OFFICE OF POLICY, PROCEDURES, AND TRAINING

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POLICY DIRECTIVE #20-04-ELI

(This Policy Directive Replaces PD #20-01-ELI)

CHANGE OF RESIDENCE (MOVING) OUT OF NEW YORK STATE

Date: June 11, 2020	**Subtopic(s):** 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 reflect clarification of the Office of Temporary and Disability Assistance (OTDA) requirements for moves out of New York State.

POLICY

New York City may authorize a moving out of state allowance to applicants/participants moving to another state or country when it is determined that the applicants/participants:

- Have residence in another state or country;
- Belong in another state or country;
- Have legally responsible relatives or friends able or willing to support or aid in supporting them; and
- Authorization of a moving out of state/country allowance is in the best interest of both the person requesting the move and the State.

Revised

Refer to PD #01-31

The Human Resources Administration (HRA) is responsible for issuing benefits until applicants/participants physically move 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:

Revised

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

New

There is no standard allowance for the above items; therefore, HRA must determine what is reasonable on a case-by-case basis.

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 (i.e. credible claim of domestic violence), and the need for alternative housing is urgent.

Revised

REQUIRED ACTION

Applicant/Participant comes to the Transportation Unit

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

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

- 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 this procedure. The Transportation Unit staff will have citywide Paperless Office System (POS) access for all Job Centers.

Note: All out of state requests for moving allowance must be made prior to the actual move. If the applicant has already moved, they are not entitled to reimbursement.

Applicant/Participant comes to the local Job Center

When applicants/participants come to their local Job Center and inform the JOS/Worker of their intention to move, the JOS/Worker must:

Authorization of Moving Expenses

- Request documentation or make collateral contacts as follows:
  - Verification of employment in the new location (statement from the employer with starting date, salary, position) or if applicant/participant has or will be receiving unearned income (e.g. SSI, SSD);

Revised

- A written statement from the primary tenant will be required, as will verification of address (e.g., utility bill), if the applicants/participants will be living with family or friends. If the applicants/participants' move to the home of a family member or friend is temporary until they get their own residence, and the move includes their furniture and other belongings, the statement from the primary tenant must specify that there is room to accommodate the applicants/participants and their belongings;
- 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;

New

Note: An order of protection or a police/incident report are not necessary if a Domestic Violence Liaison (DVL) has deemed the claim as credible.

- When the applicant/participant is moving or transferring a Section 8 voucher to another state, obtain:

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

- Instruct the applicant/participant to obtain an estimate from a licensed moving company that agrees to be paid once the move is completed. If the moving expenses exceed the maximum amount of the standard allowance for the household size below, three estimates will be needed. Refer to the chart below. The estimates must be original, itemized, binding and based on visual assessment of items to be moved;

HH Size	Amount	Maximum amount
1	$ 900.00	$1,000.00
2	$1,100.00	$1,300.00
3	$1,200.00	$1,325.00
4 persons or more	$1,250.00	$1,350.00

- 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; and
  - Request a written approval for the lowest estimate from the Center Director or the Center Director's designee, if there are three estimates.

Revised

- 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 CA/SNAP in the new state);

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"*

Note: If the moving expenses amount is within the standard allowance (refer to chart on page 5), the three estimates from moving companies are no longer required. In that case enter one estimate amount and mover address information.

Drill Down Window

This window allows you to enter (3) mover estimates and the mover address information.

Mover name
Mover Address | Street Number Dir/Name/Type
1st Estimate .00

Mover name
Mover Address | Street Number Dir/Name/Type
2nd Estimate .00

Mover name
Mover Address | Street Number Dir/Name/Type
3rd Estimate .00

Moving Reason | Moving Detail

Move out of State? Yes No

Items Moved: Boxes, Beds, Chairs, Tables, Dressers, Sofas

Other Items (Specify)

Date items were moved? 00/00/0000 | Document... | Scan

OK | Cancel

- 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);
- one moving estimate, if the moving expenses amount is within the standard allowance (refer to chart on page 4); or
- the three moving estimates and 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).

Note: The case must be in 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:

  - Bernice Cook, Center Director, Transportation Unit, (718) 222-2430, cookb@hra.nyc.gov;
  - Anadina Guerrero, Administrative Assistant to Director, Transportation Unit, (718) 473-8328, guerreroan@hra.nyc.gov;
  - Martha Barnes, Supervisor, Transportation Unit, (718) 473-8306, barnesma@hra.nyc.gov.

