



# OFFICE OF POLICY, PROCEDURES, AND TRAINING

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Office of Procedures

## POLICY DIRECTIVE #21-05-OPE

*(This Policy Directive Replaces PD #10-36-OPE)*

### PROCESS FOR RETURNED MAIL

Date: June 17, 2021	Subtopic(s): Mail, Operations
<b>AUDIENCE</b>	This policy directive is for all staff in the Job Centers, Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Centers, the Office of Central Processing (OCP), Income Clearance Program (ICP), and Mailer and Match Action Program (MMAP). These instructions are informational for all others.
<b>REVISION TO THE PRIOR DIRECTIVE</b>	<p>This policy directive has been revised to inform staff that:</p> <ul style="list-style-type: none"><li>• Any references to Division of Financial Review and Processing (DFRP) were replaced with MMAP.</li><li>• Staff must scan and index return mail received by OCP, ICP, or MMAP.</li><li>• New York City Work Accountability and You (NYCWAY) action codes for returned mail were updated.</li><li>• Removed the section on Processing Returned Mail at the Bureau of Reconciliation and Control (BORAC).</li><li>• Details of the Mail Worklist were provided.</li><li>• Added information about the Office of Child Support Services Application Letter (<b>OCSS-63</b>) if it is returned.</li><li>• If the address on the returned mail envelope does not match the address in the Paperless Office System (POS)/Welfare Management System (WMS), verify the address using the information in the POS Document Browser and change the residential and/or mailing address in POS.</li><li>• If the returned mail is employment related, enter a case note in NYCWAY indicating the nature of the returned mail and the action taken.</li><li>• Added closing codes <b>G69</b> (failure to recertify on [date]) and <b>G70</b> (failure to recertify on [date]).</li></ul>

#### 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

- Returned mail must always be scanned into the electronic case record and must include the returned mail envelope.
- Returned mail must be indexed as returned mail and should not be indexed as the form/document (i.e., M-327h).
- Any references to Food Stamps were replaced with Supplemental Nutrition Assistance Program (SNAP).
- Removed references to the Transitional Benefit Alternative (TBA) SNAP process.
- Any references to the Mail Processing Unit (MPU) were removed. All mail returned to the NCA SNAP Center is forwarded to the Center Director's designee
- Any references to the Special Populations Change Center (F25) were replaced with MMAP.
- Updates were made to include the Streamlined Paperless Office System (SPOS).

## BACKGROUND

Staff in each location must follow the same instructions when handling returned mail to ensure that every possible step is taken so that applicants/participants receive all correspondence from the Family Independence Administration (FIA).

## REQUIRED ACTION

### Processing Returned Mail at OCP, ICP, and MMAP

When mail is returned to OCP, ICP, or MMAP, the Job Opportunity Specialist (JOS)/Worker must:

- check the contents of the envelope for the case number, name, or Social Security number (SSN).
- use the case number, name, or SSN to verify the address and to identify the Center responsible for the case via the **Individual Inquiry** screen in the Welfare Management System (WMS).

When verifying the address in WMS, the JOS/Worker must check the residence address, the mailing address, and the care of (c/o) designation. The JOS/Worker must:

Revised

- scan and index the returned mail received by OCP, ICP, or MMAP
- If the address on the returned mail is not the same address that is indicated in WMS, re-mail the letter/correspondence using the address in WMS.
  - If the address on the returned mail matches the address in WMS, enter the appropriate Action Code (see below) in NYCWAY.

Revised

<u>Code</u>	<u>Description</u>
<b>824C</b>	Center received returned mail from <b>originating Center</b> (mail returned back to the Center that sent it)
<b>824O</b>	Center received returned Office of Child Support Services (OCSS) mail form <b>OCSS-63</b> .

If the Action Code **824C** is posted, the case will be placed on the “Mail Worklist” in the appropriate Job Center for follow-up actions.

If the Action Code **824O** is posted, the case will be placed on the “OMAIL” worklist and will be worked on by OCSS staff.

Upon review, if mail is returned to OCP, ICP, or MMAP that belongs to an NCA SNAP case, designated workers must:

- batch returned mail by location.
- attach an identifying cover sheet.
- forward the mail to the appropriate NCA SNAP Center.

### Processing Returned Mail at Job Centers

All mail returned to the Job Center is forwarded to the Center Director’s Designee. The Center Director’s Designee must:

- Enter the appropriate Action Code in the **Master Menu Screen** in NYCWAY indicating where the mail was forwarded from using one of the following codes:

Revised

<u>Code</u>	<u>Description</u>
<b>824C</b>	Center received returned mail from <b>originating Center</b> (mail returned back to the Center that sent it)
<b>824O</b>	Center received returned Office of Child Support Services (OCSS) mail form <b>OCSS-63</b> .

Revised

- If the returned mail is a Notice of Intent (NOI) or a conciliation letter, enter Action Code **821** in NYCWAY.
- Print the Mail Worklist, which includes case numbers of all cases that had mail returned to the Agency and where the above cases were posted, which is then used to update case information/action as needed.
- Batch the returned mail by Unit and caseload and forward it with a copy of the Mail Worklist to the appropriate Supervisor for

distribution to a JOS/Worker for follow-up action.

The assigned JOS/Worker must review the case address (residential and mailing) in the POS **Address Information** screen and the POS **Document Browser** to determine if the address in the POS file and WMS **Inquiry** information are the same as the returned mail address.

If the address on the envelope does not match the address in WMS/POS, the JOS/Worker must:

Revised

- Verify the address using the information in the POS Document Browser, and if appropriate, change the residential and/or mailing address in POS.
- Forward the new mail to the correct address shown in POS.
- If the returned mail is a work activity appointment letter or a conciliation notice, forward the returned mail to the Associate Job Opportunity Specialist I (AJOS I) via the in-center referral.

The AJOS I must:

- Enter Action Code **105E** in NYCWAY to generate a second letter/notice to the participant at the correct address shown in POS.
- Enter Action Code **995** into NYCWAY to close out the returned mail process on the Mail Worklist.
- If the returned mail is a Notice of Recertification Appointment ([W-908T](#)), mail a new **W-908T** to the correct address shown in POS.

If the address on the envelope matches the address in WMS/POS and the address is verified in the POS Document Browser, the JOS/Worker must do the following:

Six month reporting households are not required to report changes in address between certification periods. Therefore, an NCA SNAP case must be established for six month reporting cases closed with code **E60**.

- Access the POS **Tools** menu and select **Case Comments** to make a detailed case entry.
- Check WMS for possible infractions. If WMS indicates that there is a closing action pending (i.e., appointment was given, and participant failed to attend), let the case close on that issue.
- If there are no pending infractions and the address cannot be verified, initiate a case action to close the CA case using closing code **E60** (unable to locate). A manual separate SNAP determination is required for six-month reporters.
- If the participant contacts the agency during the 10-day clock down period, inform them that a closing is pending on the case.

Tell the participant they must submit current address verification to stop the closing. Settle the Case in Conference (SIC) if documentation is submitted.

Refer to [PD#19-04-EMP](#)

Revised

- If the returned mail is employment related, enter a case note in NYCWAY indicating the nature of the returned mail and the action taken. **Note:** cases in this situation will not proceed to conciliation per the pre-conciliation process outlined in the Agency's conciliation policy. Refer to [PD#19-04-EMP](#).

If the applicant/participant is residing in temporary/transitional housing, or if the mail was sent to a general post office box, do not initiate a closing based on the returned mail. If a closing action has already started and it is too late to stop the closing, reopen the case and ensure that any missed benefits are restored.

If the returned mail for a participant residing in temporary/transitional housing is a recertification notice and there has been no updated information provided on the current address/location, outreach to the participant to try to get an updated address to send the recertification notification. If the participant contacts the Job Center by phone or in person or submits the recertification via ACCESS HRA (AHRA) prior to the end of the recertification period, during the interview, confirm the recipient's address so POS can be updated. If the individual does not submit their recertification or complete their recertification interview, the case must be closed for failure to recertify using CA closing code **G69** (failure to recertify on [date]) or **G70** (failure to recertify on [date]).

Revised

New Information

**Note:** **G69** is used when the client has submitted a recertification form but failed to complete a phone recertification interview. This code is used during the COVID-19 Emergency Declaration. **G70** is used when the client failed to submit a recertification form and also failed to complete a phone recertification interview. This code is used during the COVID-19 Emergency Declaration.

If an applicant/participant claims that they failed to keep an appointment due to non-receipt of mail and a case record review indicates that a reported address change was not processed or processed incorrectly, follow the instructions described on page 4 under "If the address on the envelope does not match the address in WMS/POS."

New Information

Returned mail must always be scanned into the electronic case record and must include the returned mail envelope.

## New Information

**Note:** When indexed, returned mail must be indexed using the document type for returned mail (Doc Type “Returned Mail” Doc ID “5416”) and should not be indexed as the form/document that was sent.

For example, if the returned mail is the Mailed-in Recertification/Eligibility Questionnaire (**M327h**), when the returned mail and envelope are indexed into the electronic case record, it should not be indexed as the **M327h**. It should be indexed as returned mail.

### Processing Returned Mail at the NCA SNAP Center

These instructions do not cover the return of the Periodic Report or mail returned to MMAP.

Instructions on mail returned to MMAP and the returned periodic reports will be issued under separate cover and are not addressed in this directive.

In certain instances, when mail is returned to the Agency, a Request for Contact/Missed Interview Form (**LDSS-4753**) must be sent prior to taking any adverse action on the case. The [LDSS-4753](#) must be sent for:

See [PD#17-10-OPE](#) for process on mail returned to MARU

- **Applicants** – NCA SNAP applicants who filed their SNAP application by mail or facsimile (fax) and the appointment notice sent is returned undeliverable with no forwarding address, the agency must first attempt to contact the applicant using the telephone number listed on their application. If unable to contact the applicant via telephone, Form **LDSS-4753** must be sent. Applicants have 30 days from the application file date to contact the Center and schedule an eligibility interview. The Mail Application Referral Unit (MARU) was established to centralize the receipt of all mailed/faxed NCA SNAP applications. See [PD#17-10-OPE](#) for more information on mail sent out by/returned to MARU.

