



OFFICE OF POLICY, PROCEDURES, AND TRAINING

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Office of Procedures

POLICY DIRECTIVE #17-09-OPE

(This Policy Directive Replaces PD #13-25-OPE)

REQUESTS FOR REPLACEMENT OF STOLEN SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS AND/OR CASH ASSISTANCE

Date: May 5, 2017	Subtopic(s): SNAP benefits
AUDIENCE	The instructions in this policy directive are for all Job Center, Non Cash Assistance (NCA) Supplemental Nutrition Assistance Program (SNAP) Center, and HIV/AIDS Services Administration (HASA) staff.
REVISIONS TO THE PRIOR DIRECTIVE	<p>This policy directive has been revised to:</p> <ul style="list-style-type: none"> • update the Replacement of Stolen SNAP Benefits Liaison List (Attachment A); • inform staff to make a referral to the Bureau of Fraud Investigation (BFI) whenever participants report benefits inappropriately taken from their EBT account.
POLICY	<p>Generally, stolen SNAP benefits cannot be replaced unless an Agency error or inaction leads to the loss of a participant’s SNAP benefits. Final decisions to replace SNAP benefits reported stolen from the EBT system are made by the New York State Office of Temporary and Disability Assistance on a case-by-case basis.</p> <p>Alleged stolen SNAP benefits may only be replaced if:</p> <ul style="list-style-type: none"> • the participant contacted EBT Customer Service to report a lost, stolen, or compromised Common Benefit Identification Card (CBIC) and requested a deactivation of that CBIC; and/or requested a Personal Identification Number (PIN) restriction at a Job Center, SNAP Center, or HASA Center and • EBT Customer Service or HRA failed to take appropriate steps to deactivate the lost, stolen, or compromised CBIC, or failed to process a requested PIN restriction after a participant requested a CBIC deactivation and/or a PIN restriction.

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

No replacement SNAP benefits will be issued for any SNAP benefits stolen prior to a request for a deactivation of a compromised CBIC and/or a requested PIN restriction.

Cash Assistance (CA) benefits that have been reported stolen from the EBT system may not be replaced when a valid issuance transaction has occurred.

A valid issuance transaction has occurred when funds have been withdrawn from the participant's EBT account using the participant's CBIC and PIN as selected by the participant. It also occurs when a retailer reprocesses a withdrawal to correct a situation where the EBT receipt reflects the correct withdrawal amount, but equipment failed to deduct the money from the EBT account.

REQUIRED ACTION

Participants must call EBT Customer Service immediately upon knowledge of a lost, stolen, or compromised CBIC.

See [PD #16-19-SYS](#) for instructions on processing PIN restrictions.

If a CA/SNAP or NCA SNAP participant contacts a Job Opportunity Specialist (JOS)/Worker to say that his/her CBIC has been lost, stolen, or compromised, or someone has gained information about his/her identity that may result in benefits being stolen, and/or requests a PIN Restriction from a Job Center, SNAP Center or HASA Center, the participant must be instructed to call the toll-free EBT Customer Service helpline at **(888) 328-6399** immediately. The EBT Customer Service representative is responsible for disabling the CBIC to prevent future use.

In addition, the JOS/Worker will instruct the participant to come to the Job Center/NCA SNAP Center/HASA Center to complete and sign an EBT Customer Service Automated Response Unit (ARU) Personal Identification Number (PIN) Restriction Permission Form (**EBT-64**) and request a new CBIC and/or PIN.

Once Form **EBT-64** is signed, the Administrative System transaction to restrict the PIN must be completed within an hour of the form being completed, and prior to the request for a new CBIC.

Participants should be reminded to keep their PIN confidential, and never let anyone, even store cashiers, see them enter their PIN in processing their transaction. JOS/Workers should inform participants that their benefits may be used without the CBIC itself, since transactions may be processed by "keying in" the CBIC and PIN numbers without the physical CBIC.

