Human Resources Administration
Department of Social Services

**OFFICE OF POLICY, PROCEDURES, AND TRAINING**
James K. Whelan, Executive Deputy Commissioner

**Stephen Fisher, Assistant Deputy Commissioner**
Office of Procedures

# POLICY DIRECTIVE #18-07-ELI

*(This Policy Directive Replaces PD #15-31-ELI)*

## CHANGE OF RESIDENCE (MOVING) OUT OF NEW YORK STATE

| **Date:** | **Subtopic(s):** |
|---|---|
| April 2, 2018 | Housing Issues, Cash Assistance (CA), Supplemental Nutrition Assistance Program (SNAP) Benefits |

**AUDIENCE**

The instructions in this policy directive are for staff in the Job Centers and informational for all other staff.

**REVISIONS**

This policy directive has been revised to update the Family Independence Administration (FIA) Transportation Unit contact information, and to remind staff that:

- All out of state move requests should be made before the actual move;
- The case must be in a Single Issue/Active (SI/AC) status prior to the referral to the Transportation Unit;
- Before closing the case, the Transportation Unit must be contacted.

**POLICY**

New York City may authorize a move of an applicant/participant to another state or country when it is determined that the applicant/participant:

- Has residence in another state or country;
- Belongs in another state or country;
- Has legally responsible relatives able or willing to support or aid in supporting him/her; or
- Has friends willing to support or aid in supporting him/her.

Refer to PD #01-31

Authorization may also be granted in cases where the welfare of the person requesting the move and the interest of the State will both benefit. The Human Resources Administration (HRA) is responsible for issuing benefits until the applicant/participant physically moves out of the state, at which time the case is closed.

Supplemental Nutrition Assistance Program (SNAP) rules require that all states' Electronic Benefits Transfer (EBT) systems be interoperable so that SNAP applicants/participants in one state or territory can use their EBT cards to access their SNAP benefits while in another state or territory. However, Puerto Rico does not fall under the jurisdiction of the interoperability regulations.

SNAP participants moving to Puerto Rico

For SNAP participants moving to Puerto Rico, the remaining SNAP benefits on the household's EBT card must not be converted to cash benefits. These households will have to reapply for assistance in Puerto Rico.

When an applicant/participant is moving out of the state or out of the country, the cost of the following items may be covered by the Agency:

- Transportation;
- Transfer of baggage; and
- Other reasonable and necessary expenses including lodging and transportation costs of an attendant, but excluding charges for the attendant's time and services.

The cost of shipping furniture to the new state or country is not an allowable expense except in the following circumstances:

- The move is to a less expensive rental property and the amount paid for a security deposit and moving expenses is less than the amount of two years' difference in rentals; **or**
- The move is necessitated by one of the following criteria:
  - A disaster/catastrophe and/or a vacate order is placed against the premises by a health agency or code enforcement agency;
  - A serious medical or physical disability. Such need must be verified by a specific medical diagnosis;
  - The individual or family is rendered homeless as a result of having been put out by another occupant with whom they were sharing accommodations;
  - The move is from temporary to permanent housing;

- The move is from permanent housing to temporary housing due to the unavailability of permanent housing;
- The move is from one temporary accommodation to another temporary accommodation due to the unavailability of permanent housing;
- The move is from an approved relocation site to an approved cooperative apartment; or
- There is a living situation that adversely affects the mental or physical health of the individual or family, and the need for alternative housing is urgent.

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## REQUIRED ACTION

Applicant/Participant comes to the Transportation Unit

When the applicant/participant comes directly to the Transportation Unit at the Job Center #62 to request a moving out of state allowance:

Refer to CD #13-35 and CD #15-14 Revised

- The JOS/Worker will register the application, put the case in SI/AC status, and forward it to the Transportation Unit queue.
- The participant will be referred to the Transportation Unit staff.

The Transportation Unit staff will conduct the interview and complete the process described in the procedure. The Transportation Unit staff will have citywide Paperless Office System (POS) access for all Job Centers.

New

**Note:** All out of state applicants/participants move requests must be made prior to the actual move.

Applicant/Participant comes to the local Job Center

When the applicant/participant comes to the local Job Center and has informed the JOS/Worker of his/her intention to move, the JOS/Worker must:

Authorization of Moving Expenses

- Discuss the move, the applicant/participant's plans for financial maintenance at the new location, and a possible alternate means of financing the move;
- Request documentation as follows:

  - Verification of employment in the new location (statement from the employer with starting date, salary, position);

- A written statement from the primary tenant will be required, as will verification of address (e.g., utility bill), if the applicant/participant will be living with family or friends. If the applicant/participant's move to the home of a family member or friend is temporary until s/he gets his/her own residence, and the move includes his/her furniture and other belongings, the statement from the primary tenant must specify that there is room to accommodate the applicant/participant and his/her belongings;
- A statement from the child care services agency that will be releasing the child/children which indicates to whom and when the child is being discharged;
- Documentation from family court to verify that all parties are consenting to the permanent relocation of the child/children out of the state/country, if there is an order of child support/child visitation in effect;
- If the applicant/participant is a victim of domestic violence include:

    - domestic violence referral
    - current order of protection
    - police/incident reports;

- When an applicant/participant is moving or transferring his/her Section 8 to another state, obtain:

    - the Section 8 voucher (portability voucher)
    - the new Section 8 lease
    - the documentation that the Section 8 apartment passed inspection;

- If eviction is pending, obtain the Order to Show Cause or other housing court documents;

- Instruct the applicant/participant to obtain estimates from three licensed moving companies that agree to be paid once the move is completed. The estimates must be original, itemized, binding and based on visual assessment of items to be moved;
- Verify that the movers are licensed and insured interstate moving companies that are willing to move and deliver the applicant/participant's belongings and abide by the Agency's process of payment. Verification can be obtained by contacting:

    - NY State Department of Transportation, Office of Safety and Security Services at (800) 786-5368 or e-mail at nymoving@dot.state.ny.us; or

- U.S. Department of Transportation, Federal Motor Carrier Safety Administration at (888) 368-7238 or www.safer.fmcsa.dot.gov.

- Contact the new social service district for verification of both the maximum rent allowance and the address at which the applicant/participant can apply for assistance (if applying for Cash Assistance (CA)/SNAP in the new state in that particular district);
- After the estimates from the licensed and insured movers have been verified and all data obtained, request a written approval for the lowest estimate from the Center Director or the Center Director's designee.