See [PB#18-31-ELI](#) for 10-day reporting rules.

- **Participants** – NCA SNAP participants subject to 10-day reporting rules are required to report any changes (e.g. income, address, household size, etc) by the 10th day of the month following the month in which the change occurred. Failure to report changes, including address, by the 10th day of the month following the month of occurrence without good cause may result in a case closing or other adverse action.

The **LDSS-4753** should not be sent to NCA SNAP participants who:

Revised

- are subject to six-month reporting rules.
- were sent a recertification appointment notice that is returned undeliverable. However, if the participant subsequently fails to keep their recertification interview appointment, the Worker must then send Form **LDSS-4753** as a notification of missed interview.

A follow-up with the above participants to obtain the correct address must be done during the next contact, periodic report, or at recertification (whichever comes first).

Revised

All mail returned to the NCA SNAP Center is forwarded to the Center Director's Designee. The Center Director or their Designee is responsible for the control and processing of all case actions resulting from information received by mail, including returned mail and inter-office mail.

Clerical Staff

Clerical Staff assigned to handle mail are responsible for opening, sorting, and distributing all incoming mail. Clerical Staff assigned to handle mail must do the following:

- Open and date stamp mail.
- Utilize WMS **Inquiry** to ascertain the case number and annotate the information on the envelope.
- Annotate the **Recertification Log** in POS whenever a SNAP Benefits Application/Recertification (**LDSS-4826**) is received by:
  - clicking on the **LDSS-4826 Received** button at the bottom left corner of the **Recertification Log**, and
  - clicking "**Yes**" to the question, "**Was the LDSS-4826 returned undelivered?**"
- Forward mail that indicates a case action(s) is required to the Center Director or their Designee for review and annotation.
- Upon receipt of annotated mail returned by the Center Director or their Designee, control the action to be taken by listing the case on a Control of Assignments and Referrals (**W-708**) card, including the due date for the completion of all paperwork.
- Distribute the annotated mail to the assigned Worker.

The Center Director or their Designee reviews the mail received from the Worker to determine the required follow-up case action(s). If a case action is necessary, the Center Director or their Designee must do the following:

- Annotate the envelope of the returned mail with the source of the mail (i.e., returned mail), the action required (closing/change of address), and the name of the Worker receiving the assignment.
- Forward the mail back to the Clerk for control and distribution to the assigned Worker.
- Review all case actions and responses prepared by the Worker for sign-off.
- Annotate the case and action taken on the weekly report of the Center's returned mail activity.

## Worker

Upon receipt of returned mail, the assigned Worker initiates a case action in accordance with the instructions annotated on the returned mail by the Center Director or their Designee.

The Worker must review the case address (residential and mailing) in the POS **Address Information** screen and the POS **Browser** to determine if the address in the POS file and WMS **Inquiry** information are the same as the returned mail address.

- If the addresses match, the Worker must do the following:
  - Check WMS for possible infractions. If WMS indicates that there is a pending infraction related to the returned mail, stop the infraction.
  - If there are no pending infractions, complete and send the **LDSS-4753**. Request that the participant verify their address and current shelter information in the "Request for Contact" section of the form.
  - If the participant fails to respond to the **LDSS-4753** and there are still no other pending infractions, initiate a case action to close the case using closing code **M20** (failed to provide requested information within certification period).
  - Access the POS **Tools** menu and select **Case Comments** to make a detailed case entry.
  - If the participant responds to the notice with current address verification within 10 days, resolve the issue and settle the case in conference (SIC) and change the address accordingly.
- If the addresses do not match, the Worker must do the following:

## Revised

Refer to [PB#21-25-SYS](#)

- Review the electronic case by accessing Streamlined POS (SPOS). If there is documentation that shows the address change was reported but not processed in WMS:

— Go to the **Change Case Data** activity



- Enter the change of address in the POS **Address Information** screen.
  - Re-mail the letter/notice using the correct address.
- If the participant failed to report an address change:

Households subject to the 10-day reporting rule:

- If there are no pending infractions, complete and send the **LDSS-4753**. In the “Request for Contact” section of the form, request the change of address information, current shelter expense, and household composition within 10 calendar days.
- If the participant fails to respond to the **LDSS-4753** within 10 calendar days and there are no other pending infractions, close the case using code **M20**.

Households subject to the six-month reporting rule or receiving Transitional SNAP benefits:

- Pend the information until the next required six-month contact (Periodic Report or recertification). If the returned mail itself was a recertification appointment notice, no action is to be taken until the recertification date. If the individual fails to report to the recertification appointment, the [LDSS-4753](#) must then be sent as per current recertification procedure.

The Worker must check to determine if the applicant/participant receives mail via a general post office box or resides in a hotel, shelter, or other temporary housing.

In these instances, if the address on the returned mail does not match the address in our files or the mail was sent to a residential address different from what was provided by the applicant/participant, re-mail the information contained in the returned mail to the correct mailing address (i.e., the address in our files or the address provided to us by the applicant/participant).

See [PB #10-109-OPE](#) regarding Mailing Address for Homeless Applicants/Participants

If the applicant/participant is residing in temporary/transitional housing, or the mail was sent to general post office box, do not initiate a closing. If a closing action has already started and it is too late to stop the closing, reopen the case and ensure that any missed benefits are provided.

In all instances, have the returned mail scanned into the electronic case record. The Worker must enter a case comment regarding the action taken on the returned mail and forward it to the Center

Director or their Designee for review and sign-off.

### **Preventive Action in Job and NCA SNAP Centers**

To ensure that mail gets to the intended destination, it is imperative that all address changes be processed immediately.

Revised

Job Center staff should use POS to update all address changes in the **Address Information** window. NCA SNAP Center staff should use SPOS to process the address change.

Changing a participant's address may also involve authorizing a new budget if the shelter amounts differ. This is especially critical in the Job Centers on direct vendor cases where there may be a change in the landlord's name and/or address as well.

### **PROGRAM IMPLICATIONS**

Paperless Office  
System (POS)  
Implications

POS implications are covered in this directive.

SNAP Implications

An NCA SNAP case must be established and a manual separate SNAP determination must be done when a CA case is closed with code **E60** (unable to locate) for households subject to the SNAP six-month reporting rules.

Medicaid  
Implications

Use of closing code **E60** (unable to locate) to close the CA case will close the Medicaid case for the same reason, and a separate Medicaid determination is not required.

### **LIMITED ENGLISH PROFICIENT (LEP) AND DEAF/HARD- OF HEARING IMPLICATIONS**

Staff must obtain appropriate interpretation services for individuals who are Limited English Proficient (LEP) or deaf/hard-of-hearing. Please refer to [PD #18-10-OPE](#) and [PD #17-19-OPE](#) for detailed instructions.

## FAIR HEARING IMPLICATIONS

### Avoidance/ Resolution

To avoid inappropriate adverse actions, process all changes of address and address corrections immediately. Ensure that the address is complete including any "in care of" designation and the apartment number. Prior to initiating a case closing for inability to locate, review the case record documentation. Remember that CA closing code **E60** should be used only if there are no pending infractions. If there is a pending infraction, the case must be closed on that issue.

### Conferences at Job Centers

An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If an applicant/participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. In Model Offices, the Receptionist at Main Reception will issue an FH&C ticket to the applicant/participant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.

The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the 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 reason for the Agency's action(s) to the applicant/participant.

If the determination is that the applicant/participant has presented good cause for the infraction or that the outstanding Notice of Intent (NOI) needs to be withdrawn for other reasons, the FH&C AJOS/Supervisor I will Settle in Conference (SIC), post Action Code **820** (Good Cause Granted) or **820H** (Good Cause Granted for Wellness, Comprehensive Assessment, Rehabilitation and Employment [WECARE] infractions), refer the applicant/participant back to the JOS/Worker by posting Action Code **10FH** or **16FH** (for referrals back to WeCARE), and enter detailed case notes in New York City Work, Accountability and You (NYCWAY).

The AJOS/Supervisor I will forward all verifying documentation submitted by the applicant/participant to the appropriate JOS/Worker for corrective action to be taken.

In addition, if the adverse case action still shows on the “Pending” (08) screen in WMS, the AJOS/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (**LDSS-3722**), change the **02** to **01** if the case has been granted Aid to Continue (ATC), or prepare and submit a PA Recoupment Data Entry Form – WMS (**LDSS-3573**) to delete a recoupment. The AJOS/Supervisor I must complete a Conference Report (**M-186a**).

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

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

#### Conferences at NCA SNAP Centers

If an applicant/participant comes to the NCA SNAP Center and requests a conference, the Receptionist must alert the Center Director’s designee that the applicant/participant is to be seen. If the applicant/participant contacts the Eligibility Specialist directly, advise the applicant/participant to call the Center Director’s designee.

In Model Offices, the Receptionist at Main Reception will issue an SNAP Conf/Appt/Problem ticket to the applicant/participant to route him/her to the NCA SNAP Reception area and does not need to verbally alert the Site Manager. The SNAP Receptionist will alert the Center Director once the applicant/participant is called to the NCA/SNAP Reception desk.

The Center Director’s designee will listen to and evaluate the applicant’s/participant’s complaint regarding the case closing. The applicant/participant must provide current verification of address to resolve the issue. After reviewing the documentation, case record, and discussing the issue with the Group Supervisor/Eligibility Specialist, the Center Director’s designee will decide to resolve or defend the case based on all factors and whether the case was closed correctly.