SNAP benefits reported stolen

If a participant reports that his/her SNAP benefits have been stolen, he/she must be informed of the instances (listed on the bottom of page 1 in this policy directive) in which SNAP benefits may be replaced.

See [PD #16-19-SYS](#) for instructions on processing PIN restrictions.

Participants who inform the JOS/Worker that they contacted EBT Customer Service about a lost, stolen, or compromised CBIC prior to the theft of their SNAP benefits must come to the Job Center/ NCA SNAP Center/HASA Center to complete and sign an **EBT-64** and the Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (**W-130B**).

Form **W-130B** poses the following questions:

- Did you contact EBT Customer Service to report a lost, stolen or compromised CBIC or PIN before the alleged theft of SNAP benefits?
- If yes, when was this contact made?
- Did you come into a Job Center or a NCA SNAP Center and see a worker to request and complete a PIN Restriction Permission Form?
- If yes, when was this request made?
- Was the PIN restriction processed on the card?
- When did you realize that SNAP benefits were stolen from the EBT system?
- How much in SNAP benefits was stolen from your EBT account?

Space is available on the **W-130B** for the participant to list any information he/she has concerning the theft of his/her SNAP benefits from the EBT system.

Participant believes that his/her CA and/or SNAP benefits were stolen from the EBT system

See [PB #17-44-OPE](#) for information on protecting CBIC information

If a CA or SNAP participant informs HRA staff that there is any suspicious activity involving his/her CA and/or SNAP benefits, the participant must be advised to call HRA’s BFI Hotline at **(718) 722-8001** or the NYC Department of Investigation at **(212) 825-5900** to report such suspicious activity.

New information

New information

Job Center, NCA SNAP Center, and HASA Center staff are also required to independently report participant’s claims of suspicious activity to BFI through POS’s automated referral or through the HRA Intranet, and record in POS that a BFI referral was made.

See [PD #12-12-OPE](#) for information on fraud referrals to BFI.

If the JOS/Worker suspects that a participant is committing fraud in order to obtain SNAP benefits, the JOS/Worker is required to report that information to BFI.

Attachment A has been revised to update the Liaison List

After the participant has completed the **W-130B**, the JOS/Worker signs the form and gives the participant a copy. The JOS/Worker must inform the participant that he/she will be notified via mail of HRA's decision. Thereafter, the JOS/Worker will contact the Job Center/NCA SNAP Center/HASA Center's Regional Liaison as listed on the Replacement of Stolen SNAP Benefits Liaison List (**Attachment A**).

The liaisons are trained to review and process a participant's request to replace SNAP benefits stolen from the EBT system.

The liaisons will keep a log of all incoming requests and review the participant's request for replacement of stolen SNAP benefits with the Transactions and Card History on the EBT Administrative terminal.

Liaisons are responsible for determining if a participant's request to replace stolen SNAP benefits meets the criteria outlined in this policy directive. The liaison will review information and decide if there was a failure at either the EBT Customer Service or at the Job Center/NCA SNAP Center/HASA Center after the participant requested his/her CBIC to be deactivated or PIN restricted respectively. Proof of a participant's request to restrict his/her PIN can be documented via a completed **EBT-64**. Additionally, HRA can verify with EBT Customer Service that a participant contacted EBT Customer Service to report a lost, stolen, or compromised CBIC and requested a deactivation of that CBIC prior to the alleged SNAP benefit theft. EBT Customer Service will inform liaisons of the date(s) of participant contact, if any.

If the liaison has determined that the participant's request to replace stolen SNAP benefits does not meet the criteria for replacing SNAP benefits as listed in this policy directive, the liaison will notify the JOS/Worker that the SNAP benefits will not be replaced.

If the liaison has determined that EBT Customer Service failed to deactivate a CBIC reported lost, stolen, or compromised or the Job Center/NCA SNAP Center/HASA Center failed to process a requested PIN restriction **and** SNAP benefits were subsequently stolen from the EBT system, the liaison will document his/her findings and forward the information to OTDA.