POS

If the applicant/participant makes a request for the furniture/moving allowance and meets the established criteria, the JOS/Worker must enter the request in the POS **SI Record Special Grant Requests** window. POS will log in the request for moving allowance on the POS automated Participant Request Control Card (**W-111F**) to track the request.

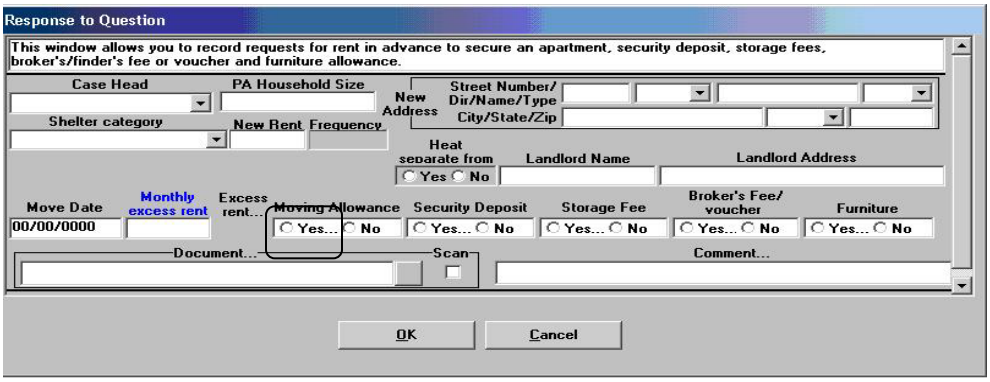
Refer to PD #10-22-SYS

**Note: SI Grant Requests Task List** window appears in the **Application Interview**, **Change Case Data**, **Recertification Interview**, and **Non-Food Emergency Interview** POS Activities.

The JOS/Worker will:

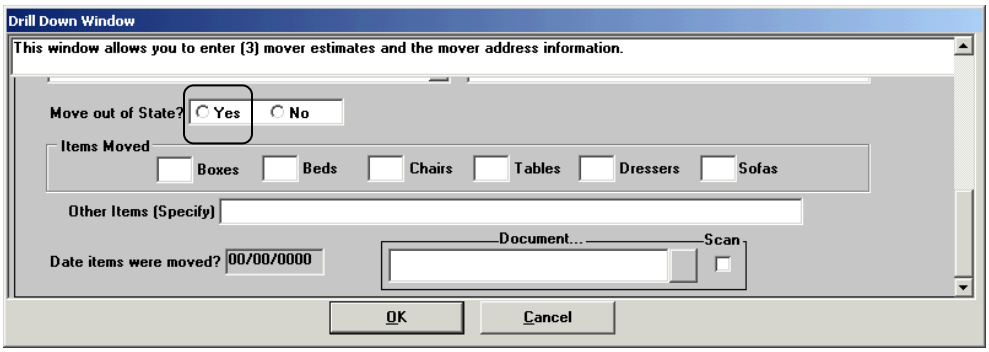
Refer to PD #10-22-SYS for detailed instructions on how to process single issuance grant requests in POS

- Go to the **Task 2** (Record Special Grant Requests) and click **Yes** for the Housing Related Benefits;
- In the **Response to Question** window, click **Yes** for Moving Allowance;




- In the Moving Allowance drill down window indicate that the move is out of State and enter the moving allowance request;

Refer to PB #14-54-SYS




**Note:** If the answer is **Yes** for **Move out of State**, the request does not require a referral to Rental Assistance Unit (RAU). The case is referred to the Transportation Unit. The JOS/Worker sees the following message in the window: *"For moves out of New York State, a referral to the Rental Assistance Unit is not required. A referral to the Transportation Unit is required"*

- Click **OK** and **Next** and the **SI Grant request** window appears;
- Complete **Task 3** (Request Details);
- Complete **Task 4** (EAF/E-SNA and EAA Eligibility Determination);

Refer to PD #10-22-SYS

**Note**: **Task 4** has two possible windows: the **EAF/E-SNA Eligibility Determination** window and the **EAA Financial Eligibility Determination** depending on case category. If an applicant is applying for Emergency Assistance for Adults (EAA), only the **EAA Financial Eligibility Determination** window will appear. If an applicant is applying for Emergency Assistance to Families/Emergency Safety Net Assistance (EAF/E-SNA), Family Assistance (FA), Safety Net Cash Assistance (SNCA), Safety Net Non-Cash Assistance (SNNC) or Safety Net Federally Participating (SNFP), only the **EAF/E-SNA Eligibility Determination** window will appear.

- After completing **Task 1-4**, for active CA cases, The Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137A**) form is automatically prefilled. The JOS/Worker will print the **W-137A** form in **Task 5** (Print Forms for Client to Sign), and capture the participant's signature. No form is required for the applicant.
- Once all signatures are saved, click **Next** to continue. The status of **Task 5** will change to **Completed** and POS will display the updated **SI Grant Requests and Issuance Task List** screen;
- Suspend the **Activity**;
- Prepare the **M-442j** form;

- Create the Transportation Unit referral packet with the following documentation:

The Transportation Unit referral packet

  - the **M-442j** form;
  - the **W-137A** form (for participants only);
  - the three moving estimates;
  - the approval of the lowest estimate on a separate document signed with a person's name and title;
  - the verification that the moving company has met all requirements or a written statement that a collateral contact and verification have been made;
  - all related documents.

- Scan and index the Transportation Unit referral packet into the HRA One Viewer under the Document Type **M-442j**.

(**Note:** make sure that all scanned documents are clear and legible).

New

**Note:** Case must be in a SI/AC status prior to the referral to the Transportation Unit**.**

Send an e-mail to the Transportation Unit

- To inform the Transportation Unit that the referral packet is in the HRA One Viewer, send an e-mail to one of the following contact persons:

  - Michael Dicks, Deputy Center Director, Burial Claims/Transportation Unit, (718) 473-8296, dicksm@hra.nyc.gov;
  - Michele Henry, Supervisor II, Burial Claims/Transportation Unit, (718) 473-8309, henrym@hra.nyc.gov;
  - Martha Barnes, Supervisor, Burial Claims/Transportation Unit, (718) 473-8306, barnesma@hra.nyc.gov.