The Center Director’s designee is responsible for ensuring that further appeal by the applicant/participant through a Fair Hearing request is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

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

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## RELATED ITEMS

[PB#10-109-OPE](#)  
[PB#18-13-ELI](#)  
[PB#21-25-SYS](#)  
[PD#16-15-OPE](#)  
[PD#17-10-OPE](#)  
[PD#19-04-EMP](#)

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## ATTACHMENTS

<b>LDSS-4753</b>	Food Stamps – Request for Contact/Missed Interview (Rev. 1/03)
<b>LDSS-4826</b>	Supplemental Nutrition Assistance Program (SNAP) Application/Recertification (Rev. 2/18)
<b>OCSS-63</b>	Office of Child Support Services Application Letter (Rev. 11/27/20)
<b>OCSS-63 (S)</b>	Office of Child Support Services Application Letter (Spanish) (Rev. 11/27/20)
<b>W-708</b>	Control of Assignments/Referrals (Rev. 2/25/11)
<b>W-908T</b>	Don't Lose Your Benefits! Recertify Now! (Rev. 2/4/21)
<b>W-908T (S)</b>	Don't Lose Your Benefits! Recertify Now! (Spanish) (Rev. 2/4/21)

FOOD STAMPS - REQUEST FOR CONTACT/MISSED INTERVIEW

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS				
		GENERAL PHONE NO. FOR QUESTIONS OR HELP _____		
		OR    Agency Conference                      _____		
		Record Access                                      _____		
		Legal Assistance information                  _____		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	PHONE NO.

In order for us to see if you can get or continue to get food stamp benefits, please see the checked (☑) box below:

1.    ☐    **REQUEST FOR CONTACT**

We recently received information about a change in your household. In order for us to make sure you can still get food stamp benefits, we need the following:

In order for us to make sure you can still get food stamp benefits, we need you to contact us by \_\_\_\_\_ to provide the information/documentation requested above.

**If you do not contact us by this date, your food stamp benefits may be reduced or stopped.**

This decision is based on 18 NYCRR 387.17.

2.    ☐    **MISSED INTERVIEW - APPLICATION**

You recently applied for food stamp benefits. In order for us to see if you can get food stamp benefits, you must be interviewed. You were scheduled for an interview on \_\_\_\_\_, but you missed that interview.

**You must be interviewed, or you will be denied food stamp benefits.**

Please call us at \_\_\_\_\_ to set up another interview.

This decision is based on 18 NYCRR 387.7.

3.    ☐    **MISSED INTERVIEW - RECERTIFICATION**

We recently told you that you must apply if you want continued food stamp benefits. In order for us to see if you can continue to get food stamp benefits, you must be interviewed. You were scheduled for an interview on \_\_\_\_\_, but you missed that interview.

**You must be interviewed, or your food stamp benefits will be discontinued as of \_\_\_\_\_.**

Please call us at \_\_\_\_\_ to set up another interview.

This decision is based on 18 NYCRR 387.7.

**NOTE:** You have the right to request that the Food Stamp in-office interview be waived in hardship situations. Hardship generally includes, but is not limited to, illness, transportation difficulties, care of a household member, hardship due to residency in a rural area, prolonged severe weather, or work or training hours that prevent you from coming in during regular office hours.

FOOD STAMPS - REQUEST FOR CONTACT/MISSED INTERVIEW

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS				
<div></div>		GENERAL PHONE NO. FOR QUESTIONS OR HELP _____		
		-----		
		OR    Agency Conference _____		
		Record Access _____		
		Legal Assistance information _____		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	PHONE NO.

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1.    ☐    **REQUEST FOR CONTACT**

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In order for us to make sure you can still get food stamp benefits, we need you to contact us by \_\_\_\_\_ to provide the information/documentation requested above.

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This decision is based on 18 NYCRR 387.17.

2.    ☐    **MISSED INTERVIEW - APPLICATION**

You recently applied for food stamp benefits. In order for us to see if you can get food stamp benefits, you must be interviewed. You were scheduled for an interview on \_\_\_\_\_, but you missed that interview.

**You must be interviewed, or you will be denied food stamp benefits.**

Please call us at \_\_\_\_\_ to set up another interview.

This decision is based on 18 NYCRR 387.7.

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**You must be interviewed, or your food stamp benefits will be discontinued as of \_\_\_\_\_.**

Please call us at \_\_\_\_\_ to set up another interview.

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**NOTE:** You have the right to request that the Food Stamp in-office interview be waived in hardship situations. Hardship generally includes, but is not limited to, illness, transportation difficulties, care of a household member, hardship due to residency in a rural area, prolonged severe weather, or work or training hours that prevent you from coming in during regular office hours.

FOOD STAMPS - REQUEST FOR CONTACT/MISSED INTERVIEW

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS				
<div></div>		GENERAL PHONE NO. FOR QUESTIONS OR HELP _____		
		-----		
		OR    Agency Conference _____		
		Record Access _____		
		Legal Assistance information _____		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	PHONE NO.

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In order for us to make sure you can still get food stamp benefits, we need you to contact us by \_\_\_\_\_ to provide the information/documentation requested above.

**If you do not contact us by this date, your food stamp benefits may be reduced or stopped.**

This decision is based on 18 NYCRR 387.17.

2.    ☐    **MISSED INTERVIEW - APPLICATION**

You recently applied for food stamp benefits. In order for us to see if you can get food stamp benefits, you must be interviewed. You were scheduled for an interview on \_\_\_\_\_, but you missed that interview.

**You must be interviewed, or you will be denied food stamp benefits.**

Please call us at \_\_\_\_\_ to set up another interview.

This decision is based on 18 NYCRR 387.7.

3.    ☐    **MISSED INTERVIEW - RECERTIFICATION**

We recently told you that you must apply if you want continued food stamp benefits. In order for us to see if you can continue to get food stamp benefits, you must be interviewed. You were scheduled for an interview on \_\_\_\_\_, but you missed that interview.

**You must be interviewed, or your food stamp benefits will be discontinued as of \_\_\_\_\_.**

Please call us at \_\_\_\_\_ to set up another interview.

This decision is based on 18 NYCRR 387.7.

**NOTE:** You have the right to request that the Food Stamp in-office interview be waived in hardship situations. Hardship generally includes, but is not limited to, illness, transportation difficulties, care of a household member, hardship due to residency in a rural area, prolonged severe weather, or work or training hours that prevent you from coming in during regular office hours.





## SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION/RECERTIFICATION



*This application can ONLY be used to apply for SNAP*

If you are blind or seriously visually impaired and need this application in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request an application in an alternative format, see the instruction book (LDSS-4826A), or [www.otda.ny.gov](http://www.otda.ny.gov).

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format?    ☐ Yes    ☐ No

If Yes, check the type of format you would like:    ☐ Large Print    ☐ Data CD    ☐ Audio CD  
☐ Braille, if you assert that none of the other alternative formats will be equally effective for you.

If you require another accommodation, please contact your social services district.

If you are only applying for SNAP you can use this shorter application. If you would like to apply for other benefits such as Temporary Assistance, Child Care Assistance, Home Energy Assistance or Medicaid please ask for a different application.

### When You Are Applying For SNAP

- You can file an application the same day you receive it. We must accept your application if, at a minimum, it contains your name, address, (if you have one), and a signature. This information will establish your application filing date.
- You must complete the application process, including having an interview and signing the certification statement on page 8 of the application/recertification for your eligibility to be determined. If you are eligible, benefits will be provided back to the date you filed your application.
- You can apply for and get SNAP for eligible household member(s) even if you or some other members of your household are not eligible for benefits because of immigration status. For example, ineligible alien parents can apply for SNAP for their children and receive benefits for their eligible children.
- You can still apply and be eligible for SNAP even if you have reached your Temporary Assistance time limits.

**Need SNAP Benefits Right Away? You May Be Eligible For Expedited Processing of your SNAP Application:**

If your household has little or no income or liquid resources, **or** if your rent and utility expenses are more than your income and liquid resources, **or** you are a migrant or seasonal farmworker with little or no income or resources when you apply, you may be eligible to get SNAP within 5 calendar days of the date you apply. When a resident of an institution is jointly applying for SSI and SNAP prior to leaving the institution, the recorded filing date of the application is the date of release of the applicant from the institution.

**Where You Can Apply For SNAP**

If you live **outside of** New York City, you can apply on-line at [myBenefits.ny.gov](http://myBenefits.ny.gov), or call or visit the social services district in the county where you live and ask for an application package, which can be mailed or dropped off to that appropriate office. You can get the address and phone number of the social services district in your county by calling toll free 1-800-342-3009.

If you live in **New York City** and you are **not** also applying for Temporary Assistance, you can apply on-line at [myBenefits.ny.gov](http://myBenefits.ny.gov), or call or visit any SNAP Office and ask for an application package. You can get the address and phone number by calling 1-718-557-1399 or toll free 1-800-342-3009.

**Having Problems Coming To Us For A SNAP Interview Appointment?**

If it is difficult for you to come in for a SNAP interview appointment (reasons may include employment, health issues, transportation or child care problems), in some circumstances; we can interview you by telephone, or you may have someone else apply for you. Please contact your social services district if you have any questions, to see if you are eligible for a telephone interview, **or if you need** to reschedule an interview.

**NON-DISCRIMINATION NOTICE** – In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audio tape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

## NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

**SNAP APPLICATION / RECERTIFICATION**

Application Date	Interview Date	Center/Office	Unit	Worker	Case Type	Case Number	Registry Number	Version	<input type="checkbox"/> Apply <input type="checkbox"/> Recertify	Lang
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Legal Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Other phone where you can be reached: \_\_\_\_\_

Residence Address: \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_, NY Zip Code 1

Mailing Address (if different) \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_, NY Zip Code 1

Known by Any Other Name: \_\_\_\_\_ Are You: ☐ Applying or ☐ Recertifying Do you want to receive notices in: ☐ Spanish and English or ☐ English Only

We must accept your application if, at a minimum, it contains your name, address (if you have one), and signature in this box. →

APPLICANT/REPRESENTATIVE SIGNATURE

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DATE SIGNED

List everyone who lives with you even if they are not applying. List yourself first.