OTDA will review the case and inform the liaison of their decision. The liaison will then inform the JOS/Worker of OTDA's decision. If a SNAP benefit replacement has been approved by OTDA, the decision must include the replacement amount.

If OTDA authorizes a SNAP benefit replacement, it must be replaced using Issuance Code **24** (replace stolen benefits) in Job Centers/HASA Centers and Issuance Code **26** (replace stolen benefits) in NCA SNAP Centers.

The JOS/Worker will record the decision on the Action Taken on Your Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (**W-130G**). The JOS/Worker will mail the original **W-130G** to the participant after scanning and indexing a copy into the participant's case record.

CA benefits reported stolen from the EBT system

If a participant reports that his/her CA benefits have been stolen from the EBT system, the JOS/Worker must inform the participant that CA benefits **cannot** be replaced when a valid issuance transaction occurred even if someone else used the participant's CBIC and PIN.

A valid issuance transaction has occurred when funds have been withdrawn from the participant's EBT account using the participant's CBIC and PIN as selected by the participant. It also occurs when a retailer reprocesses a withdrawal to correct a situation where the EBT receipt reflects the correct withdrawal amount, but equipment failed to deduct the money from the EBT account.

Cash reported lost or stolen

Lost or stolen cash may be replaced under the Emergency Assistance to Families (EAF) Program for Family Assistance (FA) and Safety Net Federally Participating (SNFP) cases. Prior to issuing a replacement, the participant must:

- report the alleged loss/theft of cash to the local police precinct using the NYPD – Job Center Report/Referral (**W-451**); and
- provide a written statement including the date, time, and amount of the alleged loss/theft, and the attempts made to recover the alleged lost/stolen cash.

The Associate Job Opportunity Specialist (AJOS) II /PAA II can approve or deny the request to replace the alleged lost/stolen cash based on the credibility of the information presented in the police report and the participant's written statement.

If a decision has been made to replace the alleged lost/stolen cash, a prorated portion of the participant’s semi-monthly pre-added allowance is to be issued using Code **14** (Replacement of Lost or Stolen Cash) for the number of days remaining until the participant’s next benefit date. The amount of the issuance cannot exceed the amount of the alleged lost/stolen cash.

See [PD #15-23-ELI](#) for EAF eligibility.

Additionally, the AJOS II /PAA II should determine if any emergency needs (e.g. shelter) resulted from the alleged lost/stolen cash, and if any, evaluate the participant’s eligibility for an EAF grant to meet the emergency need.

Lost or stolen CA shelter payments

See [PD #15-22-OPE](#) for replacing restricted CA shelter payments.

CA grants can be issued to replace restricted two-party or direct vendor CA shelter payments that are reported lost or stolen.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications

There are no POS implications.

Medicaid Implications

There are no Medicaid implications.

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 applicants/participants must receive either adequate or timely and adequate notification of all actions taken on their case.

Conferences at Job Centers

An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If the individual comes to a 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 individual 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 applicant/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 Agency's decision to the applicant/participant.

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

The designee will listen to and evaluate the individual's complaint regarding the SNAP case. The SNAP Center Director's designee is responsible for ensuring that further appeal by the individual through a Fair Hearing request is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Evidence Packets

For Fair Hearing purposes, all evidence packets must include complete and relevant documentation including a copy of the Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (**W-130B**) and the Action Taken on Your Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (**W-130G**).

REFERENCES

00-ADM-8
 06-ADM-14
 TASB Chapter 11, Section E, F, Chapter 21, page 411
 18 NYCRR, Sec 352.7(g)(1)(i); 372.2(a)(6); 381.2; 381.8
 SSL 21-a

RELATED ITEMS

[PD #12-12-OPE](#) Fraud Referrals to BFI
[PD #15-22-OPE](#) Check Replacement for Restricted Shelter Payments
[PD #15-23-ELI](#) Emergency Assistance to Needy Families with Children (EAF)
[PD #16-19-SYS](#) Electronic Benefit Transfer (EBT) System
[PB #17-44-OPE](#) Protecting Common Benefit Identification Card (CBIC) Information
[CD #06-18](#) Protect Your Benefits

ATTACHMENTS

☒ Please use Print on Demand to obtain copies of forms.