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 applicants/participants via telephone to inform them 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 the JOS/Worker's 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."*

[Request Action] 1:18:41 PM Friday, March 28, 2014
File Edit Tools Window Help
Request Type: Moving Expenses Financially Eligible for: EAF? No E-SNA? Yes EAA?
Grant Info: Incomplete Referrals and Outcomes: Complete Documentation and Verification: Complete
CA Household Size: 2 Monthly Home Energy Allowance: $39.50
Monthly Rent Allowance: $250.00 Monthly Fuel for Heating Allowance: $.00
Grants Referrals and Outcomes Documentation and Verification
Move out of State: Yes No
SI Grant Details
SI Grant Needed? Yes No
Decision Due Date: 03/19/2014 Overdue? Yes Overdue Reason:
Approved Mover Name: Mover License:
Comments: View Benefit Issuance History
SI Grant Decision
RAU Referral Required? Yes No Ready for Referral to RAU? Yes No Was Decision Received? Yes No
Decision: Issue Grant Issue Grant Conditionally Deny Grant
Conditions
Retrieve Prior Payment History
Decision: Not ready for decision Accept Deny
Approved Amount: $.00 Approved Period From: 00/00/0000 To: 00/00/0000
Denied Amount: $.00
Close Next Request Previous Request

- 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.

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 until the available balance in the EBT SNAP account is totally withdrawn.
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 #18-10-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 missing 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 participant to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.

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)
18 NYCRR 311.3(a)(1)
18 NYCRR 352.7(o)
Social Services Law section 121

ATTACHMENTS

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. 03/16/2020)
W-137A (S)	Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 03/16/2020)
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. 03/16/2020)
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. 03/16/2020)

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.	

SAMPLE

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

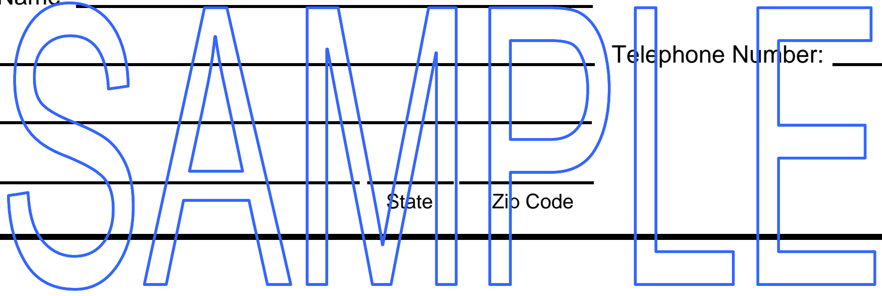
To (Agency):	From (Agency):
☐ Job Center ☐ Other	☐ Job Center ☐ Other
Attention (Name of Agency Representative):	By (Name of Agency Representative):

Applicant/Participant Name: ______________

Present Address: ______________ Telephone Number: ______________

____

City State Zip Code



Subject: ______________

Comments:

______________ Worker Signature

______________ Worker Title

☐ Job Center

☐ Other

______________ Telephone Number

______________ Date

______________ Supervisor Signature

______________ Section

______________ Telephone Number

______________ Date

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

NYC Human Resources Administration
Department of Social Services
Family Independence Administration

Participant Request Control Card

Job Center No. ____________ Group ____________ Month __________ Year ______ Page _________ of ____

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

SAMPLE

Group Total __________ **Job Center Total** __________

Fecha: ______________________

Nombre del caso: ______________________

Número de caso: ______________________

Unidad de casos: ______________________

Centro: ______________________

Teléfono del Trabajador(a): ______________________

Teléfono de FH&C .: ______________________

Petición para la Asistencia de Emergencia, asignaciones adicionales, o para añadir una persona al caso de Asistencia en Efectivo (solo para participantes)

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

Recuerde:

(1) Se le podría pedir prueba de los datos que usted proporcione. Si tiene problemas para obtener las pruebas, su trabajador debe ayudarle con eso.

(2) Podría tener que reunirse con su trabajador de casos. En tal caso, se le programará una cita.

SAMPLE

SECCIÓN I: ASISTENCIA DE EMERGENCIA

Solicito el siguiente tipo de asistencia de emergencia:

La razón por la que necesito la asistencia de emergencia es:

(Gire la hoja)

(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) por necesidad especial:

☐ Alquiler atrasado
☐ Reparación de artículos del hogar de primera necesidad

☐ Hipoteca y/o impuestos atrasados
☐ Asignación para embarazo
☐ Asignación para restaurante porque no puedo preparar comidas donde vivo
☐ Asignación para entierros – usted o su representante debidamente autorizado debe solicitar esta asignación en esta dirección:
Office ofBurial Services
33-28 Northern Boulevard, 3rd Floor
Long Island City, NY 11101
Teléfonos: 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
☐ Comisión del agente inmobiliario/ vale de pago (*voucher*)
☐ Muebles y otros artículos del hogar
☐ Almacenamiento de muebles y artículos personales

SAMPLE

Nueva dirección: ______________________________
(incluya número de apartamento)