Revised

If the applicant/participant comes directly to the Transportation Unit, no e-mail is required.

Upon receipt of the documentation, the Transportation Unit will schedule and conduct an in-person interview with the applicant/participant requesting the moving expenses.
Once the interview is completed, the case is forwarded to the Center Director's designee for approval. Upon approval, moving expenses such as transportation and lodging (when appropriate) are provided to the applicant/participant in the form of a voucher.

In most circumstances, transportation is via bus; however, in special circumstances airfare may be provided to the applicant/participant (e.g., cross country or out of country moves).

Approval of the Request

When the cost of moving furniture has been approved, the Transportation Unit will:

- Notify the approved moving company and the JOS/Worker; and
- Contact the applicant/participant via telephone to inform him/her to set up a moving date with the moving company.

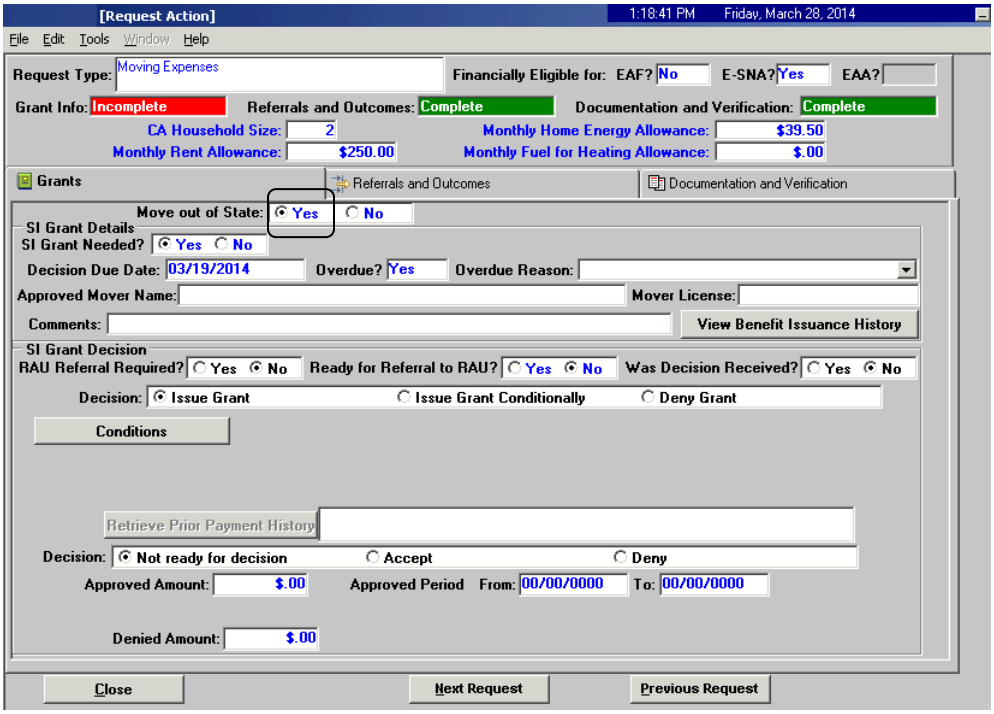
Upon notification of the moving date, the JOS/Worker will:

Refer to PD #10-22-SYS

- Return to the POS Activity that is suspended in his/her queue;
- Access the **SI Grant Requests and Issuance Task List** window; Go to **Task 6** (Outstanding Requests List**)** window and select the moving allowance request;
- Click the **Edit** button to access the **Request Action** screen;

Refer to PB #14-54-SYS

**Note:** POS displays the following message in the **Single Issuance Request Action** window: *"A referral to the Transportation Unit is required for this moving allowance request. A referral to RAU is not required."*




- Click **Yes** for **Was Decision Received?** question;

- If the request is denied, click on the **Deny** radio button in the **Decision** field of the window and record the reason for denial;
- If the request is approved, click on the **Accept** radio button in the **Decision** field of the window and enter the approved amount;
- Enter all required information in the **Request Action** window;
- Enter detailed case comments;
- Complete the **Activity**; and
- Send the case to the AJOS/Supervisor for approval.

The AJOS/Supervisor will:

- Review and approve the case;
- Print either the Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (**W-145HH**) form to notify an applicant of the decision, or the Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (**W-137B**) to notify a participant;
- The **W-145HH** form or the **W-137B** form must be saved in the HRA One Viewer.

Payment for the cost of moving furniture will not be issued to the moving company until the applicant/participant has physically left New York State. The moving company mails an invoice to the Transportation Unit after the move is completed. The Transportation Unit worker processes the required paperwork on the request for payment to the moving company and submits it to the Transportation Unit Director for approval. The contents of the request for payment to the moving company are then submitted to the Finance Office. Payment is sent directly from the Division of Accounts Payable within the Finance Office to the Vendor.

Revised

Closing the Case

The Transportation Unit will inform the JOS/Worker when the applicant/participant actually leaves the state via the Referral/Information Form (**W-34A**). Upon receipt of the **W-34A** form, the JOS/Worker will scan and index it into the HRA One Viewer. The JOS/Worker must ensure that all due benefits have been issued to the applicant/participant, contact the Transportation Unit before closing the case, and then proceed to close the case using CA case closing code **E66** (Not a Resident of the State).

**Note:** If the applicant applied for Emergency Assistance “One-Shot Deal” only, the case should be closed using CA case closing code **Y96** (Case Closed After Being Accepted for Emergency Assistance).

**PROGRAM IMPLICATIONS**

| | |
|---|---|
| POS Implications | POS implications are included in the procedure. |
| SNAP Implications | SNAP benefits will be accessible in the other state via the EBT system. |
| Medicaid Implications | There are no Medicaid implications associated with this procedure. |

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

Staff must obtain appropriate interpretation services for individuals who are Limited English Proficient (LEP) and Deaf or Hard-of-Hearing. Please refer to PD #16-14-OPE and PD #17-19-OPE for detailed instructions.