Attachment A Replacement of Stolen SNAP Benefits Liaison List
W-130B Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (Rev. 10/31/13)
W-130B (S) Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (Spanish) (Rev. 10/31/13)
W-130G Action Taken on Your Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (Rev. 10/31/13)
W-130G (S) Action Taken on Your Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System (Spanish) (Rev. 10/31/13)
W-451 NYPD – Job Center Report/Referral (Rev. 5/7/14)
EBT-64 EBT Customer Service Automated Response Unit (ARU) Personal Identification Number (PIN) Restriction Permission Form (Rev. 5/21/10)
EBT-64 (S) EBT Customer Service Automated Response Unit (ARU) Personal Identification Number (PIN) Restriction Permission Form (Spanish) (Rev. 5/21/10)

REPLACEMENT OF STOLEN SNAP BENEFITS LIAISON LIST

REGION / DIVISION	LIAISON	ALTERNATE
Job Support Services Brooklyn / Staten Island / Family Services Call Center	Tavita Srikishun (929) 221-3333	Glenn Glover (929) 221-3329
Job Support Services Bronx / Queens	Josefina Reyes (929) 221-6925	Jeannette Grantham (718) 883-8387
Job Support Services Manhattan / Special Needs / Field Operations Support / Special Populations	Hortensia Espinosa (212) 620-5046	Joanne Kent (929) 252-6465
Supplemental Nutrition Assistance Program (SNAP) Centers	Margaret Rhoden (929) 221-6933	Jennifer Powell (929) 221-6988
HIV/AIDS Services Administration (HASA) Centers	Tanya Rosalia (212) 620-9245	Florencio Soto (212) 620-9251

Date: _____
Case Number: _____
Case Name: _____
Job Center/
NCA SNAP Center: _____

Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System

Please complete this form if you are requesting replacement of Supplemental Nutrition Assistance Program (SNAP) benefits stolen from the EBT system.

I am requesting: Replacement of SNAP benefits stolen from the EBT system.

Did you contact EBT Customer Service to report a lost, stolen or compromised CBIC or PIN before the alleged theft of SNAP benefits? No Yes

If yes, when was this contact made? _____

Did you come into a Job Center or a SNAP Center and see a worker to request and complete a PIN Restriction Permission Form?

No Yes

If yes, when was this request made? _____

Was the PIN restriction processed on the card? No Yes

When did you realize that SNAP benefits were stolen from the EBT system? _____

How much in SNAP benefits was stolen from your EBT account? _____

List any information you have concerning the theft of your SNAP benefits from the EBT system.

Participant's Signature

Date of Request

Worker's Signature

Date

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Centro de Trabajo/
Centro de NCA SNAP: _____

Petición para Reemplazar Beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP) Robados del Sistema de EBT

Favor de llenar este formulario si está solicitando reemplazo de sus beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP) robados del sistema de EBT.

Estoy solicitando: Reemplazo de beneficios de SNAP robados del sistema de EBT.

¿Contactó usted al Departamento de Atención al Cliente de EBT para reportar un CBIC o una clave (PIN) perdidos, robados, o inseguros antes del presunto robo de beneficios de SNAP? No Sí

En caso afirmativo, ¿cuándo se hizo este reporte? _____

¿Se presentó usted a un Centro de Trabajo o Centro de SNAP para reunirse con un trabajador para solicitar y llenar un Formulario de Permiso para Restricción de PIN? No Sí

En caso afirmativo, ¿cuándo se presentó la petición? (indique la fecha) _____

¿Se tramitó la restricción del PIN de la tarjeta? No Sí

¿Cuándo se dio usted cuenta que los beneficios de SNAP fueron robados del sistema? _____

¿Qué cantidad de beneficios de SNAP fue robada de su cuenta de EBT? _____

Liste cualquier información que tenga sobre el robo de sus beneficios de SNAP del sistema EBT.