L N	First Name	M I	Last Name	Social Security Number (SSN) of applying member (If none, write "NONE")	Date of Birth	Marital Status	Sex M or F	Is this person applying?		Relationship to you	Do you buy and/ or prepare food with this person?		Hispanic or Latino?		Enter Y (Yes) or N (No) for each race* (Codes Defined Below)					
								Yes	No		Yes	No	Yes	No	I	A	B	P	W	
<b>1</b>								<input checked="" type="checkbox"/>		<b>self</b>	<input checked="" type="checkbox"/>									
<b>2</b>																				
<b>3</b>																				
<b>4</b>																				
<b>5</b>																				
<b>6</b>																				
<b>7</b>																				
<b>8</b>																				

\*Race/Ethnic Codes: **I** – Native American or Alaskan Native, **A** – Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** – White

The provision of this information is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for this information is to ensure that program benefits are distributed without regard to race, color or national origin.

Are you and is everyone living with you a US citizen? ☐ Yes ☐ No If No, who is not a citizen? \_\_\_\_\_

Are you or is anyone in your household applying for or receiving SNAP or Temporary Assistance in another place? ☐ Yes ☐ No

Are you or is anyone living with you a veteran? ☐ Yes ☐ No If Yes, who \_\_\_\_\_

Do you or does anyone live in a drug or alcohol treatment center, State-certified group living facility or State-certified supervised/supportive apartment? ☐ Yes ☐ No

If you are recertifying for SNAP, list on Page 9 what has changed since your last application or recertification (such as moved, had a baby, someone moved in or out of your household).

You may use page 9 if you need more room or there is other information that you think we might need.

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Go to Page 3

## INCOME

List **ALL** your income and the income of everyone living with you. This includes, but is not limited to wages, income from self-employment minus the cost of producing self-employment (for example: babysitting, cleaning, income from a roomer or boarder), child support, pensions, veteran's benefits, disability, social security or SSI, grants or scholarships for rent or food, Temporary Assistance, and income from friends or relatives.

Name of Person Receiving Income	Source of Income	Hours Worked Per Month	How Often is it Received? (for example, weekly, bi-weekly, monthly)	Gross Amount Received Before Deductions

Do you or does anyone living with you have child/dependent care costs related to employment or training? ☐ Yes ☐ No If Yes, who \_\_\_\_\_.

Amount paid \$ \_\_\_\_\_. How often paid (e.g., weekly, monthly) \_\_\_\_\_.

Have you or has anyone living with you changed or quit jobs or reduced any form of income in the last 30 days – including reduced work hours or income? ☐ Yes ☐ No

Do you or does anyone living with you have any potential income that has not yet been received? ☐ Yes ☐ No If Yes, explain on Page 9.

Are you or is anyone living with you participating in a strike? ☐ Yes ☐ No If Yes, who \_\_\_\_\_.

Are you or is anyone living with you a boarder, foster child, or foster adult? ☐ Yes ☐ No

If Yes, check B for boarder or F for foster and write their name. ☐ B ☐ F Name: \_\_\_\_\_.

## RESOURCES

Resources do not affect the eligibility of most households applying for SNAP. However, some resource information is used to determine if you qualify for expedited processing of your application.

How much money does everyone in your household have? (For example, on your person; in your home, in checking and savings accounts, or other locations, including jointly held accounts) \$ \_\_\_\_\_ Belongs to \_\_\_\_\_.

Other financial assets? (For example, stocks, bonds, retirement accounts, savings bonds, mutual funds, IRAs, trust funds, money market certificates) ☐ Yes ☐ No

If Yes, amount \$ \_\_\_\_\_ Type \_\_\_\_\_ Owner \_\_\_\_\_.

How many cars, trucks or other vehicles do you or anyone in your household have?

\_\_\_\_ #1 Year \_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Owner \_\_\_\_\_

\_\_\_\_ #2 Year \_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ Owner \_\_\_\_\_

Do you or anyone applying own any property including your own home? ☐ Yes ☐ No If yes, list property \_\_\_\_\_ Owner \_\_\_\_\_

Has anyone applying sold, given away or transferred cash or property in the last three months to qualify for SNAP? ☐ Yes ☐ No

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### EDUCATION/TRAINING AND LANGUAGE

Enter the name of each applying person in the household aged 16 or older, including yourself. For each person, put an "X" in the box in the "Highest Level of Education" section, using the education and training codes shown below. Check only one box per person. If you enter an "X" in the "0" column for a person, (indicating they do not have a high school diploma or a high school equivalency diploma), enter their highest school grade completed in the "Highest School Grade Completed" box (example – if a person is in 10<sup>th</sup> grade, put "9" in the "Highest School Grade Completed" box). Leave the "Highest School Grade Completed" box blank if the "0" column is not checked for a person in high school or obtaining a high school equivalency diploma.

Additionally, please identify the primary language spoken for each individual in the SNAP household that is age 16 or older. The primary language is the language the individual speaks most often.

Name (First and Last)	Highest Level of Education* (Codes Defined Below)							Highest School Grade Completed (see information below)	What is the Individual's primary language spoken?
	0	1	2	3	4	5	8		

\* Education and Training Codes: **0** – Less than a high school diploma or equivalency; **1** – High school diploma or high school equivalency diploma; **2** – Associates Degree (2-year college degree); **3** – Bachelor's degree (4-year college degree); **4** – Graduate degree (Master's or higher); **5** – Completion of an Individualized Education Plan (IEP); **8** – Unknown

**NOTE:** The provision of information regarding highest level of education, highest school grade and primary language spoken is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for this information is to meet federal reporting requirements.

### LIVING ARRANGEMENTS AND EXPENSES

Check all the descriptions that apply to your household:

☐ Own home or paying for home    ☐ Renting    ☐ Migrant/seasonal farmworker    ☐ No permanent residence    ☐ Live with relatives or friends

List expenses:

Monthly rent or mortgage payment \$ \_\_\_\_\_ Tax on home per year \$ \_\_\_\_\_ Insurance on home per year \$ \_\_\_\_\_

Pay separately for Heat? ☐ Yes ☐ No If yes, specify type of heating: ☐ Gas ☐ Electric ☐ Oil ☐ Wood ☐ Coal ☐ Propane ☐ Other (list) \_\_\_\_\_

Heat Co. Name \_\_\_\_\_ Heat Co. Acct. No. \_\_\_\_\_

Pay for air conditioning, either in your electric bill or as a separate fee? ☐ Yes ☐ No

Pay separately for utilities (other than heating/cooling)? ☐ Yes ☐ No (for example, lights, cooking gas, garbage/trash, water, initial installation of utilities).

Does anyone else pay any of these expenses for you (some examples are Section 8 or other subsidy program)?

☐ Yes ☐ No If yes, who pays what? \_\_\_\_\_

Are you or is anyone living with you paying legally obligated child support? ☐ Yes ☐ No If yes, who \_\_\_\_\_

Name(s) of child(ren) support is being paid for \_\_\_\_\_

Payment amount \$ \_\_\_\_\_ Frequency of payments (for example, weekly, bi-weekly, monthly) \_\_\_\_\_

Are you, and/or anyone living with you, disabled or at least age 60? ☐ Yes ☐ No If yes, who \_\_\_\_\_

If so, does such person have medical bills? ☐ Yes ☐ No If yes, list on page 9 what they are for, how much and who is responsible for payment.

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## LIVING ARRANGEMENTS AND EXPENSES (cont'd)

Are you, and/or anyone living with you, on Medicaid with a spenddown? ☐ Yes ☐ No *If yes, who* \_\_\_\_\_ Amount \$ \_\_\_\_\_

Are you or anyone living with you (16 or 17 years of age) enrolled in school or training? ☐ Yes ☐ No *If yes, who* \_\_\_\_\_ Name of School/Training Program \_\_\_\_\_

Are you or anyone living with you, between the ages of 18 and 49 years of age, attending a school or training program (above High School)? ☐ Yes ☐ No *If yes, who?* \_\_\_\_\_

*Name of School/Training program* \_\_\_\_\_ *Full Time (FT)* ☐ Yes ☐ No *Income* ☐ Yes ☐ No *Expenses* ☐ Yes ☐ No

**Are there adults in the household age 16 and older (including the applicant) who:**

Are pregnant? ☐ Yes ☐ No *If yes, who* \_\_\_\_\_

Have any medical conditions that limit their ability to work or the type of work that they can perform? ☐ Yes ☐ No *If yes, who* \_\_\_\_\_

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## Answer these questions:

Are you or is anyone living with you violating a condition of probation or parole or fleeing to avoid prosecution, custody or confinement for a felony and actively being pursued by law enforcement? ☐ Yes ☐ No *If yes, who* \_\_\_\_\_

Are you or is anyone living with you in violation of probation or parole according to a court? ☐ Yes ☐ No *If yes, who* \_\_\_\_\_

Have you or has anyone living with you ever been disqualified from receiving SNAP because of fraud or intentional program violation? ☐ Yes ☐ No *If yes, who* \_\_\_\_\_

Have you or has anyone living with you been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs after September 22, 1996? ☐ Yes ☐ No  
*If yes, who* \_\_\_\_\_

Have you or has anyone living with you been convicted of buying or selling SNAP benefits for a combined amount of \$500 or more, after September 22, 1996? ☐ Yes ☐ No  
*If yes, who* \_\_\_\_\_

Have you or has anyone living with you been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996? ☐ Yes ☐ No  
*If yes, who* \_\_\_\_\_

**You may use page 9 if you need more room or there is other information that you think we might need.**

## READ THE IMPORTANT INFORMATION BELOW

**SNAP PENALTY WARNING** – Any information you provide in connection with your application for SNAP will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied SNAP. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Anyone who is violating a condition of probation or parole or anyone who is fleeing to avoid prosecution, custody or confinement for a felony, and is actively being pursued by law enforcement, is not eligible to receive SNAP benefits.

If a SNAP household member is found to have committed an Intentional Program Violation (IPV), the member will not be able to get SNAP benefits for a period of:

- 12 months for the first SNAP-IPV;
- 24 months for the second SNAP IPV;
- 24 months for the first SNAP-IPV, that is based on a court finding that the individual used or received SNAP benefits in a transaction involving the sale of a controlled substance. (Illegal drugs or certain drugs for which a doctor's prescription is required.)
- 120 months if found guilty of making a false statement about who you are or where you live in order to get multiple SNAP benefits simultaneously, unless permanently disqualified for a third IPV.

