ליינען די מעלדונג, רופט אייער ארבעטער.

Importante avviso allegato. Se occorre aiuto per leggere l'avviso, rivolgersi al proprio operatore di riferimento.

Form W-200G
Rev. 12/21/16

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

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

(Effective January 1, 2017)

The Human Resources Administration (HRA) provides a shelter allowance and a personal needs allowance so that low-income aged or disabled adults who need a supervised and supportive living arrangement can afford housing in state licensed homes and residences. The type of care that is offered in these homes and residences is known as congregate care. HRA provides an allowance for each individual receiving care in a Level 1, Level 2, or Level 3 certified congregate care facility who files an application and is deemed eligible for Cash Assistance (CA). The allowance is based on the rates provided for care and maintenance under the Supplemental Security Income (SSI) Program for SSI beneficiaries residing in the same facility, less the amount of any personal needs allowance included in the SSI rate. There are three (3) levels of congregate care facilities, each with a different rate of payment. These rates change each year in accordance with the Cost of Living Adjustment (COLA) received by SSI recipients.

Congregate Care Level	Shelter Type Code	Description	Semimonthly Shelter Rate	Semimonthly Personal Needs Allowance
Level 1	**15**	Family-type homes for adults licensed by the Office of Children and Family Services (OCFS), Office of Mental Health (OMH), or Office of Mental Retardation and Developmental Disabilities (OMRDD) and operated by HRA through the Division of Voluntary and Proprietary Homes for Adults (DVPHA). These are smaller residential programs serving the mentally retarded, the mentally ill, and the frail elderly. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	$430.00	$70.50
	28	Same as above in a rest of the state facility.	$411.00	
Level 2	**16**	Adult homes licensed through the New York State Department of Health (DOH) and community residences licensed through OMH. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	$503.50	$81.50
	29	Same as above in a rest of the state facility.	$488.50	
	31	Residential Alcohol and Substance Abuse Treatment Programs. Facility in NYC, Nassau, Suffolk, Westchester or Rockland.	$503.50	
	32	Same as above in a rest of the state facility.	$488.50	
	43	Community residences licensed through OMH/OMRDD. These are principally small group homes and supported apartments. Cases that were previously coded as Shelter Type **16**, but live in an apartment-like setting and are now coded as Shelter Type **43**. The case can be larger than a family size of 1.	$503.50	
Level 3	**42**	DOH Adult Homes and Enriched Housing facilities. The case **must be** a family size of 1.	$617.50	$97.00

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

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

Congregate Care Budget Worksheet

(Effective January 1, 2017)

Use this form for households residing in congregate care shelter (shelter type codes **15, 16, 27, 28, 29, 31, 32, 42,** or **43**) only.

Total Household size _____ Number in-Care _____ Number not-in-Care _____

Enter shelter type code _____

Section 1: Calculation of Income/Needs

Enter Semimonthly (S/M) amounts. (Be sure to use conversion chart for weekly and monthly amounts.)

A. Unearned Income:				**S/M Amounts**
		How Often	**Gross Income**	
1.	Workers' Compensation			$
2.	New York State Disability			$
3.	Unemployment Insurance Benefits			$
4.	Supplemental Security Income (SSI)			$
5	Social Security benefits (non SSI)			$
6.	Veterans' pension or compensation			$
7.	Black Lung disease program			$
8.	Spina bifida			$
9.	Child support/Combined Child and Spousal Support[1] **Total Amount of Child Support** **Income** | **Number of Children** (If household is in receipt of child support/combined child and spousal support income, subtract up to $50/$100 from the S/M amount above and enter the net amount on the right-hand side.)			$
10.	Other (including Alimony/Spousal Support Only[2]) (specify):			$
11.	**Total S/M Unearned Income (add lines 1 through 10)**			$

[1] CA households with one child are entitled to have up to $50 S/M disregarded and households with two or more children are entitled to have up to $100 S/M disregarded. If determined eligible for cash assistance, child support/combined child and spousal support is not budgetable but is assigned to the Agency through the Office of Child Support Enforcement (OCSE).

[2] No disregards are applied. Income received from combined child and spousal support where the last child on the CA case is 21 years of age or older, or alimony/spousal only support orders.

Section 1: Calculation of Income/Needs (continued)

Total number in household _____

B. Household Needs I. In-Care Household Member(s)		S/M Amounts
12.	Personal needs allowance (PNA)	$
13.	Actual shelter cost (see Maximum Shelter Rate on chart below)	$
14.	**Total S/M needs for in-care household member(s) (add lines 12 and 13)**	$

B. Household Needs II. Not-In-Care Shelter Resident(s)		S/M Amounts
15.	PNA* (see chart below based on shelter type code)	$
16.	Room and/or Board (rate negotiated by facility)	$
17.	**Total S/M needs for not-in-care shelter resident(s) (add lines 15 and 16)**	$

* For shelter type code 43, use the basic CA grant amount that includes the pre-added allowance, energy grant, and pro-rated shelter of the shelter maximum for the household size.