**FAIR HEARING IMPLICATIONS**

| | |
|---|---|
| Avoidance/ Resolution | To avoid any delay in benefits issuance or incorrect denial of moving expenses, ensure that all case actions are taken as outlined in this policy directive. |
| Conferences | If the participant comes to the Job Center to request a conference because s/he has not received benefits from the “move from” district, the Receptionist must alert the Fair Hearing and Conference (FH&C) Unit that the participant needs to be seen by an AJOS/Supervisor I. If the participant calls the JOS/Worker directly, the JOS/Worker must tell the participant to call the FH&C Unit. In Model Centers, the Receptionist at Main Reception will issue an FH&C ticket to the participant to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.<br><br>The AJOS/Supervisor I will listen to and evaluate the participant’s complaint and contact the “move from” district for instructions. After reviewing the case record and discussing the issue with the Worker and Group Supervisor, the AJOS/Supervisor I will determine if the participant’s complaint can be resolved. The AJOS/Supervisor I is responsible for ensuring that further appeal by the 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 all relevant documentation submitted with the referral to the Transportation Unit, the electronic case record, and any other relevant documentation. |

**RELATED ITEMS**

PD #01-31
PD #10-22-SYS
PB #14-54-SYS
CD #13-35
CD #15-14

**REFERENCES**

01 INF 14
02 INF 39
05-INF-03
18 NYCRR 352.6(a)(1)

**ATTACHMENTS**

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

| | |
|---|---|
| **M-442j** | Referral Summary Form for Applicants/Participants Moving Permanently Out of New York State (Rev. 12/21/15) |
| **W-34A** | Referral/Information Form (Rev. 8/16/10) |
| **W-111F** | Participant Request Control Card (Rev. 09/02/11) |
| **W-137A** | Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Rev. 04/27/17) |
| **W-137A (S)** | Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 04/27/17) |
| **W-137B** | Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Rev. 4/28/17) |
| **W-137B (S)** | Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 4/28/17) |
| **W-145HH** | Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Rev. 01/04/17) |

**W-145HH (S)** Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only) (Spanish) (Rev. 01/04/17)

Form M-442j
Rev. 12/21/15

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

To: FIA's Transportation Unit
25 Chapel Street, 6th Floor, Room #606
Brooklyn, NY 11201

Date: _____

Case Number: _____

From Job Center: _____

Case Name: _____

Current Address: _____

_____

# REFERRAL SUMMARY FORM
## For Applicants/Participants Moving Permanently Out of New York State/Country

**Case Composition:**

| Last Name, First Name | Birth Date |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |
| **6.** | |
| **7.** | |
| **8.** | |
| **9.** | |
| **10.** | |
| **11.** | |
| **12.** | |



Exact address to which applicant/participant requests transportation:

C/O (if applicable) _____ Number _____ Street _____

City _____ State or Country _____ Zip Code _____

Worker _____ Date _____ Phone Number _____

Supervisor _____ Date _____ Phone Number _____

AJOS-II _____ Date _____ Phone Number _____

Form W-34A
Rev. 8/16/10

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

Date: _____

Case Name: _____

Case Number: _____

# Referral/Information Form

☐ Referral ☐ Message ☐ Enclosure ☐ Inquiry ☐ Report

| To (Agency): | From (Agency): |
|---|---|
| ☐ Job Center ☐ Other | ☐ Job Center ☐ Other |
| Attention (Name of Agency Representative): | By (Name of Agency Representative): |

Applicant/Participant Name: _____

Present Address: _____ Telephone Number: _____

_____

_____

City State Zip Code



Subject: _____

Comments:

_____ _____ ☐ Job Center ☐ Other _____ _____

Worker Signature | Worker Title | Telephone Number | Date

_____ _____ _____ _____

Supervisor Signature | Section | Telephone Number | Date

Form W-111F
Rev. 09/02/11

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

# Participant Request Control Card

Job Center No. _____ Group _____ Month _____ Year _____ Page _____ of ____

| | Request Date 1 | No. of Ext. Days 2 | Participant's Name 3 | Case Number 4 | Case-Load 5 | Participant Request | | | | | Action Taken | | Sign Off Date 13 | Req. Iss. Date 14 | Act. Iss. Date 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | H/H Add. 6 | Other Add. Allow (Specify) 7 | Emergencies | | | Approved 11 | Denied 12 | | | |
| | | | | | | | | Shelter 8 | Utility 9 | Other (spec) 10 | | | | | |
| 1 | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | | | |



**Group Total** _____ **Job Center Total** _____

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

Date: _____

Case Name: _____

Case Number: _____

Caseload: _____

Center: _____

Worker Telephone No.: _____

FH&C Telephone No.: _____

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

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



**Remember:**

(1) You may be asked for proof of what you tell us. If you have trouble obtaining proof, your Worker must help you.

(2) You may still need to see your Worker. If you do, you will be given an appointment.

## SECTION I: EMERGENCY ASSISTANCE

**The type of emergency assistance I am requesting is:**

| |
|---|
| |

**The reason I need emergency assistance is:**

| |
|---|
| |

**See next page** ➡

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

## SECTION II: ADDITIONAL ALLOWANCES

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

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

☐ **Expenses related to moving:**

- ☐ Moving expenses
- ☐ Security deposit/agreement
- ☐ Broker's/finder's fee/voucher
- ☐ Furniture and other household items
- ☐ Storage of furniture and personal belongings



New Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

When did you move? _____ New rent: $ _____

Landlord's name: _____

Primary tenant's name: _____

Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

**See next page** ➡

## SECTION III: WORK ACTIVITY-RELATED SUPPORTIVE SERVICES

**I am requesting the following supportive services:**

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

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

## SECTION IV: ADD PERSON TO CASE



**If you do not have all this information, you can still submit this form to your Worker.**
**I want to add the following person(s) to my cash assistance case:**

- ☐ **New Baby**
- ☐ **Child entered home**
- ☐ **Child under 18 years of age** (whose immigrant status has changed since my last application/recertification)
- ☐ **Spouse/Adult living with me** who has not previously applied (this person must complete an application to receive assistance)
- ☐ **Spouse** who previously applied and was denied because of immigration status and his/her status has changed now
- ☐ **Myself/Adult payee to the case**
- ☐ **Other** _____
- ☐ **Other** _____

**Name:** _____ **Name:** _____

**Date moved in/returned:** _____ **Date moved in/returned:** _____

**Date of Birth:** _____ **Date of Birth:** _____

**Social Security Number (if known):** _____ **Social Security Number (if known):** _____

_____ _____ _____ ☐ AM ☐ PM
Participant's Signature Date of Request Time of Request

_____ _____
Worker's Name Date

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

Fecha: _____

Nombre del Caso: _____

Número del Caso: _____

Unidad de Casos: _____

Centro: _____

Núm. Telefónico del Trabajador: _____

Núm. Telefónico de FH&C: _____

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

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

**Recuerde:**

(1) Puede que se le pida comprobante de los datos que usted nos proporcione. Si tiene problemas al obtener pruebas, su trabajador tiene que ayudarle.

