



OFFICE OF POLICY, PROCEDURES, AND TRAINING

POLICY DIRECTIVE #24-01-ELI

ONE-TIME SIX MONTH EARNED INCOME DISREGARD

Date: January 22, 2024	Subtopic(s): Cash Assistance Budgeting, SNAP Budgeting
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HAVE QUESTIONS ABOUT THIS PROCEDURE?

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AUDIENCE

This policy directive is for the Benefits Access Centers (BAC), Special Projects Center staff, and is informational for all other staff.

Note: A procedure for HIV/AIDS Services Administration (HASA) will be issued under separate cover.

PURPOSE

The purpose of this policy directive is to inform staff of changes to SSL section 131-a(8)(a) as authorized by Part X of Chapter 56 of the Laws of 2023 (SFY 2023-24 New York State Budget) and to provide guidance for implementation. These changes went into effect on December 29, 2023.

POLICY

Cash Assistance (CA) participants who are seeking employment or training opportunities often face barriers to economic security as any increase in income may disqualify them from receiving benefits. The State Fiscal Year (SFY) 2023-24 New York State Budget, enacted on May 3, 2023, created new income disregard provisions designed to support CA participants who start new jobs or participate in employment and training activities by allowing them to earn more income while retaining access to CA and other support services.

The SFY 2023-24 State Budget established a new disregard on all earned income that a CA participant gets from participation in a qualified work activity or training program, provided the individual's overall income does not exceed 200% of the Federal Poverty Level (FPL) for their household size. This disregard does not apply to Supplemental Nutrition Assistance Program (SNAP) benefits.

The SFY 2023-24 State Budget will also disregard all earned income of a CA participant following a new job for a maximum of six consecutive months, once per lifetime, provided that the individual's overall income does not exceed 200% of the FPL for their household size. Following the six-month period, regular budgeting of income for purposes of CA eligibility would apply. This disregard does not apply to SNAP benefits.

BACKGROUND

Both the training income disregard and one-time 100% employment income disregard apply only to CA participants and cannot be used for applicants. A participant is defined as an individual who submitted an application for CA or had someone else submit an application for CA on their behalf, and who has been determined eligible for CA. The definition of household size for the purpose of applying the 200% FPL includes all individuals who are active on the CA case.

Training and Work Activity Income Disregard Implications

Provided that the individual's total gross income is not more than 200% of the FPL for their household size, all of the earned income of a CA participant from participation in the following training or work activities is now exempt and must be disregarded as income or resources in determining eligibility or budgeting CA benefits:

- Subsidized Employment;
- Work Experience;
- Job Search;
- Vocational Education;
- Secondary School;
- Job Skills Training;
- Educational Training;
- Job Readiness Training;
- Community Service; and
- On-the-Job Training.

All training activities must be approved work activity assignments consistent with the participant's Employment Assessment (EA) / Employment Plan (EP) in order for the participant to be eligible for the training income disregard.

CA participants in the Transitional Employment Advancement Program (TEAP) are not eligible for either the training income disregard or the one-time 100% employment income disregard.

Staff are encouraged to consider grant diversion if it will help improve the CA participant's employability as they complete an approved training program and advance toward greater economic security. Refer to [09-ADM-11](#) for more information. This may be helpful for CA participants who have already used their one-time 100% six-month employment disregard and need additional supports in obtaining sustained employment.

One-Time 100% Employment Income Disregard Implications

The one-time 100% earned income disregard (EID) allows staff to disregard all of the individual's income earned from employment when determining eligibility or level of CA benefits, provided that it be for no more than six consecutive months from the initial date the new budget is authorized and that the individual's overall total gross income shall not be more than 200% of the FPL for their household size.

Note: The 100% EID does not apply to the earned income of individuals who are not active members of the CA portion of the case. For example, ineligible non-citizen legally responsible relatives and non-legally responsible care takers on child only cases.

Any new job, including multiple new jobs gained during the six consecutive month period, will be eligible for the one-time 100% employment disregard, if the individual's overall total gross income is not more than 200% of the FPL for their household size.

***Example:** David receives CA and gets a new job. David timely reports their updated income due to the new job to DSS/HRA. Staff reviews David's income and determines they are eligible for the 100% EID beginning July 1. Staff will not include David's income in their CA case for six months so they can save money and catch up on bills.*

Once initiated, the disregard period will follow the participant if they move, as long as the individual's total gross income does not exceed 200% of the FPL for their household size.