Firma del Participante

Fecha de la Petición

Firma del Trabajador

Fecha

Date: _____
Case Number: _____
Case Name: _____
Job Center/NCA SNAP Center: _____
Worker Telephone No: _____
FH&C Telephone No: _____

Action Taken on Your Request for Replacement of Supplemental Nutrition Assistance Program (SNAP) Benefits Stolen from the EBT System

On _____, you requested replacement of SNAP benefits stolen from the EBT system.
(Date)

- Your request has been accepted. You will receive \$ _____ for the period _____ to _____.
- The Human Resources Administration cannot approve your request for replacement of SNAP benefits stolen from the EBT system. Stolen SNAP benefits can only be replaced due to Agency error, such as a SNAP participant submitting a request to restrict a PIN but the Agency failed to take action and SNAP benefits were subsequently stolen from the EBT system. After reviewing your request, the Agency determined that the Agency or EBT customer service did not fail to deactivate a reported lost, stolen, or compromised Common Benefit Identification Card (CBIC) or complete a requested PIN restriction prior to your reported theft of SNAP benefits. You did not report the theft of SNAP benefits until _____ and the alleged theft of SNAP benefits occurred on _____.

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 1** of this notice or write to us at the address on **page 1** of this notice. Sometimes this is the fastest way to solve a problem you may have. We encourage you to do this even if you have asked for a Fair Hearing. If you ask for a conference, you are still entitled to a Fair Hearing.

STATE FAIR HEARING

How to Ask for a Fair Hearing: If you believe the decision(s) we are making is/are wrong, you may request a State Fair Hearing by telephone, 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/oah/forms.asp>

What to Expect at a Fair Hearing: The State will send you a notice that tells you when and where the Fair Hearing will be held. At the hearing, you will have a chance to explain why you think our decision is wrong. To help explain your case, you can bring a lawyer and/or witnesses such as a relative or a friend to the hearing, and/or give the Hearing Officer any written documentation related to your case, such as: pay stubs, leases, receipts, bills and/or doctor's statements etc. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give that person a letter to show the Hearing Officer that you want that person to represent you. At the hearing, you, your lawyer or your representative can also ask questions of witnesses whom we bring, or you bring, to explain the case.

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

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

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

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

FAIR HEARING REQUEST

Deadline: If you want the State to review our decision, you must ask for a Fair Hearing within ninety (90) days from the date of the notice for 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: _____ Case Number: _____
Name M.I. Last Name

Address: _____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Centro de Trabajo/
Centro de SNAP: _____
Núm. de Teléfono
del Trabajador: _____
Núm. de Teléfono de
FH&C: _____

Medidas Tomadas con Respecto a su Petición de Reemplazo de Beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP) Robados del Sistema de EBT

El _____, usted solicitó reemplazo para beneficios del SNAP robados del sistema de EBT.
(Fecha)

Su petición ha sido aceptada. Usted recibirá \$ _____ para el período de _____ al _____.

La Administración de Recursos Humanos no puede aprobar su petición de reemplazo de sus beneficios de SNAP que fueron robados del sistema de EBT. Los beneficios de SNAP robados sólo pueden ser reemplazados a raíz de un error de la Agencia, tal como en el caso que un participante de SNAP presente solicitud para restringir un PIN sin que la petición no se lleve a cabo por la Agencia, y los beneficios de SNAP sean robados como resultado. Tras revisar su petición, la Agencia ha determinado que la Agencia o el servicio al cliente de EBT no dejó de desactivar como debió una Tarjeta de Identificación de Beneficios Comunes (CBIC) reportada perdida, robada o comprometida, ni tampoco dejó de llevar a cabo una restricción solicitada del PIN antes de que usted haya reportado el robo de beneficios de SNAP. Usted no reportó el robo de beneficios de SNAP hasta _____ y el presunto robo de beneficios de SNAP ocurrió el _____.