______________ ______________ ______________
Ciudad Estado Código Postal

¿Cuándo se mudó? ____________________ Nuevo alquiler: $__________

Nombre del arrendador: ______________________________

Nombre del inquilino principal: ______________________________

Dirección: ______________________________
(incluya número de apartamento)

______________ ______________ ______________
Ciudad Estado Código Postal

(Gire la hoja)

SECCIÓN III: SERVICIOS DE APOYO RELACIONADOS CON ACTIVIDADES DE TRABAJO

Solicito los siguientes servicios de apoyo para:

☐ Vestimenta para los participantes que realicen actividades relacionadas con la búsqueda de trabajo, que se encuentren en circunstancias **excepcionales**, tales como la falta de vivienda o incendio reciente y falta de vestimenta adecuada.

☐ Actividad/participación relacionada con obtener alguna licencia, uniformes o alguna tarifa de bienes duraderos, dentro de los límites aprobados, a la hora de presentar documentación que compruebe la necesidad de dichos artículos.

☐ Asignación para cuidado infantil dentro de los límites aprobados, de ser necesario.

☐ Transporte público necesario

☐ Otros servicios de apoyo relacionados con actividades de trabajo:

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

SECCIÓN IV: AÑADIR UNA PERSONA AL CASO

SAMPLE

Usted puede presentar este formulario a su trabajador de casos aunque no tenga toda la información necesaria.

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

☐ **un recién nacido**

☐ **un menor que se ha integrado al hogar**

☐ **un menor de 18 años de edad** (cuyo estado migratorio ha cambiado desde mi última solicitud/recertificación)

☐ **un cónyuge/adulto que vive conmigo** quien no haya presentado solicitud anteriormente (para poder recibir asistencia dicha persona debe rellenar una solicitud)

☐ **un cónyuge** quien anteriormente haya presentado solicitud y haya sido rechazado por su estado migratorio, pero dicho estado ya ha cambiado.

☐ **a mí mismo/adulto beneficiario del 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):____________________

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

______________________ Worker's Name ______________ Date

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.

SAMPLE

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

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

☐ One payment in the amount of $ _________________________ .
Period covered, if applicable: ___________________________ .

How we will pay:

☐ Broker's or finder's fee/voucher paid to broker/finder

☐ You must pick up check at your Job Center

☐ Check mailed to your home

☐ We will add it to your regular Cash Assistance grant which you can get through the EBT system

☐ Security deposit/agreement/ voucher paid/provided to landlord

☐ Check sent directly to landlord/vendor

☐ Other action:
____

☐ You will receive a second notice informing you as to how your ongoing benefits will be affected.

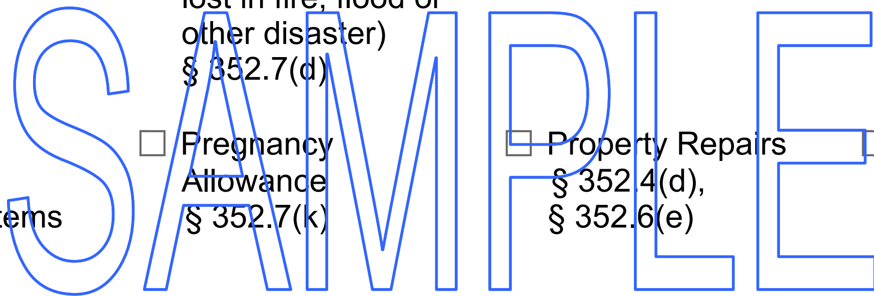
(Turn page)

☐ On _______________, you were referred to the Office of Burial Services at 33-28 Northern Boulevard, 3rd Floor, Long Island City, NY 11101, (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/ Agreement § 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

(Turn page)

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.

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.

SAMPLE

(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.

SAMPLE

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**

(Turn page)

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."

SAMPLE

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.

(Turn page)

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:________________

SAMPLE

Department of Social Services
Human Resources Administration
Department of Homeless Services

Family Independence Administration

Fecha: ______________________

Número de caso: ______________________

Nombre del caso: ______________________

Centro: ______________________

Unidad de casos: ______________________

Teléfono del trabajador: ______________________

Teléfono para programar conferencias FH&C: ______________________

Medida tomada en cuanto a su Petición para la Asistencia de Emergencia, las asignaciones adicionales o para añadir a personas al caso de Asistencia en Efectivo (solo para participantes)

A continuación, se ofrece la explicación (junto a la casilla marcada con ☒) sobre la decisión de la Agencia en cuanto a su(s) programa(s) de beneficio(s).

Este aviso solo se aplica a su petición para recibir una asignación adicional, con el fin de satisfacer una necesidad especial, de cambiar algún subsidio o alguna solicitud para la asistencia de emergencia. Si se niega la petición para recibir asistencia adicional, su caso continuo de Asistencia en Efectivo no se verá afectado.