B. Household Needs III. All Household Members		S/M Amounts
18.	Other (specify):	$
19.	Pregnancy allowance (Enter the number of medically verified pregnant women on the case ____)	$
20.	**Total S/M household needs (add lines 14, 17, 18, and 19)**	$

Personal Needs Allowances and Shelter Rates		
Shelter Type	**S/M PNA**	**S/M Shelter Rate**
15	$70.50	$430.00
16 31 43	$81.50	$503.50
29 32	$81.50	$488.50
27	$22.50	Negotiated Rate
28	$70.50	$411.00
42	$97.00	$617.50

Section 2: 185% Gross Income Limitation Calculation

21.	Multiply amount on line 20 by 1.85	$
22.	Compare amount entered on line 11 with amount on line 21. (a) If the amount entered on line 11 is greater than the amount on line 21, the household does not meet the 185% Gross Income Limitation and is ineligible for Cash Assistance (CA) – check ☑ ineligible. Do not continue. Complete Form **W-122D/W-122DD** to determine Supplemental Nutrition Assistance Program (SNAP) eligibility. (b) If the amount entered on line 11 is equal to or less than the amount entered on line 21, the household meets the 185% Gross Income Limitation – check ☑ eligible. Complete Section 3.	☐ Ineligible ☐ Eligible

Section 3: Net Income Test

		S/M Amounts
23.	Total S/M unearned income (from line 11)	$
24.	Total S/M household needs (from line 20 - round down to the nearest 50¢)	$
25.	OCSE sanction: Enter 25% needs reduction amount, if applicable (multiply amount on line 24 by 0.25)	$
26.	S/M needs (line 24 minus line 25)	$
27.	Budget deficit (line 26 minus line 23 – round down to the nearest 50¢) Enter amount if greater than zero (0). If equal to or less than zero (0), do not enter amount here; enter amount on line 28.	CA Grant $
28.	Budget surplus – if amount on line 23 is equal to or more than line 26, the household has **failed the net income test** and is **not eligible for CA**. Complete Form **W-122D/W-122DD** to determine Supplemental Nutrition Assistance Program (SNAP) eligibility.	$

Authorization Period: From: _____ To: _____.

Authorized by

Date

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

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Unidad de Casos: _____
Centro: _____

Hoja de Cálculos de Presupuesto para Cuidado en Grupo

(A partir del 1º de enero, 2017)

Use este formulario sólo para hogares que residan en un refugio de cuidado en grupo (códigos de tipo de refugio **15, 16, 27, 28, 29, 31, 32, 42,** o **43**).

Número Total de Personas en el Hogar_____ Número de Personas beneficiarias de Cuidado_____

Número de Personas no Beneficiarias de Cuidado_____

Anote el código de tipo de refugio_____

Sección 1: Cálculos de Ingreso/Necesidades

Anote las cantidades quincenales. (Asegúrese de usar la tabla de conversión para cantidades semanales y mensuales.)

A. Ingreso No Salarial:				**Cantidad Quincenal**
		Con qué Frecuencia	**Ingreso Bruto**	
1.	Indemnización para Trabajadores			$
2.	Indemnización para Discapacitados del Estado de Nueva York			$
3.	Beneficios de Seguro de Desempleo			$
4.	Ingreso Suplementario de Seguridad (SSI)			$
5	Beneficios de Seguro Social (no SSI)			$
6.	Pensión o indemnización para Veteranos			$
7.	Programa de enfermedad de Pulmón Negro			$
8.	Espina bífida			$
9.	Manutención de Niños/Manutención de Niños y Conyugal Combinada[1] **Total de la Manutención de Niños** **Ingreso** | **Número de Niños** (Si el hogar recibe ingreso de manutención de niños/manutención de niños y conyugal combinada, reste hasta $50/$100 de la cantidad quincenal de arriba y anote la cantidad neta correspondiente a la mano derecha.)			$
10.	Otro ingreso (incluyendo Sólo Pensión Alimenticia/Pensión Conyugal[2]) (en concreto):			$
11.	**Total Quincenal de Ingreso no Salarial (sume las líneas 1 a 10)**			$

[1] Los hogares de Asistencia en Efectivo (CA) de un niño tienen derecho a que se omita hasta $50 quincenales, y los hogares de dos o más niños tienen derecho a que se omita hasta $100 quincenales. Si a usted se le determina elegible para asistencia en efectivo, la manutención de niños/pensión alimenticia y pensión conyugal combinada no es presupuestable, sino que se asignará a la Agencia mediante la Oficina de Ejecución de Manutención de Niños (Office of Child Support Enforcement - OCSE).