Firma del 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 **primera página** de este aviso, o escribanos a la dirección que también aparece en la **primera página** 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) a:
14 Boerum Place, Brooklyn, NY 11201.

(5) POR INTERNET: Complete una solicitud de formulario electrónico conectándose a:
<http://www.otda.ny.gov/eah/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 noventa (90) días a partir de la fecha de este aviso para asuntos del Programa de Asistencia de Nutrición Suplementaria.

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: _____ Núm. del Caso: _____

Nombre I. Apellido

Dirección: _____
Teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____

NYPD – Job Center Report/Referral

Part I – To be filled in by referring agency

Date: _____

To:	From:
Complainant's Name:	Case Number (if applicable):
Complainant's Address:	Apt. No./Fl.:
Check <input checked="" type="checkbox"/> One: <input type="checkbox"/> CA/SNAP Participant <input type="checkbox"/> SSI Participant <input type="checkbox"/> Applicant	

Part II – For Job Center use only

Incident to be reported:			
Type of check:	Check No.:	Amount \$	(if applicable)
Action required:		Date:	
Worker's Signature:		Date:	

Part III – For police use only

SAMPLE

The above-named complainant reported the following incident (check one below) to the _____ today.
Precinct No. _____

The incident occurred on _____ at _____
DatePlace/Address

The complaint has been recorded under _____ by _____
UF 61 No.Police OfficialShield Number

Burglary Rape Mugging
 Physical abuse (battered woman) Vandalism Other (specify) _____

The following items(s) were reported as lost/stolen or destroyed. Check appropriate box(es).

Cash Assistance check	<input type="checkbox"/> lost	<input type="checkbox"/> stolen] Check No's., if known _____ Amount: \$ _____
SSI check	<input type="checkbox"/> lost	<input type="checkbox"/> stolen	
Other check (specify) _____	<input type="checkbox"/> lost	<input type="checkbox"/> stolen	
Cash	<input type="checkbox"/> lost	<input type="checkbox"/> stolen	
Property (specify) _____	<input type="checkbox"/> lost	<input type="checkbox"/> stolen	<input type="checkbox"/> destroyed

Police Official's Signature	Date
Applicant/Participant's Signature	Date

Instructions 1. Take the original and duplicate copies to the Police Precinct.
2. Return the completed and signed original to the Job Center.

Date: _____
Case Number: _____
Case Name: _____
CIN: _____

EBT Customer Service Automated Response Unit (ARU) Personal Identification Number (PIN) Restriction Permission Form

Payee's Name _____

As the payee for the case indicated above, I am requesting that the Agency

- Restrict
- Unrestrict

SAMPLE

access to the EBT Customer Service ARU PIN selection function for all of my applicable Client Benefit Identification Cards (CBICs).

Payee's Signature _____ Date _____

Worker's Signature _____ Date _____

To Be Completed by Designated Person	
EBT Restriction Action <input type="checkbox"/> Yes <input type="checkbox"/> No	EBT Restriction Lifted <input type="checkbox"/> Yes <input type="checkbox"/> No
Signature _____	Date _____

Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
CIN: _____

**Formulario de Permiso de Restricción del Número de Identificación Personal (PIN)
Unidad de Reacción Automatizada (ARU) de Atención al Cliente de EBT**

Nombre del Beneficiario _____

Como beneficiario del caso indicado más arriba, solicito que la Agencia

Restrinja

Levante la restricción del

acceso a la función de selección del Número de Identificación Personal (Personal Identification Number – PIN) de la Unidad de Reacción Automatizada (Automated Response Unit – ARU) de Atención al Cliente de EBT para todas mis Tarjetas de Identificación de Beneficios del Cliente (Client Benefit Identification Cards – CBICs) que correspondan.

Firma del Beneficiario

Fecha

Firma del Trabajador

Fecha

To Be Completed by Designated Person

EBT Restriction Action Yes No

EBT Restriction Lifted Yes No

Signature

Date