Additionally, a court may bar an individual from participation in SNAP for an additional 18 months.

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## READ THE IMPORTANT INFORMATION BELOW (cont'd)

Permanent disqualification of an individual for:

- The first SNAP-IPV based on a court finding of using or receiving SNAP benefits in a transaction involving the sale of firearms, ammunition or explosives.
- The first SNAP-IPV based on a court conviction for trafficking SNAP benefits for a combined amount of \$500 or more (Trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices.)
- The second SNAP-IPV based on a court finding that an individual used or received SNAP benefits in a transaction involving the sale of controlled substances. (Illegal drugs or certain drugs for which a doctor's prescription is required.)
- All third SNAP-IPV Intentional Program Violations.

Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to \$250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable Federal and State laws.

You may be found ineligible for SNAP or found to have committed an IPV if:

- You make a false or misleading statement, or misrepresent, conceal or withhold facts in order to qualify for benefits or receive more benefits; or
- Purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or
- Commit or attempt to commit an act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of SNAP benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

Additionally, the following is not allowed and, you may be disqualified from receiving SNAP benefits and/or be subject to penalties for actions that include:

- Using or have in your possession EBT cards that do not belong to you, without the card owner's consent; or
- Using SNAP benefits to buy nonfood items, such as alcohol or cigarettes, or to pay for food previously purchased on credit; or
- Allowing someone else to use your electronic benefit transfer (EBT) card in exchange for cash, firearms, ammunition, explosives or drugs, or to purchase food for individuals who are not members of the SNAP household.

If you get more SNAP benefits than you should have (overpayment), you must pay them back. If your case is active, we will take back the amount of the overpayment from future SNAP benefits that you get. If your case is closed, you may pay back the overpayment through any unused SNAP benefits remaining in your account, or you may pay by cash.

If you have an overpayment that is not paid back, it will be referred for collection, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges.

Any SNAP benefits expunged from your EBT account will be used to reduce current overpayments. If you apply for SNAP again, and have not repaid the amount you owe, your SNAP benefits will be reduced if you begin to get them again. You will be notified, at that time, of the amount of reduced benefits you will get.

**CONSENT** – I understand that by signing this application form I agree to any investigation made by the New York State Office of Temporary and Disability Assistance or my local social services district to verify or confirm the information I have given or any other investigation made by them in connection with my request for SNAP benefits. If additional information is requested, I will provide it. I will also cooperate with State and Federal personnel in a SNAP Quality Control Review.

I understand that by signing this application/certification, I consent to an investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this application to be used in referrals to available weatherization assistance programs and my utility company's low income programs. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the Office of Temporary and Disability Assistance and the local Social Services District and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program (LIHEAP) performance measurement.

**CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE (UI) INFORMATION** – I authorize the New York State Department of Labor (DOL) to release any confidential information, maintained by DOL for Unemployment Insurance (UI) purposes, to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with State and local agency employees working in local social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of SNAP applied for in this application and for investigations to determine whether I received benefits to which I was not entitled.

**READ THE IMPORTANT INFORMATION BELOW (cont'd)**

**RELEASE OF INFORMATION TO SERVICE PROVIDERS** - I give permission to the social services district and New York State to share information regarding Supplemental Nutrition Assistance Program benefits that I or any member of my household for whom I can legally give authorization have received, for purposes of verifying my eligibility for services and payment related to program administration provided by a State or local contractor. Such services may include, but are not limited to, job placement or training services provided to help me or my household members obtain and retain employment.

**SUA (STANDARD UTILITY ALLOWANCE) INFORMATION** – I understand that SNAP recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). If I have not received a HEAP benefit of greater than \$20 in the current month or previous 12 months, or other similar energy assistance program benefits, I must pay separately for a heating, air conditioning or utility expense in order to receive a Standard Utility Allowance.

**CHANGES** – I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangement, able-bodied adult without dependents (ABAWD) status including if my hours of work fall below 80 hours per month, pregnancy status or address to the best of my knowledge or belief in accordance with my reporting requirements.

**REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES** – I understand that my household must report child care and utility expenses in order to get a SNAP deduction for these expenses. I further understand that my household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a SNAP deduction for these expenses. I understand that failure to report/verify the above expenses will be seen as a statement by my household that I/we do not want to receive a deduction for those unreported/unverified expenses. A deduction for these expenses may make me eligible for SNAP or may increase my SNAP benefits. I understand that I may report/verify these expenses at any time in the future. This deduction would then be applied to the calculation of SNAP in future months in accordance with the rules for change reporting and processing changes.

In applying for SNAP, I understand that the social services district will request and use information available through the Income and Eligibility Verification System to investigate my application, and may verify this information through collateral contacts if discrepancies are found. I also understand that such information may affect my eligibility for SNAP and/or level of SNAP benefits I receive.

**PRIVACY ACT STATEMENT – COLLECTION AND USE OF SOCIAL SECURITY NUMBER (SSN)** – The collection of SSN's is authorized for each household member with respect to SNAP pursuant to the Food and Nutrition Act of 2008. The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other State and Federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. The information will be used to check identity and to verify earned and unearned income.

If a SNAP claim arises against your household, the information on this application, including all SSN's, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Anyone applying for SNAP must provide a SSN. SSN's of ineligible members will also be used and disclosed in the manner above. If you or anyone applying/recertifying does not have a SSN, a SSN must be applied for with the Social Security Administration (SSA.gov).

Besides using the information, you give us in this way, the State also uses the information to prepare statistics about all the people receiving benefits from the Home Energy Assistance Program. The information is used for quality control by the State to make sure local districts are doing the best job they can. It is used to verify who your energy supplier is and to make certain payments to such vendors.

**CITIZENSHIP/IMMIGRATION STATUS**– I swear and/or affirm under penalty of perjury that the information I have provided about the citizenship and immigration status of myself and everyone living with me is true and correct. I understand that any information I provide to verify the immigration status of anyone applying for SNAP may be checked for authenticity with the United States Citizenship and Immigration Services.

For SNAP, citizenship must be documented **only if questionable**.



READ THE IMPORTANT INFORMATION BELOW (*cont'd*)

**AUTHORIZED REPRESENTATIVE** – You can authorize someone who knows your household circumstances to **apply** for SNAP for you. You can also authorize someone outside your household to get SNAP benefits for you and to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may do so by printing the person's name, address and phone number below. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, **both** the Authorized Representative and a responsible adult member of the SNAP household must sign and date the signature sections at the bottom of this page, unless the Authorized Representative has been otherwise designated by the household in writing.

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IF YOU WOULD LIKE TO AUTHORIZE SOMEONE, PRINT THE PERSON'S NAME, ADDRESS AND TELEPHONE NUMBER, AND SIGN BELOW.

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**CERTIFICATION:** I swear and/or affirm under the penalties of perjury that the information I have given or will give to the local Social Services district is correct.  
Your signature is required below to complete the application process.

APPLICANT SIGNATURE (or Responsible Adult Household Member)  X	DATE SIGNED  11
Authorized Representative SIGNATURE  X	DATE SIGNED

IF YOU HELPED COMPLETE THIS APPLICATION / RECERTIFICATION FOR SOMEONE ELSE, PRINT YOUR NAME AND ADDRESS HERE. YOU MAY ALSO VOLUNTARILY PRINT YOUR TELEPHONE NUMBER.

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Use this area for additional information:

Who: \_\_\_\_\_ Explanation: \_\_\_\_\_

Who: \_\_\_\_\_ Explanation: \_\_\_\_\_

Who: \_\_\_\_\_ Explanation: \_\_\_\_\_

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I CONSENT TO WITHDRAW MY APPLICATION/RECERTIFICATION. I understand that I may reapply at any time.

SIGNATURE

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DATE

***For Agency Use Only***

Eligibility Determined by \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person Who Obtained Eligibility Information: \_\_\_\_\_ Date \_\_\_\_\_

Reason \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Withdrawal ☐ Denial ☐ Recert. Closing

Eligibility Approved by \_\_\_\_\_ Date \_\_\_\_\_

SNAP Authorization Period: From \_\_\_\_\_ To \_\_\_\_\_

☐ IN-PERSON INTERVIEW

☐ TELEPHONE INTERVIEW

Comments:



# NYS Agency-Based Voter Registration Form

**"If you are not registered to vote where you live now, would you like to apply to register here today?"**

- ☐ **YES** If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below
- ☐ **NO** because I choose not to register **OR**
- ☐ I am already registered at my current address **OR**
- ☐ I asked for and received a mail registration form

*If you do not check any box, you will be considered to have decided not to register to vote at this time.*

Signature

Date

Please Print Name

## Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料: 若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683  
으로 전화 하십시오.