(2) Puede que usted aún necesite reunirse con su Trabajador. En tal caso, se le programará una cita.



## SECCIÓN I: ASISTENCIA DE EMERGENCIA

**Solicito el siguiente tipo de asistencia de emergencia:**

| |
|---|
| |

**La razón por la cual necesito la asistencia de emergencia se reseña a continuación:**

| |
|---|
| |

**Vea la próxima página** ➡

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

## SECCIÓN II: ASIGNACIONES ADICIONALES

**Solicito la(s) siguiente(s) asignación(es) para necesidad(es) especial(es):**

- ☐ Alquiler atrasado
- ☐ Reparación de artículos de primera necesidad del hogar
- ☐ Hipoteca y/o impuestos atrasados
- ☐ Asignación para embarazo
- ☐ Asignación para restaurante porque no puedo preparar comidas en donde vivo
- ☐ Asignación para entierros – usted o su representante debidamente autorizado debe solicitar esta asignación en la:
  Burial Claims Unit
  25 Chapel Street, Sala 606
  Brooklyn, NY 11201
  Teléphono: (718) 473-8310
- ☐ Asignación adicional para combustible
- ☐ Reparaciones a la propiedad
- ☐ Reemplazo de ropa perdida debido a desastres tal como falta de albergue o incendio
- ☐ Otras asignaciones:

☐ **Gastos relacionados con la mudanza:**

- ☐ Gastos de mudanza
- ☐ Depósito/acuerdo de garantía
- ☐ Cuota/comprobante de agente
- ☐ Muebles y otros artículos del hogar
- ☐ Almacenamiento de muebles y artículos personales



Nueva Dirección: _____
(con número de apartamento)

_____ _____ _____
Ciudad Estado Código Postal

¿Cuándo se mudó? _____ Nuevo alquiler: $_____

Nombre del casero: _____

Nombre del inquilino principal: _____

Dirección: _____
(con número de apartamento)

_____ _____ _____
Ciudad Estado Código Postal

**Vea la próxima página** ➡

## SECCIÓN III: SERVICIOS DE APOYO RELACIONADOS CON ACTIVIDADES DE TRABAJO

**Solicito los siguientes servicios de apoyo:**

- ☐ Ropa para participantes que realicen actividades relacionadas con la búsqueda de trabajo, que se encuentren en circunstancias **excepcionales**, tales como la carencia de techo o incendio reciente y falta de vestimenta adecuada.
- ☐ Cuota de autorización, relacionada con actividad/participación, de uniformes o bienes duraderos dentro de los límites aprobados, a la hora de presentar la documentación que compruebe la necesidad de dichos artículos.
- ☐ Asignación de cuidado infantil dentro de los límites aprobados, de ser necesario.
- ☐ Transporte público necesario
- ☐ Otros servicios de apoyo relacionados con actividades de trabajo:

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

## SECCIÓN IV: AÑADA A UNA PERSONA AL CASO



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

**Deseo añadir a la(s) siguientes persona(s) a mi caso de Asistencia en Efectivo:**

- ☐ **Recién nacido**
- ☐ **Niño ingresado al hogar**
- ☐ **Niño menor de 18 años de edad (cuyo estado migratorio haya cambiado desde mi última solicitud/recertificación)**
- ☐ **Cónyuge/Adulto que viva conmigo** quien no haya presentado solicitud anteriormente (Para recibir asistencia dicha persona debe llenar una solicitud.)
- ☐ **Cónyuge** quien anteriormente haya presentado solicitud y haya sido rechazado por su estado migratorio, pero dicho estado ya ha cambiado.
- ☐ **Yo mismo(a)/Beneficiario adulto al caso**
- ☐ **Otra Persona** _____
- ☐ **Otra Persona** _____

**Nombre:** _____
**Fecha de mudanza/regreso:** _____
**Fecha de Nacimiento:** _____
**Número de Seguridad Social (de saberlo):** _____

**Nombre:** _____
**Fecha de mudanza/regreso:** _____
**Fecha de Nacimiento:** _____
**Número de Seguridad Social (de saberlo):** _____

_____ _____ _____ ☐ AM ☐ PM
Firma del Participante | Fecha de la Petición | Hora de la Petición

_____ _____
Nombre del trabajador | Fecha

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

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

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

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

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



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

_____

☐ **Your request for _____ has been accepted. You will receive:**

- ☐ One payment in the amount of $ _____ .
  Period covered, if applicable: _____ .

Method of payment:

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

**See next page** ➡

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

☐ **Your request for _____ has been denied because:**

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

☐ Addition to Household § 352.30

☐ Additional Allowance for Fuel § 352.5

☐ Back Mortgage and/or Taxes § 352.7 (g)

☐ Back Rent § 352.7 (g)

☐ Broker's or Finder's Fee/Voucher § 352.6(a)

☐ Catastrophic Loss (replacement of clothing and furniture lost in fire, flood or other disaster) § 352.7(d)

☐ Furniture and Other Household Items § 352.7(a)

☐ Moving Expenses § 352.6(a)



☐ Repair of Essential Household Items § 352.7(b)

☐ Pregnancy Allowance § 352.7(k)

☐ Property Repairs § 352.4(d), § 352.6(e)

☐ Rent Security Deposit/ Letter of Guarantee § 352.6(a)

☐ Work Activity Related Supportive Services § 385.4

☐ Restaurant Allowance § 352.7(c)

☐ Semimonthly Fuel for Heating Allowance § 352.5(b)

☐ Storage of Furniture and Personal Belongings § 352.6(f)

☐ Other (specify): _____

_____ _____
JOS/Worker's Name Date

_____ _____
Supervisor's Name Date

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.**

**See next 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.

**See next page** ➡

**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** 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.

**FAIR HEARING REQUEST**

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

Print Name: _____ _____ _____ Case Number: _____
Name M.I. Last Name

Address: _____

_____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

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

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Centro: _____

Unidad de Casos: _____

Núm. de Teléfono del Trabajador: _____

Núm. de Teléfono de FH&C: _____

# Medida Tomada con Respecto a su Petición de Asistencia de Emergencia, Asignaciones Adicionales, o Añadidura de una Persona al Caso de Asistencia en Efectivo (Sólo para Participantes)

La(s) decisión(es) de la Agencia con respecto a su(s) programa(s) de beneficio(s) se reseña(n) a continuación, junto a la(s) casilla(s) marcada(s) ☒.