The six-month employment exemption only applies to new employment and cannot be applied retroactively to a job that started before December 29, 2023.

The six-month 100% employment income disregard period cannot be used nonconsecutively and if a participant leaves their employment during this time, even if no fault of their own, the period will continue to count down. If the individual is able to find a new job while the exemption period is still counting down, their income from that job would be given the disregard for however much of the six-month time period remains upon job entry, as long as the individual's total gross income does not exceed 200% of the FPL for their household size. Likewise, if the participant were to receive a raise in income, more hours, or an additional job or jobs that resulted in the individual's income increasing to over 200% FPL for their household size during the course of the six months, they would no longer be eligible for the 100% disregard, though the period would continue to count down. Their full earnings would be budgeted using normal CA budgeting procedures once they became ineligible for the 100% disregard.

The six-month 100% disregard period for new employment applies once per lifetime for the individual, not once per household. More than one participant on a case can participate in the disregard and have it applied to their new income at the same time or during overlapping periods. In addition, one individual can receive both the training and work activity income disregard and the one-time 100% employment income disregard at the same time as long as the individual's total gross income does not exceed 200% of the FPL for their household size.

REQUIRED ACTION

Training and Work Activity Income Disregard

When a CA participant reports income from a qualified training or work activity, staff will first need to determine whether the program is a qualified activity for the income exemption. Then, if it is a qualified training or work activity, staff must determine whether the individual's total gross income is at or below 200% of the FPL for their household size. All training activities must be an approved work activity assignment consistent with the participant's EA/EP in order for the participant to be eligible for the training income disregard.

The training or work activity does not have to start after December 29, 2023 to qualify for the training income disregard. However, just the income received from the training or work activity on or after December 29, 2023 is eligible for the training income disregard.

The training or work activity income disregard is not limited to six months only and is not a one-time income disregard (i.e., once per lifetime).

Below are examples showing how the training income disregard is applied.

Example - Initial Training Earnings

John Smith is a CA recipient. On January 4, 2024, John starts a subsidized training program. John receives their first paycheck on January 18, 2024, which they report to DSS/HRA on January 24, 2024. Staff reviews John's income and determines that their income is at or below the 200% FPL for their household size and that the training is a qualified training. John's training income disregard begins February 1, 2024.

Example - Increased Training Earnings

John has been working part-time at the subsidized training. On March 1, 2024, John begins working full-time in the subsidized training. John reports this to DSS/HRA on March 8, 2024, and receives their first increased paycheck the same day. Staff reevaluates John's eligibility for the training income disregard starting April 1, 2024. John's increased earnings still result in their total gross income being at or below the 200% FPL calculation for their household size, so they are able to continue receiving the training income disregard.

One-Time 100% Employment Income Disregard

Eligibility for the one-time 100% employment income disregard should be determined when a CA participant first provides proof of their income from a new job. If the total gross income of the participant is at or below the 200% FPL for their household size, the individual is eligible for the six-month disregard if they had not previously received it. There is no minimum number of hours that a participant must work to be eligible for the employment disregard. Refer to **Attachment A** (One-Time Six Month 100% Earned Income Disregard Information) for information on what the disregard is and some examples of how it is applied.

For the one-time 100% employment disregard, the six consecutive months begins with the first monthly or semi-monthly CA budget after the participant submits their first paystub, or other documentation verifying their income.

Processing Staff Responsibilities

Step 1 Processing staff should apply the one-time six month 100% EID to all CA participants that report new employment which began on or after December 29, 2023 and submits proof.

If the CA participant reports income without submitting proof, the BAC will defer the participant with the Documentation Requirement and/or Assessment Follow-Up form (**W-113K**).

Step 2 Refer to the fillable calculation toolkit (**FIA-1269**) for the 200% Federal Poverty Level Check.

Note: Processing staff must index a screenshot or pdf file of the calculation toolkit (**FIA-1269**) to the case record.

Step 3 Determine the individual’s eligibility for the 100% EID. The total gross income (all earned and unearned income) belonging to the individual who is eligible for the 100% EID program must be compared against the 200% FPL for the total household size of the case.

ELIGIBLE FOR 100% EID If the individual’s total gross income is at or below the 200% FPL standard for the household size, then the individual is eligible for the 100% EID.