যদি আপনি এই ফর্মটি ইংরেজিতে পেতে চান তাহলে 1-800-367-8683  
নম্বরে ফোন করুন

Rev 2/2015

## VOTER REGISTRATION APPLICATION (instructions on back)

☐ Yes, I need an application for an Absentee Ballot

**Please print or type in blue or black ink**

☐ Yes, I would like to be an Election Day worker

<b>1</b>	<b>Are you a U.S. citizen?</b>		<b>2</b>	<b>Will you be 18 years old on or before election day?</b>		<b>For Board Use Only</b>
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
		If you answered <b>NO</b> , do not complete this form				
<b>3</b>	Last Name		First Name	Middle Initial	Suffix	
<b>4</b>	Address where you live (do not give P.O. box)		Apt. No.	City/Town/Village	Zip Code	County
<b>5</b>	Address where you get your mail (if different than above)		P.O. Box, Star Route, etc.	Post Office	Zip Code	
<b>6</b>	Date of Birth	<b>7</b>	Sex	<b>8</b>	Telephone (optional)	Email (optional)
			<input type="checkbox"/> M <input type="checkbox"/> F			
<b>10</b>	The last year you voted		Your address was (give house number, street and city)		<b>9</b>	<b>ID Number</b> (Check the applicable box and provide your number) <input type="checkbox"/> New York State DMV number — — — — — <input type="checkbox"/> Last four digits of your Social Security number — — — — <input type="checkbox"/> I do not have a New York State DMV or Social Security number
	In county/state		Under the name (if different from your name now)			
<b>11</b>	<b>Political Party</b> <b>I wish to enroll in a political party</b> <input type="checkbox"/> Democratic party <input type="checkbox"/> Independence party <input type="checkbox"/> Republican party <input type="checkbox"/> Women's Equality party <input type="checkbox"/> Conservative party <input type="checkbox"/> Reform party <input type="checkbox"/> Green party <input type="checkbox"/> Other _____ <input type="checkbox"/> Working Families party <b>I do not wish to enroll in a political party</b> <input type="checkbox"/> No party					<b>12</b>
	<b>Affidavit: I swear or affirm that</b> <ul style="list-style-type: none"> <li>I am a citizen of the United States.</li> <li>I will have lived in the county, city or village for at least 30 days before the election.</li> <li>I will meet all requirements to register to vote in New York State.</li> <li>This is my signature or mark on the line below.</li> <li>The above information is true, I understand that if it is not true, I can be convicted and fined up to \$5,000 and/or jailed for up to four years.</li> </ul>					
						Signature or Mark in ink _____ Date _____ / ____ / ____

## (Optional) Register to donate your organs and tissues

Last Name		
First Name	Middle Initial	Suffix
Address		
Apt Number	City/Town/Village	Zip Code
Birth Date	Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Eye Color	Height	Ft. In.

**By signing below, you certify that you are:**

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.



Signature

Date

## Qualifications for Registration

### You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

### To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

## Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections

40 North Pearl St, Suite 5

Albany, NY 12207-2729

Telephone: 1-800-469-6872;

TDD/TTY users contact the New York State Relay at 711;

or visit our web site - [www.elections.ny.gov](http://www.elections.ny.gov)

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

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## Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

## To complete this form:

**It is a crime to procure a false registration or to furnish false information to the Board of Elections.**

*Box 9:* You must make one selection. For questions refer to Verifying your identity above.

*Box 10:* If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

*Box 11:* Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state party rules allow otherwise.

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Date: \_\_\_\_\_  
Case ID: \_\_\_\_\_  
Case Name: \_\_\_\_\_

## **Avoid a Reduction in Your Benefits – Complete Your Child Support Application Today**

Since you applied for or are receiving cash assistance, you must complete, sign, and return the enclosed child support application to be eligible to receive your full cash assistance benefits. The application must be returned to the New York City Office of Child Support Services (OCSS) within 10 days. If a completed application is not received in the next 10 days, you will be sanctioned and if eligible, your cash assistance payment will be reduced.

**Step 1: Complete and sign the enclosed child support application.**

Make sure you continue to receive your full cash assistance benefits by taking the steps below:

Complete the enclosed **Referral for Child Support Services form “LDSS-5145.”**




- ✓ **Fill it out.** The form should take about 30 minutes to complete. The better you complete it, the easier it will be to establish a child support order and collect child support.
- ✓ **Sign it.** We will not be able to process the form without your signature.

Need help completing this form? Call \_\_\_\_\_.

(Turn over)

**Step 2: Return your completed, signed application to OCSS within 10 days.**

There are 3 ways to return your application:

1.		<b>Use the ACCESS HRA mobile app</b> to upload the form. Select “Child Support Form LDSS-5145” as the document category.
2.		<b>Mail</b> the form to the Office of Child Support Services using the attached postage-paid Business Reply Envelope (no cost to you) or to: <b>Office of Child Support Services</b> <b>Attention: Borough Offices</b> <b>P.O. Box 830</b> <b>New York, NY 10013</b>
3.		<b>Email</b> it to <a href="mailto:dcse.cseweb@dfa.state.ny.us">dcse.cseweb@dfa.state.ny.us</a> , with the subject line “LDSS-5145.”



**What happens if I don't return the signed form?**

- \* Your Cash Assistance benefit may be reduced by 25%,
- \* You may lose Medicaid for yourself,
- \* You will become ineligible for some rental assistance programs, **and**
- \* You won't start the process of opening a child support case, which can provide up to \$200 a month in addition to your Cash Assistance benefit – and more once you leave Cash Assistance.



**If you have any safety concerns** please contact your FIA worker, who will refer you to an HRA Domestic Violence Liaison. Together you can decide if child support is safe for your family.



**Do you have a medical or mental health condition or disability?**

Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at **212-331-4640**. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

Fecha: \_\_\_\_\_  
Identificación del caso: \_\_\_\_\_  
Nombre del encargado  
del caso: \_\_\_\_\_

## Evite una reducción en sus beneficios: complete hoy su solicitud de manutención infantil

Debido a que pidió o está recibiendo ayuda económica, debe completar, firmar y devolver la solicitud de manutención infantil adjunta para ser elegible y recibir sus beneficios completos de ayuda económica. Debe devolver la solicitud a la Oficina de Servicios de Manutención Infantil (Office of Child Support Services, OCSS) de la Ciudad de Nueva York en los próximos 10 días. Si no se recibe una solicitud completa en los próximos 10 días, será sancionado y, si es elegible, se reducirá su pago por ayuda económica.

### Paso 1: complete y firme la solicitud adjunta de manutención infantil.

Asegúrese de continuar recibiendo sus beneficios completos de ayuda económica siguiendo estos pasos:




Complete el **formulario adjunto de Remisión para servicios de manutención infantil "LDSS-5145"**.

- ✓ **Complételo.** Tardará unos 30 minutos en completarlo. Cuanto mejor lo complete, más fácil será establecer una orden de manutención infantil y cobrarla.
- ✓ **Fírmelo.** No podremos procesar el formulario sin su firma.

¿Necesita ayuda para completar este formulario? Llame al \_\_\_\_\_.

**Paso 2: Envíe su solicitud completa y firmada a OCSS en 10 días.**

Hay 3 formas de devolver su solicitud:

1.		<b>Use la aplicación móvil ACCESS HRA</b> para subir el formulario. Seleccione "Child Support Form LDSS-5145" (Formulario de manutención infantil LDSS-5145) como categoría del documento.
2.		<b>Envíe por correo</b> el formulario a la Oficina de Servicios de Manutención Infantil en el sobre franqueado adjunto (sin costo para usted) o envíelo a: <b>Office of Child Support Services</b> <b>Attention: Borough Offices</b> <b>P.O. Box 830</b> <b>New York, NY 10013</b>
3.		<b>Envíelo por correo electrónico</b> a <a href="mailto:dcse.cseweb@dfa.state.ny.us">dcse.cseweb@dfa.state.ny.us</a> , con el asunto: "LDSS-5145".



**¿Qué sucede si no devuelvo el formulario firmado?**

- \* Su beneficio de ayuda económica puede reducirse en 25 %;
- \* Puede perder los beneficios de Medicaid;
- \* Podría perder elegibilidad para algunos programas de asistencia para el pago del alquiler, y
- \* No podrá empezar el proceso de apertura de un caso de manutención infantil, lo que puede darle hasta \$200 más al mes en el beneficio de ayuda económica, y más cuando deje la ayuda económica.



**Si tiene alguna preocupación de seguridad**, comuníquese con el trabajador de FIA, que lo remitirá con un Coordinador de violencia doméstica de la Administración de Recursos Humanos (HRA). Juntos pueden decidir si la manutención de menores es segura para su familia.



**¿Tiene alguna condición médica o de salud mental o alguna discapacidad?**

¿Lo dificulta esta condición entender este aviso o cumplir lo que se pide? ¿Lo dificulta esta condición obtener otros servicios de la HRA? **Podemos ayudarlo.** Llámenos al **212-331-4640**. También puede pedir ayuda en una oficina de la HRA. Por ley, usted tiene derecho a pedir este tipo de ayuda.



Card Number: \_\_\_\_\_

[illegible]

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

Case Number: \_\_\_\_\_

Case Name: \_\_\_\_\_

Fair Hearing & Conference \_\_\_\_\_

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

## DON'T LOSE YOUR BENEFITS! RECERTIFY NOW!

- Your Cash Assistance Recertification period is now open.
- You have until \_\_\_\_\_ to complete the three steps below

### First, Complete Your Cash Assistance Recertification Form.



- 1 Go to [www.nyc.gov/accesshra](http://www.nyc.gov/accesshra) or use the AccessHRA mobile application
- 2 Log into your account (or set one up)
- 3 Click "Yes" to "Do you want to start your online Recertification now?" on the Home page
- 4 Fill out your information and submit your form

See **page 2** for other ways to submit your Recertification form.

### Then, Submit Required Documentation



Submit any change in your living situation such as changes in income, resources, shelter (rent, utility, heat, telephone, etc.), family size, child care costs and any other changes;

HRA's mobile app is the easiest and fastest way to submit your documentation.

Download the app today! [www.nyc.gov/accesshramobile](http://www.nyc.gov/accesshramobile)

### After You Submit, be ready for our call!



We will call you for your interview within 7 days after you submit your recertification at the telephone number you gave us.

(Turn page)

**Documents you MAY need to submit include:**

- Proof of WHO LIVES IN YOUR HOME (anyone who has moved in or left your home);
- Proof of your household INCOME;
- Proof of your EXPENSES (such as rent, utilities, child care, medical expenses);
- Information about any ASSETS or resources you have (such as bank statements).

A full list of documents you need to give us will be provided after your interview.

**Don't have access to the internet?**

If you don't have access to the internet, contact \_\_\_\_\_ to receive a Recertification form in the mail. When you get the Recertification form in the mail, you can send it back to us:



By fax to:

\_\_\_\_\_



By mail. Please follow the instructions in the recertification application.



In person: visit the Open Center in the borough that you live. Visit [www.nyc.gov/hra](http://www.nyc.gov/hra) to see which of our locations are open or call DSS Infoline at **718-557-1399**. Once you are at the location, you can use your PC banks to submit online or you can fill out a paper form and leave it in our drop box.