SAMPLE

El día ______________________ , usted pidió:
(Fecha)

☐ Asistencia de emergencia

☐ Asignación adicional para:

☐ Su petición para ______________________ **ha sido aceptada. Usted recibirá:**

☐ Un pago de $ ______________________ .

Plazo de tiempo cubierto, si corresponde: ______________________ .

Cómo se hará el pago:

☐ Por vale/comisión, a nombre del agente inmobiliario o del intermediario

☐ Por cheque, a ser recogido en su centro de trabajo

☐ Por cheque, enviado a su vivienda

☐ Por medio del sistema de la tarjeta EBT, añadido a su Asistencia en Efectivo normal

☐ Por medio del depósito de seguridad/contrato/vale de pago/entregado al arrendador

☐ Por cheque, enviado directamente al arrendador/representante

☐ Otra medida:

____

☐ Usted recibirá un segundo aviso informándole cómo se verán afectados sus beneficios continuos.

(Gire la hoja)

☐ El día _______________, usted fue referido para que solicitara la asignación para entierros en la Oficina de Servicios para Entierros (Office of Burial Services), ubicada en el 33-28 Northern Boulevard, 3rd Floor (3er piso), Long Island City, NY 11101, teléfono (718) 473-8310.

☐ **Su petición para ____________________________________ ha sido rechazada porque:**

La(s) ley(es) y/o el reglamento que nos permite hacer esto es el artículo 18 NYCRR (favor de ver a continuación las secciones (§) del reglamento que aplican):

☐ Adición al hogar § 352.30

☐ Asignación adicional para combustible § 352.5

☐ Hipoteca y/o impuestos atrasados § 352.7 (g)

☐ Alquiler atrasado § 352.7 (g)

☐ Comisión del agente inmobiliario o del intermediario/vale de pago § 352.6(a)

☐ Pérdida por catastrófe (reemplazo de ropa y muebles destruidos por fuego, inundación u otro tipo de desastre) § 352.7(d)

☐ Muebles y otros artículos del hogar § 352.7(a)

☐ Gastos de mudanza § 352.6(a)

☐ Reparación de artículos esenciales para el hogar § 352.7(b)

☐ Asignación para el embarazo § 352.7(k)

☐ Reparaciones a la propiedad § 352.4 (d), § 352.6(e)

☐ Depósito de seguridad/ contrato de alquiler § 352.6(a)

☐ Actividad de trabajo relacionada a los Servicios de Apoyo § 385.4

☐ Asignación para restaurantes § 352.7(c)

☐ Asignación quincenal de combustible para calefacción § 352.5(b)

☐ Almacenamiento de muebles y artículos personales § 352.6(f)

☐ Otro (especifique):

____

_______________________________________ _______________
Nombre del trabajador(a)/JOS Fecha

_______________________________________ _______________
Nombre del supervisor(a) Fecha

(Gire la hoja)

SAMPLE

¿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**. Llámenos al 212-331-4640. También 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 LA SECCIÓN ADJUNTA A ESTE AVISO SOBRE CONFERENCIAS Y DERECHOS DE APELACIÓN ADMINISTRATIVA PARA SABER CÓMO APELAR ESTA DECISIÓN.

SAMPLE

(Gire la hoja)

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

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 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.

SAMPLE

(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 consigo 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

(Gire la hoja)

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, tal como 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).

SAMPLE

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 MATERIALES DE POLÍTICA: Las expediciones 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 determina si se debe solicitar una 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 solicitai expediciones de políticas y manuales, 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 oi 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.

(Gire la hoja)

PETICIÓN DE AUDIENCIA IMPARCIAL

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

Nombre en letra de molde: ________________ ________ __________________________ Número de caso:_______

Nombre Inicial 2do nombre Apellido

Dirección: ____

____ Teléfono:______________

Ciudad: ________________ Estado: ______ Código postal: ____________

Firma: ____ Fecha: ________________

SAMPLE

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)

SAMPLE

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 ____________ (Date) (within the last three months) and were issued one of the following:
  - ☐ 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.**

SAMPLE

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**

SAMPLE

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:**

SAMPLE

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)

SAMPLE

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 ____________ (Fecha) (dentro de los últimos tres meses), y haber recibido uno de los siguientes:
  - ☐ 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.

SAMPLE

☐ 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**

SAMPLE

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:**

SAMPLE

Nombre en Letras de Molde: ______________________ ______ ______________________ Núm. del Caso: ______________
Nombre I. Apellido

Dirección: ____

Ciudad: ______________ Estado: ______ Código Postal: ______________ Teléfono: ______________

Firma: ____ Fecha: ______________