Refer to **Attachment B** Processing staff will review pay stubs and calculate the monthly income budget in the Paperless Office System (POS).

Refer to **Attachment B** (CA Budget Calculation with End Effective Date in POS) for screenshots of putting an end date in POS to create the expiring budget.

Processing staff will complete the EID eligible POS budget with income applied for CA and SNAP (Program Indicator **B**). Processing staff must not authorize the eligible budget. They must write a case comment with the provisional budget number, gross income amount, pay frequency, and line number of the employed individual. Budgets are stored in the Welfare Management System (WMS) for up to 13 months. Processing staff must scan and index the Budget Results Screen (**NSBL80**) for this budget to the case file for documentation purposes.

Designated EID liaisons will enter any cases that are eligible for the 100% EID onto an online form ([Earned Income Disregard Form](#)) which will automatically create a SharePoint list to be reviewed and processed by the Special Projects Center staff. Refer to the [Special Projects Center Responsibilities and SharePoint Form](#) section.

For households eligible for the 100% EID, a manual notice will be prepared explaining that the employment income is EXEMPT for CA budgeting purposes for a period of six months but both the employment income or training income is countable earned income for SNAP budgeting purposes. Refer to the [Issuing the Manual Notice](#) section.

INELIGIBLE FOR 100% EID

If the individual's total gross income is above the 200% FPL standard for the household size, then the individual is ineligible for the 100% EID.

Processing staff will create a new budget for the case and enter the earned income associated with the individual on the **NSBL06** screen using Program Indicator 'B' (both CA and SNAP). The income is not eligible for the 100% EID and must be counted towards both CA and SNAP.

If the household is ineligible for CA, processing staff must authorize the ineligible budget. They must write a case comment with the budget number, gross income amount, pay frequency, action taken on the case (i.e., case closed due to excess income), and line number of the employed individual. The applicable BAC will process the required action.

Note: Households that reside in temporary housing that have the full cost of their shelter included in their CA standard of need may be eligible for CA even if an individual in the household has gross income in excess of 200% of the FPL for their household size.

Special Projects Center Responsibilities and SharePoint Form

HRA will maintain a SharePoint list of all individuals who are participating in one of the 100% EID programs. This file will be requested by OTDA once system changes are made in order to properly identify participants of either program and to enter this information into WMS.

The SharePoint Form will be managed by the Special Projects Center (SPC).

The SharePoint form contains the following fields:

- Number of Adults with newly reported Earned Income in the Cash Assistance household (income earned on or after 12/29/2023)
- How many people are in the Cash Assistance household?
- Case Number
- First Name (1st Adult on the Case)
- Last Name (1st Adult on the Case)
- Client Identification Number (CIN number) (1st Adult on Case)
- Is the individual's income below 200% of FPL based on Federal Poverty Guidelines (**FIA-1269**)?
- Monthly Gross Income (1st Adult on Case)
- Amount of Earned Income Reported (1st Adult on Case)
- Date Earned Income Reported (1st Adult on Case)
- Earned Income Documentation Submitted? (verify in Viewer before submitting a response of "yes")

Special Projects Center staff will review documents and budget the EID eligible cases for SNAP only. The 'from date' and 'to date' (six months out) must be entered in the budgeting screen.

Special Projects Center staff will create a new budget for the case and enter the earned income with the individual on the **NSBL06** screen using Program Indicator '**F**' (SNAP Only). This will ensure that the income is counted for SNAP only and disregarded for CA. (Only enter Program Indicator '**F**' with the training income or new job income that is intended to be used for the 100% EID program. Any other income must be budgeted per current budgeting methodologies.) Program Indicator '**F**' must be used even if the individual is currently in CL, RJ, or NA status for SNAP.

- Use income source code '**01** – Salary, Wages' for those individuals who are eligible for the one-time consecutive six-month 100% EID.
- Use income source code '**02** – On the Job Training' for individuals in receipt of training/internship income.

Eligible cases will be assigned to BAC 80 for the six-month period.

These cases will be re-budgeted at the end of the six-month period, once the 100% EID expires. Staff will use the **WINR0750** (PA/FS Cases With End Of Month Expiring Authorizations Center Report) for the cases that need to be re-budgeted. The **WINR0750** is used for expiring budgets and is attached as an example.

Vendor Referrals to the Special Projects Center

Special Projects Center staff will pull a worklist from Self-Sufficiency, Employment, Assessment, and Management System (SEAMS) of the participants who reported new income after December 29, 2023.