For other submission options, please call DSS Infoline at **718-557-1399**.

**Child Care Notice**

If you have children under the age of 13, you may need child care in order to participate in a work activity. If you have a child care provider, have them complete the child care provider enrollment form, **which is being sent to you in a separate envelope**. Send it to us in the envelope that comes with it.

**Interview Information**

We will CALL YOU for an interview from a number you may not know (info: <https://on.nyc.gov/3tgfBhD>) within 7 days. The numbers that you may see are:

347-227-3301 • 718-269-3231 • 929-267-5002 • 914-274-5743

(Turn page)

## What happens if I do not have my interview?

### Cash Assistance

If you do not complete the recertification process (see first page for recertification steps) by \_\_\_\_\_, we will think that you do not want Cash Assistance. We will then close your Cash Assistance case and send you a notice telling you the closing date. This decision is based on 18 NYCRR § 351.22.

### Medical Assistance

You do not need an interview to keep your medical assistance. However, you must tell us about any changes in address, income, resources or household size.

### SNAP Benefits

If you, an adult member of your household or your authorized representative do not give us your recertification form and have an interview by \_\_\_\_\_ your SNAP benefits will stop. You will not get SNAP benefits unless you apply again and are eligible. If any proof is still needed after the interview, you will be told what you need to give, and you will have at least ten days to give it. This decision is based on 18 NYCRR § 387.17.

## What if I no longer want or need assistance?

If you do not want or need Cash Assistance, SNAP benefits and/or medical assistance, please tell us. If you want any of these benefits to stop, check the box(es) on **page 4** next to the benefit(s) and tell us the reason why. It is important for you to tell us why you want your case closed because you may be able to get medical assistance for up to a year. You may also be able to get help with your child care expenses.

If you check any of the box(es) on **page 4**, sign, date, and send this form to the address of the Job Center listed on **page 2** of this form.

(Turn page)

- ☐ I do not want or need **CASH ASSISTANCE**. (If you check this box but still want SNAP benefits, you must give us the recertification form in one of the ways described on **page 1** of this notice. Your medical assistance will continue unless you also check the next box.)
- ☐ I do not want **MEDICAL ASSISTANCE**.
- ☐ I do not want **SNAP** benefits.

I no longer want the above checked benefits because:

Participant's Signature

Case Number

Date Signed

**Do you have a medical or mental health condition or disability?** Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Use the **Help For People With Disabilities** form in this mailing. You can also call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.**  
**BE SURE TO READ THE INTERVIEW/APPLICATION RIGHTS FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS AND THE CONFERENCE AND FAIR HEARING INFORMATION SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.**

(Turn page)

### **Interview/Application Rights for Supplemental Nutrition Assistance Program (SNAP) Benefits**

You have a right to:

- complete your SNAP interview over the phone.
- ask for an application for SNAP benefits. This office must accept the application as long as it is signed and your name can be read (and address, if you have one).
- apply for SNAP benefits in person, by mail, fax or through an authorized representative. An interview may be required.

If all members of your household are now receiving Supplemental Security Income (SSI) or plan to apply for SSI, you may apply for SNAP benefits at the Social Security office instead of turning in your recertification form at the SNAP Center. If you choose to do this, the Social Security office must also get your application by the date noted on **page 3** in the SNAP Benefits section of this notice. They will interview you and send your application and supporting documents to the SNAP Center to see if you can still get SNAP benefits.

### **Services and Other Information**

- ✓ Social services may send you information and education about family planning for up to 90 days from the date stated in this notice. A loss of Cash Assistance and medical assistance benefits will require a review of your eligibility for social services within 30 days of the decision. This does not mean that your services will end. It means that your eligibility for these services will have to be reviewed. For further information, please contact your Worker.
- ✓ Even though you may no longer be eligible for Cash Assistance, SNAP benefits, or medical assistance, you still may be eligible for help with your heating costs. You can find out by applying for the Home Energy Assistance Program (HEAP). Call HEAP Central at (800) 692-0557 for information on HEAP.

**(Turn page)**

## Conference and Fair Hearing Information

### CONFERENCE

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

### STATE FAIR HEARING

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

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

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

**(1) TELEPHONE:** Call **(800) 342-3334**. (Please have this notice in hand when you call.)

**(2) WRITE:** Send a copy (and keep a copy for yourself) of this entire notice, with the "Fair Hearing Request" section completed, to:

**Office of Administrative Hearings  
New York State Office of Temporary and Disability Assistance  
P.O. Box 1930  
Albany, NY 12201**

**(3) FAX:** Fax a copy of this entire notice, with the "Fair Hearing Request" section completed, to: **(518) 473-6735**.

**(4) IN PERSON:** Bring a copy of this entire notice, with the "Fair Hearing Request" section completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance at: **14 Boerum Place, Brooklyn NY 11201**

**(5) ONLINE:** Complete an online request form at:  
**<http://www.otda.state.ny.us/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 such as 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.

**AVAILABILITY OF POLICY MATERIALS:** The Office of Temporary and Disability Assistance (OTDA) policy issuances and HRA policy 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. OTDA policy issuances and manuals are posted on the OTDA website at <http://www.otda.ny.gov/legal>. In addition, upon request to HRA, specific OTDA and HRA policy issuances and manuals are also available to explain how the agency reached its determination. To request policy issuances and manuals, call **(718) 722-5012**, or fax **(718) 722-5018**, or email [CRO@hra.nyc.gov](mailto:CRO@hra.nyc.gov) or write to **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, NY 11201**.

**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.

(Turn page)



## FAIR HEARING REQUEST

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

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

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

☐ 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 de caso: \_\_\_\_\_

Nombre del caso : \_\_\_\_\_

Número de teléfono de Audiencia \_\_\_\_\_

Imparcial y Conferencia: \_\_\_\_\_

## ¡NO PIERDA SUS BENEFICIOS! ¡RECERTIFIQUE AHORA!

- El periodo de recertificación para recibir su beneficio de Asistencia en Efectivo (*Cash Assistance Recertification*) está abierto.
- Usted tiene tiempo hasta el \_\_\_\_\_ para completar los tres pasos siguientes:

### Primero, complete el formulario de recertificación para la Asistencia en Efectivo.



1. Entre a la página web [www.nyc.gov/accesshra](http://www.nyc.gov/accesshra) o use la aplicación móvil de Access HRA.
2. Ingrese a su cuenta (o cree una cuenta nueva).
3. En la página de inicio, donde dice "Do you want to start your online Recertification now?" (¿Quisiera iniciar su recertificación por Internet ahora?) Haga clic en "Yes" (Sí).
4. Complete el formulario con sus datos y envíelo.

Para ver otras maneras de presentar su formulario de recertificación, lea la **página 2**.

### Luego, envíe los documentos requeridos.



Presente todo cambio en la situación de vida de su hogar, como por ejemplo: cambios en sus ingresos, recursos, albergue (alquiler, servicios públicos, calefacción, teléfono, etc.), número de integrantes de su hogar, costos de cuidado infantil y cualquier otro cambio.

La aplicación móvil de *HRA* es la manera más rápida y fácil de presentar sus documentos.

¡Descargue la aplicación hoy mismo! [www.nyc.gov/accesshramobile](http://www.nyc.gov/accesshramobile)

### Después de que haya enviado los documentos, ¡esté listo para que lo(a) llamemos!



Lo(a) llamaremos para su entrevista dentro de los 7 días posteriores a la fecha en que haya presentado su recertificación, al número de teléfono que nos haya proporcionado.

(Gire la hoja)

**Entre los documentos que usted TENDRÍA que presentar se incluyen:**

- Prueba de QUIÉN VIVE EN SU HOGAR (toda persona que se haya integrado o que se haya mudado del hogar);
- Prueba de los INGRESOS de su hogar;
- Prueba de sus GASTOS (por ejemplo: alquiler, servicios públicos, cuidado infantil y gastos médicos);
- Información sobre BIENES o recursos que usted tenga (por ejemplo: los estados de cuentas bancarias).

Se le proporcionará la lista completa de los documentos que debe entregarnos luego de finalizar su entrevista.

**¿No tiene acceso a Internet?**

Si no tiene acceso a Internet, llame al

\_\_\_\_\_ para recibir el formulario de recertificación por correo postal. Luego de recibirlo por correo postal, puede reenviarnoslo:



Por fax al:



Por correo postal. Favor de seguir las instrucciones que aparecen en la solicitud de recertificación.



En persona: visite el Centro que esté abierto en el área donde usted vive. Para ver qué ubicaciones están abiertas, entre a la página web [www.nyc.gov/hra](http://www.nyc.gov/hra) o llame a la Línea Informativa del DSS al **718-557-1399**. Una vez que esté en el Centro, puede usar las computadoras (*PC Banks*) para presentar el formulario por Internet o puede completar un formulario de papel y dejarlo en el buzón del centro (*drop box*).



Para informarse sobre otros modos de presentar el formulario, favor de llamar a la Línea Informativa del DSS al **718-557-1399**.

**Aviso sobre el Cuidado Infantil**

Si tiene niños menores de 13 años, es posible que necesite cuidado infantil para poder participar en una actividad de trabajo. Si tiene un proveedor de cuidado infantil, haga que complete el formulario de inscripción para proveedor de cuidado infantil, **el cual se le enviará en un sobre por separado**. Reenvíenoslo en dicho sobre.

**Información sobre la entrevista**

LO(A) LLAMAREMOS para realizar la entrevista desde un número de teléfono que probablemente desconoce (información: <https://on.nyc.gov/3tgfBhD>) dentro de 7 días. Los números que tal vez vea son:

347-227-3301 • 718-269-3231 • 929-267-5002 • 914-274-5743

(Gire la hoja)

### **¿Qué sucede si no llevo a cabo mi entrevista?**

#### **Asistencia en Efectivo (Cash Assistance)**

Si no completa el trámite de recertificación (vea los pasos de recertificación en la página uno) de aquí al \_\_\_\_\_, entenderemos que no quiere recibir la Asistencia en Efectivo. Entonces, cerraremos su caso de Asistencia en Efectivo y le enviaremos un aviso que incluirá la fecha de cierre. Esta decisión se basa en la sección 351.22 del título 18 de la Compilación Oficial de los Códigos, Reglas y Regulaciones del Estado de Nueva York (18 NYCRR § 351.22).