El presente sólo corresponde a su solicitud de una asignación adicional para satisfacer determinada necesidad, un cambio en la concesión o una solicitud de asistencia de emergencia. En caso de denegarse su solicitud de asistencia adicional, no se verá afectado su caso de Asistencia en Efectivo continua.



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

| |
|---|
| |

☐ **Se ha aceptado su solicitud de _____. Usted recibirá:**

☐ Un pago en la cantidad de $_____ .

Período de cobertura, si corresponde:_____ .

Método de pago:

☐ Pago/comprobante de agente o intermediario

☐ Cheque a ser recogido por usted en su Centro de Trabajo

☐ Cheque enviado por correo a su hogar

☐ Un suplemento a su concesión pública normal, obtenible mediante el sistema de EBT

☐ Acuerdo de depósito de garantía

☐ Cheque directo al contratista

☐ Otra medida:_____

☐ Usted recibirá un segundo aviso que le informará de cómo se verán afectados sus beneficios continuos.

**Vea la próxima página** ➡

☐ El_____, se le ha enviado a la Unidad de Reclamos de Sepultura en 25 Chapel Street, Sala 606, Brooklyn, NY 11201, (718) 473-8310, para solicitar una asignación de sepultura.

☐ **Se ha denegado su petición de_____ debido a que:**

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

| | | | |
|---|---|---|---|
| ☐ Añadidura de una Persona al Hogar § 352.30 | ☐ Asignación Adicional para Combustible § 352.5 | ☐ Pagos Atrasados de Hipoteca y/o Impuestos § 352.7(g) | ☐ Alquiler Atrasado § 352.7(g) |
| ☐ Pago/Comprobante de Agente o Intermediario § 352.6(a) | ☐ Pérdida Catastrófica (reemplazo de ropa y muebles perdidos en incendio, inundación u otro desastre) § 352.7(d) | ☐ Muebles y Otros Artículos Domésticos § 352.7(a) | ☐ Gastos de Mudanza § 352.6(a) |
| ☐ Reparaciones de Artículos Domésticos Indispensables § 352.7(b) | ☐ Asignación para Embarazo § 352.7(k) | ☐ Reparaciones a la Propiedad § 352.4(d), § 352.6(e) | ☐ Depósito de Garantía de Alquiler/Carta de Garantía § 352.6(a) |
| ☐ Servicios de Apoyo Relacionados con Actividad de Trabajo § 385.4 | ☐ Asignación para Restaurante § 352.7(c) | ☐ Asignación Quincenal de Combustible para Calefacción § 352.5(b) | ☐ Almacenamiento de Muebles y Pertenencias Personales § 352.6(f) |

☐ Otro caso (en concreto):_____



_____ _____
Nombre del JOS/Trabajador Fecha

_____ _____
Nombre del Supervisor Fecha

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

**Vea la próxima página** ➡

# 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) en la **página 1** de este aviso, o escríbanos a la dirección en la **página 1** de este aviso. A veces éste resulta el modo más rápido de solucionar algún problema que tenga. Le recomendamos que así lo haga, aun si ha solicitado una Audiencia Imparcial. En el caso de solicitar una conferencia, usted seguirá teniendo derecho a una Audiencia Imparcial.

## AUDIENCIA IMPARCIAL ESTATAL

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

Si usted no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporaria y para Discapacitados 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 este aviso a la mano al llamar.)

**(2) POR ESCRITO:** Envíe una copia (y guarde una copia para sí) de todo este aviso, con la sección "Petición de Audiencia Imparcial" llenada, a:
**Office of Administrative Hearings**
**New York State Office of Temporary and Disability Assistance**
**P.O. Box 1930**
**Albany, NY 12201**



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

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

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

**Qué Puede Esperar de La Audiencia Imparcial:** El Estado le enviará una notificación que le informará de cuándo y dónde se llevará a cabo la Audiencia Imparcial. En la audiencia, usted tendrá la oportunidad de explicar la razón por la que considera que nuestra decisión es errónea. Para ayudarle a presentar su caso, usted puede traer a la audiencia a un abogado y/o testigos como familiares o amigos, y/o entregarle al Funcionario de la Audiencia cualquier documento escrito relacionado con su caso tal como: talones de paga, contratos de arrendamiento, recibos, cuentas y/o declaraciones médicas, etc. Si no puede acudir a la audiencia, puede enviar a alguien que le represente. Si tal representante no es abogado, usted debe proporcionarle una carta para que el Funcionario de la Audiencia sepa que usted desea que esa persona le represente. Durante la audiencia, usted, su abogado o su representante también pueden interrogar a los testigos por parte nuestra o suya, para aclarar el caso.

**Vea la próxima página** ➡

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

**ASISTENCIA LEGAL:** Si usted necesita asistencia legal gratuita, puede obtener tal asistencia al comunicarse con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede ubicar la Sociedad de Ayuda Legal o grupo de abogacía más cercana al buscar en las Páginas Amarillas (Yellow Pages) bajo "lawyers" (abogados).

**ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS:** Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un fax, le proporcionaremos copias gratuitas de los documentos de su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por fax, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo, llámenos al **(718) 722-5012**, 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. Éstas se le proveerán dentro de un plazo adecuado antes de la fecha de la audiencia. Se le enviarán por correo los documentos sólo si lo solicita específicamente.

**DISPONIBILIDAD DE MATERIALES DE POLÍTICA**

Las expediciones y manuales de la política de la Oficina de Asistencia Temporaria y para Discapacitados (OTDA) y las expediciones de la política y manuales de la HRA están disponibles para usted y su representante para determinar si se debe solicitar Audiencia Imparcial y prepararse para la misma. Las expediciones y manuales de la política de 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 expediciones y manuales que explican cómo la agencia llegó a su determinación. Para solicitar expediciones y manuales de políticas, llame al **(718) 722-5012**, o envíe un fax al **(718) 722-5018**, o envíe correo electrónico a **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, cómo solicitar una Audiencia Imparcial, cómo revisar su archivo o cómo obtener copias adicionales de documentos, llame o escríbanos al número telefónico y/o dirección que aparecen en la **página 1** de este aviso.