[2] No corresponden omisiones al ingreso recibido de órdenes de manutención de pensión alimenticia y conyugal combinada donde el último niño en el caso de CA tenga 21años de edad o más o sólo de pensión alimenticia/conyugal.

Sección 1: Cálculos de Ingreso/Necesidades(continuación)

Número total en el hogar _____

B. Necesidades del Hogar I. Miembro(s) del Hogar en Cuidado		Cantidad Quincenal
12.	Asignación para necesidades personales (PNA)	$
13.	Costo actual de alojamiento (vea la tarifa máxima de albergue en la tabla más abajo)	$
14.	**Total de necesidades quincenales para miembro(s) del hogar en cuidado (sume las líneas 12 y 13)**	$

B. Necesidades del Hogar II. Residente(s) en Refugio No Beneficiarios de Cuidado		Cantidad Quincenal
15.	PNA* (vea la tabla más abajo basada en el código del tipo de albergue)	$
16.	Hospedaje y/o comidas (tarifa negociada por el local)	$
17.	**Total de necesidades quincenales para residente(s) en refugio fuera de cuidado (sume las líneas 15 y 16)**	$

* Para tipo de código de refugio 43, use la cantidad de concesión básica de CA que incluya una asignación añadida anteriormente, concesión de energía, y alojamiento prorrateado del refugio máximo para el tamaño del hogar.

B. Necesidades del Hogar III. Todos los Miembro(s) del Hogar		Cantidad Quincenal
18.	Otra necesidad (en concreto):	$
19.	Asignación para embarazo (Anote el número en el caso de mujeres embarazadas verificadas por un médico ____)	$
20.	**Total de necesidades quincenales para miembro(s) del hogar (sume las líneas 14, 17, 18, y 19)**	$

Concesiones para Necesidades Personales y Tarifas de Albergue		
Tipo de Albergue	**PNA Quincenal**	**Tarifa Quincenal de Albergue**
15	$70.50	$430.00
16 31 43	$81.50	$503.50
29 32	$81.50	$488.50
27	$22.50	Tarifa Negociada
28	$70.50	$411.00
42	$97.00	$617.50

Sección 2: Cálculo de la Limitación del 185% del Ingreso Bruto

21.	Multiplique la cantidad de la línea 20 por 1.85	$
22.	Compare la cantidad marcada en la línea 11 con la cantidad de la línea 21. (a) Si la cantidad de la línea 11 es superior a la cantidad de la línea 21, el hogar no cualifica según la Limitación del 185% del Ingreso Bruto y no es elegible para Asistencia en Efectivo (Cash Assistance – CA) – marque ☑ Inelegible. No siga llenando el formulario. Llene el formulario **W-122D (S)/W-12DD (S)** para determinar si es elegible para el Programa de Asistencia de Nutrición Suplementaria (SNAP). (b) Si la cantidad en la línea 11 es igual o inferior a la cantidad de la línea 21 el hogar cualifica según la Limitación del 185% del Ingreso Bruto – marque ☑ la casilla elegible. Llene la Sección 3.	☐ Inelegible ☐ Elegible

Sección 3: Prueba de Ingreso Neto

		Cantidad Quincenal
23.	Total quincenal de ingreso no salarial (de la línea 11)	$
24.	Total de necesidades quincenales del hogar (cantidad de la línea 20 – redondee a los 50¢ inferiores)	$
25.	Sanción de OCSE: Anote la cantidad de la reducción del 25% de necesidades, si corresponde (multiplique la cantidad de la línea 24 por 0.25)	$
26.	Necesidades quincenales (línea 24 menos la línea 25)	$
27.	Déficit presupuestario (línea 26 menos línea 23– redondee a los 50¢ inferiores). Anote la cantidad si es superior a cero (0). Si la cantidad equivale o es menos que cero (0), no anote la cantidad aquí; anótela en la línea 28.	Concesión CA $
28.	Excedente del presupuesto – si la cantidad de la línea 23 equivale o es superior a la cantidad de la línea 26, el hogar **no ha pasado la prueba de ingreso salarial neto** y **no es elegible para Asistencia Efectivo**. Llene el Formulario **W-122D (S)/W-12DD (S)** para determinar la elegibilidad del Programa de Asistencia de Nutrición Suplementaria (SNAP).	$

Período de Autorización: De: _____ A: _____.

_____ _____

Autorizado por Fecha