#### **Asistencia Médica (Medical Assistance)**

Usted no necesita una entrevista para conservar su Asistencia Médica. No obstante, tiene que informarnos sobre cualquier cambio de domicilio, ingresos, recursos o número de integrantes del hogar.

#### **Beneficios de SNAP**

Si usted, un integrante adulto de su hogar o su representante autorizado no nos proporcionan su formulario de recertificación, ni llevan a cabo su entrevista de aquí al \_\_\_\_\_,

\_\_\_\_\_, sus beneficios de SNAP terminarán. No recibirá los beneficios de SNAP a menos que reenvíe una solicitud y que sea elegible. Si después de que haga su entrevista aún se necesita algún tipo de prueba, será informado(a) acerca de lo que deba enviarnos, y tendrá un plazo de hasta diez días para ello. Esta decisión se basa en la sección 351.22 del título 18 de la Compilación Oficial de los Códigos, Reglas y Regulaciones del Estado de Nueva York (18 NYCRR § 351.22).

### **¿Qué sucede si ya no deseo o no necesito asistencia?**

Si no desea o no necesita la Asistencia en Efectivo, de SNAP y/o la Asistencia Médica, favor de informarnoslo. Si desea cancelar alguno de los beneficios, marque en la **página 4** la(s) casilla(s) del beneficio(s) que no desee o no necesite y explique el motivo. Es importante que nos informe por qué desea cerrar su caso, puesto que podría recibir aún la Asistencia Médica hasta por un año. También podría recibir ayuda para cubrir sus gastos de cuidado infantil.

Si marca alguna de las casillas en la **página 4**, favor de firmar, fechar y enviar este formulario a la dirección del Centro de Trabajo listada en la **página 2** de este formulario.

(Gire la hoja)

- ☐ No deseo o no necesito el beneficio de **ASISTENCIA EN EFECTIVO (CASH ASSISTANCE)**. (Si marca esta casilla, pero aún desea los beneficios de *SNAP*, tiene que proporcionarnos el formulario de recertificación utilizando uno de los medios descritos en la **página 1** de este aviso. Su Asistencia Médica continuará, a menos que también marque la próxima casilla).
- ☐ No deseo el beneficio de **ASISTENCIA MÉDICA**.
- ☐ No deseo los beneficios de **SNAP**.

Ya no deseo los beneficios anteriormente marcados porque:

Firma del/ de la participante

Número de caso

Fecha de la firma

**¿Tiene usted alguna condición médica, de salud mental o alguna discapacidad?** ¿Se le dificulta entender o hacer lo que pide este aviso, debido a su condición? ¿Se le dificulta obtener otros servicios de la *HRA* debido a su condición? **Nosotros podemos ayudarle.** Utilice el formulario titulado ***Ayuda para las personas con discapacidades*** que le entregamos o que le enviamos con este correo postal. También puede llamarnos al 212-331-4640. Además, puede pedir ayuda cuando visite las oficinas de la *HRA*. La ley le da derecho a pedir este tipo de ayuda.

**USTED TIENE EL DERECHO DE APELAR ESTA DECISIÓN.  
ASEGÚRESE DE LEER LOS DERECHOS DE ENTREVISTA/SOLICITUD PARA LOS  
BENEFICIOS DEL PROGRAMA DE ASISTENCIA DE NUTRICIÓN SUPLEMENTARIA  
Y LA SECCIÓN DE INFORMACIÓN DE CONFERENCIAS Y AUDIENCIAS IMPARCIALES  
DE ESTE AVISO SOBRE CÓMO APELAR ESTA DECISIÓN.**

(Gire la hoja)

**Derechos de entrevista/solicitud para  
los beneficios del Programa de Asistencia de Nutrición Suplementaria (SNAP)**

Usted tiene el derecho de:

- realizar su entrevista de *SNAP* por teléfono.
- pedir una solicitud de beneficios de *SNAP*. Esta oficina debe aceptar la solicitud, siempre que esté firmada y que su nombre sea legible (y su domicilio, si tiene uno).
- presentar una solicitud de beneficios de *SNAP* en persona, por correo, por fax o mediante un representante autorizado. Es posible que se requiera una entrevista.

Si todos los miembros de su hogar actualmente reciben el Ingreso Suplementario de Seguridad (*SSI*) o tienen pensado presentar una solicitud de *SSI*, es posible que usted presente una solicitud de beneficios de *SNAP* en la oficina de Seguro Social, en vez de entregar su formulario de recertificación en el Centro de *SNAP*. Si elige hacer esto, la oficina de Seguro Social también debe recibir su solicitud para la fecha indicada en la **página 3** en la sección de beneficios de *SNAP* de este aviso. Usted será entrevistado(a) y su solicitud y documentos de prueba serán enviados al Centro de *SNAP* para verificar si aún puede recibir dichos beneficios.

**Servicios y otras informaciones**

- ✓ — La oficina de Servicios Sociales puede enviarle información y material educativo sobre planificación familiar por un periodo de hasta 90 días, contando a partir de la fecha indicada en este aviso. La pérdida de los beneficios de Asistencia en Efectivo y de Asistencia Médica resultará en una revisión de su elegibilidad para los servicios sociales, dentro de los 30 días de la fecha de la decisión. Esto no significa que sus servicios terminarán, sino que su elegibilidad para estos servicios tendrá que revisarse. Para más información, favor de comunicarse con su trabajador(a) de caso.
- ✓ — A pesar de que usted tal vez ya no sea elegible para los beneficios de Asistencia en Efectivo, de *SNAP*, o Asistencia Médica, aún puede ser elegible para obtener ayuda con sus gastos de calefacción. Puede averiguar sobre ello enviando una solicitud para el Programa de Asistencia para Energía en el Hogar (*HEAP*). Para obtener información sobre *HEAP*, llame a "HEAP Central" al (800) 692-0557.

(Gire la hoja)

## Información sobre Conferencias y Audiencias Imparciales

### CONFERENCIA

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

### AUDIENCIA IMPARCIAL ESTATAL

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

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

**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 a mano este aviso cuando llame).

**(2) POR ESCRITO:** Envíe una copia ( y guarde una para usted mismo) de todo este aviso, con la sección "Petición de Audiencia Imparcial" completada, a:

**Office of Administrative Hearings  
New York State Office of Temporary and Disability Assistance  
P.O. Box 1930  
Albany, NY 12201**

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

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

**(5) POR INTERNET:** Complete el formulario electrónico entrando a la siguiente página web:  
<http://www.otda.state.ny.us/oah/forms.asp>

(Gire la hoja)



**Qué Puede Esperar de La Audiencia Imparcial:** El Estado le enviará una notificación que le informará sobre cuándo y dónde se llevará a cabo la Audiencia Imparcial. En la audiencia tendrá la oportunidad de explicar por qué considera que nuestra decisión es errónea. Para ayudarlo(a) a presentar su caso, puede traer a un abogado y/o testigos como familiares o amigos, y/o entregarle al Funcionario de la Audiencia todo documento escrito relacionado con su caso; por ejemplo: 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 lo represente. Si tal representante no es abogado, debe proporcionarle una carta para que el Funcionario de la Audiencia sepa que es su representante. Para explicar el caso, usted, su abogado o su representante pueden también interrogar a nuestros testigos o a los suyos durante la audiencia.

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

**ASISTENCIA LEGAL:**

Si necesita asistencia legal gratuita, podría obtenerla si se comunica con la Sociedad de Ayuda Legal (The *Legal Aid Society*) de su localidad o con otro grupo de ayuda legal. Para hallar la Sociedad de Ayuda Legal u otro grupo de ayuda legal más cercano a su domicilio, busque en las Páginas Amarillas (*Yellow Pages*) bajo la palabra *Lawyers* (abogados).

**ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS:** Para prepararse para la audiencia, tiene el derecho de revisar los archivos de su caso. Si nos llama, nos escribe o nos envía su petición por fax, le proporcionaremos copias gratuitas de los mismos documentos de su archivo que se entregarán al Funcionario de Audiencias durante la audiencia imparcial. Además, si nos llama, nos escribe o nos envía su petición por fax, le enviaremos copias gratuitas de aquellos documentos específicos contenidos en su archivo que usted considere necesarios para prepararse. Para solicitar documentos o para averiguar cómo revisar su archivo, llámenos al **(718) 722-5012**, contáctenos por fax 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 solicitarlas con anticipación. Estas se le proveerán dentro de un plazo adecuado antes de la fecha de la audiencia. Los documentos solo se le enviarán por correo si así lo solicita específicamente.

**DISPONIBILIDAD DE MATERIALES DE POLÍTICA:** Las publicaciones sobre la política de la *HRA* y las de la Oficina de Asistencia Temporal y para Discapacitados (*OTDA*) están disponibles para usted y para su representante, ya sea para determinar si se debe solicitar una audiencia imparcial, o para prepararse para la misma. Las publicaciones y manuales de la política de la *OTDA* se publican en el sitio web de la *OTDA* en <http://www.otda.ny.gov/legal>. Además, previa solicitud a la *HRA*, hay disponibles publicaciones y manuales que explican cómo la agencia llegó a su determinación. Para solicitar publicaciones de políticas y manuales, llame al **(718) 722-5012**, envíe un fax al **(718) 722-5018**, envíe un correo electrónico a [CRO@hra.nyc.gov](mailto:CRO@hra.nyc.gov) o escriba a **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, NY 11201**.

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



## PETICIÓN DE AUDIENCIA IMPARCIAL

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

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

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

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

SAMPLE

Nombre en  
letra de  
molde: \_\_\_\_\_ Número de caso: \_\_\_\_\_  
Nombre Inicial 2do Apellido(s)  
Nombre

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

Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código postal: \_\_\_\_\_

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