**PETICIÓN DE AUDIENCIA IMPARCIAL**

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

En Letras de Molde: _____ (Nombre) _____ (I.) _____ (Apellido) Núm. del Caso: _____

Dirección: _____

_____ Teléfono: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Firma: _____ Fecha: _____

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

Date: _____

Case Number: _____

Case Name: _____

Caseload: _____

Worker Name: _____

Worker Telephone Number: _____

FH&C Telephone Number: _____

# Notice of Decision on Assistance to Meet an Immediate Need or Special Allowance (For Applicants Only)



The Agency's decision(s) regarding your application(s) is/are explained below next to the marked box(es) ☒.

**Immediate Needs**

This notice applies only to your request for assistance to meet an immediate need. If you have also applied for ongoing Cash Assistance, this notice does not affect your application for ongoing Cash Assistance. You will also receive a notice advising you of this Agency's decision on your application for ongoing Cash Assistance when your eligibility has been determined.

If your application for ongoing Cash Assistance is denied for failure to comply with eligibility requirements, a second request for an immediate needs/emergency grant for "no food" or items relating to personal care, filed within three months of the original application denial, may also be denied unless you can document good cause for your original failure to comply.

On _____ , you requested assistance to meet an immediate need of:

| |
|---|
| |

We are giving you this notice to tell you that your request for an immediate needs grant was evaluated and the following decision was made:

☐ An emergency preinvestigation grant in the amount of $ _____ will be available to you on _____. (Date)

☐ An emergency grant (one-shot deal) has been provided in the amount of $ _____ for _____.

☐ A Goodwill Voucher has been provided in the amount of $_____ for _____ on _____. (Date)

☐ If this box is checked, you are responsible for repaying $ _____ as shown:

☐ This amount must be repaid to us in accordance with the agreement to repay that you signed on _____. (Date)

☐ You must repay the amount shown above because it is more than the Human Resources Administration (HRA) shelter maximum of $_____ for your family size of _____ for each month of arrears that HRA agreed to pay.

**Immediate Needs** (Continued)

☐ Assistance to meet a food-related immediate need is denied because you:

- ☐ failed to establish/document identity
- ☐ have excess resources
- ☐ are an undocumented alien
- ☐ received an immediate needs grant in the past 90 days and failed to subsequently comply with eligibility requirements
- ☐ were issued same day SNAP
- ☐ other reason for denial (please specify):

☐ Assistance to meet a nonfood-related immediate need is denied because you:

- ☐ failed to establish/document identity
- ☐ have excess resources
- ☐ are an undocumented alien
- ☐ received an immediate needs grant in the past 90 days and failed to subsequently comply with eligibility requirements
- ☐ applied for Cash Assistance on _____ (within the last three months) and were issued one of the following:
  (Date)
  - ☐ immediate need(s) grant(s)
  - ☐ Goodwill Voucher(s)
  - ☐ other grants (please specify):

and subsequently, failed to comply with the eligibility requirements without good cause. The regulations that allow us to do this are 18 NYCRR § 351.1, § 351.8, and § 352.7.

☐ Other action taken on your application:



**Medical Assistance**

☐ If you need help with your medical bills, you must apply separately for Medical Assistance. If you want more information about eligibility for Medical Assistance, call the Worker's telephone number listed on **page 1**.

☐ Your Medical Assistance stays the same.

☐ Your application for Medical Assistance is being reviewed. We will send you our decision within 30 days.

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION.
BE SURE TO READ THE CONFERENCE AND FAIR HEARING INFORMATION SECTION OF THIS NOTICE FOR HOW TO APPEAL THIS DECISION.**

# Conference and Fair Hearing Section

## CONFERENCE

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

## STATE FAIR HEARING

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

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

**(2) WRITE:** Send a copy (and keep a copy for yourself) of 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 manuals are posted on the OTDA website at **http://www.otda.ny.gov/legal**. These issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. In addition, upon request to your local social services district, specific OTDA policy issuances and manuals will also be available to assist you or your representative.

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

**FAIR HEARING REQUEST**

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

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

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



Print Name: _____ _____ _____ Case Number: _____
Name M.I. Last Name

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Signature: _____ Date: _____

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

Fecha: _____

Número del Caso: _____

Nombre del Caso: _____

Unidad de Casos: _____

Nombre del Trabajador: _____

Núm. de Tel. del Trabajador: _____

Núm. de Tel. de FH&C: _____

# Aviso de Decisión sobre la Asistencia para Satisfacer una Necesidad Inmediata o Asignación Especial (Sólo para Solicitantes)



La(s) decisión(es) de la Agencia respecto a su(s) solicitud(es) se explica(n) a continuación junto a la(s) casilla(s) marcada(s) ☒.

**Necesidades Inmediatas**

Este aviso sólo corresponde a su solicitud de asistencia para satisfacer una necesidad inmediata. Si usted también ha solicitado Asistencia en Efectivo continua, el presente no afecta su solicitud de dicha asistencia. En cuanto se determine su elegibilidad, usted también recibirá un aviso que le informará de la decisión de esta Agencia sobre su solicitud de Asistencia en Efectivo continua.

Si se deniega su solicitud de Asistencia en Efectivo continua por usted no cumplir los requisitos de elegibilidad, puede que también se deniegue una segunda solicitud de concesión de necesidad inmediata/de emergencia para artículos "no alimentarios" relacionados con el cuidado personal, a menos que usted pueda documentar motivo justificado por su incumplimiento inicial de los requisitos de elegibilidad. Esta última solicitud sólo se considerará si se presenta dentro de tres meses tras la denegación inicial de solicitud.

El _____, usted solicitó asistencia para satisfacer una necesidad inmediata de:

| |
|---|
| |

Por el presente le informamos que se ha revisado su solicitud de una concesión para satisfacer necesidades inmediatas y se ha tomado la siguiente decisión:

☐ Una concesión de emergencia de preinvestigación por la cantidad de $_____ estará a su disposición el _____.
(Fecha)

☐ Se le ha otorgado una concesión única de emergencia por la cantidad de $_____ para _____.

☐ Se le ha otorgado un Comprobante de Buena Voluntad de $_____ para _____ el _____.
(Fecha)

☐ Si se marca esta casilla, usted es responsable de reintegrar la suma de $_____ tal como indicado:

☐ Esta cantidad se nos debe reembolsar conforme al acuerdo de reintegro que usted ha firmado el _____.
(Fecha)

☐ Usted debe reembolsar la suma indicada más arriba por ésta ser superior al máximo de albergue de la Administración de Recursos Humanos (HRA) de $_____ para el tamaño de su familia con _____ personas, para cada mes de atrasos que la HRA ha aceptado pagar.

**Necesidades Inmediatas** (Continuación)

☐ Se le ha denegado la asistencia para satisfacer una necesidad inmediata relacionada con la alimentación por usted:

- ☐ no establecer/no documentar su identidad
- ☐ disponder de recursos en demasía
- ☐ ser extranjero sin documentación
- ☐ recibir una concesión para necesidades inmediatas en los últimos 90 días y no cumplir posteriormente los requisitos de elegibilidad
- ☐ haber recibido beneficios de SNAP el mismo día
- ☐ Otro motivo por la denegación (en concreto por favor):

☐ Se le ha denegado la asistencia para satisfacer una necesidad inmediata no relacionada con la alimentación por usted:

- ☐ no establecer/no documentar su identidad
- ☐ disponder de recursos en demasía
- ☐ ser extranjero sin documentación
- ☐ recibir una concesión para necesidades inmediatas en los últimos 90 días y no cumplir posteriormente los requisitos de elegibilidad
- ☐ solicitar Asistencia en Efectivo el _____ (dentro de los últimos tres meses), y haber recibido uno de los siguientes:
  (Fecha)
  - ☐ concesión(es) para necesidades inmediatas
  - ☐ comprobante(s) de Buena Voluntad
  - ☐ otras concesiones (en concreto por favor):

  y posteriormente, usted no cumplió los requisitos de elegibilidad sin motivo justificado. Las reglas que nos permiten tomar esta medida son 18 NYCRR § 351.1, § 351.8, y § 352.7.



☐ Otra medida tomada respecto a su solicitud:

**Asistencia Médica**

☐ Si usted necesita asistencia para saldar las facturas médicas, debe solicitar Asistencia Médica por separado. Si desea más información sobre elegibilidad para Asistencia Médica, llame al número de teléfono del Trabajador en la **página 1**.

☐ Su Asistencia Médica permanecerá sin cambios.

☐ Se está revisando su solicitud de Asistencia Médica. Nos comunicaremos con usted respecto a nuestra decisión dentro de 30 días.

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

# Información sobre Conferencias y Audiencias Imparciales

**CONFERENCIA**

Si usted considera errónea nuestra decisión, 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) en la **página 1** de este aviso, o escríbanos a la dirección en la **página 1** de este aviso. A veces éste resulta el modo más rápido de solucionar algún problema que tenga. Le recomendamos que así lo haga, aun si ha solicitado una Audiencia Imparcial. En el caso de solicitar una conferencia, usted seguirá teniendo derecho a una Audiencia Imparcial.

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

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

**(2) POR ESCRITO:** Envíe una copia (y guarde una copia para sí) de todo este aviso, con la sección "Petición de Audiencia Imparcial" llenada, a:
**Office of Administrative Hearings**
**New York State Office of Temporary and Disability Assistance**
**P.O. Box 1930**
**Albany, NY 12201**

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

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

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



**Qué Puede Esperar de La Audiencia Imparcial:** El Estado le enviará una notificación que le informará de cuándo y dónde se llevará a cabo la Audiencia Imparcial. En la audiencia, usted tendrá la oportunidad de explicar la razón por la que considera errónea nuestra decisión. Para ayudarle a presentar su caso, usted puede traer a la audiencia a un abogado y/o testigos como familiares o amigos, y/o entregarle al Funcionario de la Audiencia cualquier documento escrito relacionado con su caso tal como: talones de paga, contratos de arrendamiento, recibos, cuentas y/o declaraciones médicas, etc. Si no puede acudir a la audiencia, puede enviar a alguien que le represente. Si tal representante no es abogado, usted debe proporcionarle una carta para que el Funcionario de la Audiencia sepa que usted desea que esa persona le represente. Durante la audiencia, usted, su abogado o su representante también pueden interrogar a los testigos por parte nuestra o suya, para aclarar el caso.

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

**ASISTENCIA LEGAL:** Si usted necesita asistencia legal gratuita, puede obtener tal asistencia al comunicarse con la Sociedad de Ayuda Legal (Legal Aid Society) de su localidad u otro grupo legal de abogacía. Usted puede ubicar la Sociedad de Ayuda Legal o grupo de abogacía más cercana al buscar en las Páginas Amarillas (Yellow Pages) bajo "lawyers" (abogados).

**ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS:** Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un fax, le proporcionaremos copias gratuitas de los documentos de su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por fax, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo, llámenos al **(718) 722-5012**, 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. Éstas se le proveerán dentro de un plazo adecuado antes de la fecha de la audiencia. Se le enviarán por correo los documentos sólo si así los solicita específicamente.

**DISPONIBILIDAD DE LOS MATERIALES DE POLÍTICA:** Las expediciones y manuales de política de la Oficina de Asistencia Temporaria y para Discapacitados (OTDA) están publicados en el sitio web de la OTDA en **http://www.otda.ny.gov/legal**. Estas expediciones y estos manuales están disponibles para que usted o su representante determinen si deben solicitar una Audiencia Imparcial o para prepararse para la misma. Además, previa solicitud a su distrito local de servicios sociales, habrá disponibles expediciones y manuales concretos de política de la OTDA, para asistirle a usted o a su representante.

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

**PETICIÓN DE AUDIENCIA IMPARCIAL**

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

Si usted no logra comunicarse con la Oficina del Estado de Nueva York de Asistencia Temporaria y para Discapacitados por teléfono, por fax, en persona o por Internet, favor de solicitar por escrito una Audiencia Imparcial antes de la fecha límite.

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



Nombre en Letras de Molde: _____ _____ _____ Núm. del Caso: _____
Nombre I. Apellido

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____ Teléfono: _____

Firma: _____ Fecha: _____