Special Projects Center staff will review the cases and determine eligibility for the 100% EID program. They must ensure the employment or training start date is on or after December 29, 2023 and use the fillable calculation toolkit (**FIA-1269**) to determine the 200% FPL for the household size.

Note: Special Projects Center staff must index a screenshot or pdf file of the calculation toolkit (**FIA-1269**) to the case record.

ELIGIBLE FOR 100% EID

Special Projects Center staff will enter any cases that are eligible for the 100% EID onto an online form ([Earned Income Disregard Form](#)) which will automatically create a SharePoint list to be reviewed and processed by the Special Projects Center / BAC 80 staff.

INELIGIBLE FOR 100% EID

If ineligible for the 100% EID, the Associate Job Opportunity Specialist (AJOSI) will approve the case for **FIA3A** automated budgeting. The applicable BAC will process the required action.

Using the cases from the SharePoint form, Special Projects Center staff will review documents and budget the EID eligible cases for SNAP only. The 'from date' and 'to date' (six months out) must be entered in the budgeting screen.

Eligible cases will be assigned to BAC 80 for the six-month period.

These cases will be re-budgeted at the end of the six-month period, once the 100% EID expires. Staff will use the **WINR0750** for the cases that need to be re-budgeted.

Suppressing the Client Notices System (CNS) Notice

Refer to [PB #09-38-SYS](#) for more information

When authorizing the new budget, staff must suppress the CNS notice as CNS has not yet been updated to account for the new EID. To suppress the CNS notice, SPC staff must use an **M3E** indicator field on the POS Turn-Around Document (TAD):

- The **A** (Manual Notice – Adequate) indicator is used when a timely 10-day notice is not required (e.g., no changes to the CA or SNAP benefits resulting from a new budget). The intended action will take effect immediately.

- The **T** (Manual Notice – Timely) indicator is used when an intended case action requires that the affected participant be informed a minimum of 10 days prior to taking the action. This gives the participant an opportunity to resolve the issue before the adverse action takes effect. This must be used when the SNAP benefit amounts decrease on a CA case.

To determine if the **A** or **T** is required, staff must determine if the new budget impacting SNAP only results in a decrease in benefits from the current budget, if so, then a **T** must be entered to ensure a timely clock down. If there is no change in the SNAP, or if it results in an increase in SNAP, then an **A** should be used to ensure that the action goes into effect immediately.

When the **A** or **T** indicator is entered to suppress the CNS notice, staff must issue a manual notice.

Issuing a Manual Notice

For active CA cases where either the training income disregard or one-time employment income disregard is being applied, the appropriate manual notice must be provided, including an explanation that the income from new employment or approved training or work activity is exempt for CA budgeting.

The manual notices include:

- Action Taken On Your Recertification: Public Assistance, Medical Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (NYC) (**LDSS-4014A/B-NYC**),
- Notice of Intent To Change Benefits: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Timely & Adequate) (NYC) (**LDSS-4015A/B NYC**), or
- Notice of Intent To Change Benefits: Public Assistance, Medical Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Adequate Only) (NYC) (**LDSS-4016A/B NYC**).

The **LDSS-4014A/B-NYC** is used only if the transaction is part of a recertification. If the results of the recertification are a reduction in benefits, then the **T** must be used in the M3E indicator field. If there is no change, or an increase in benefits, the **A** must be used in the M3E indicator field.

The **LDSS-4015A/B NYC** should be used if the resulting budget leads to a reduction in benefits and is not done at recertification. This should be accompanied by a **T** in the M3E indicator field.

The **LDSS-4016A/B NYC** should be used if the resulting budget has no change in benefits or if there is an increase in benefits. This should be accompanied by an **A** in the M3E indicator field.

The notices have been made fillable PDFs and are available on eDocs. Staff are reminded that if a participant has a reading language other than English and the notice is available in their preferred reading language, both the English and the other language version must be completed and sent to the participant.

**PROGRAM
IMPLICATIONS**

Paperless Office
System (POS)
Implications

The above process is an interim solution until systems support can be developed to assist staff with implementation of these new disregards. Staff are required to process cases as directed above until additional system enhancements are deployed.

Supplemental
Nutrition Assistance
Program
Implications

The income disregard provisions outlined in this policy directive only impact CA budgeting and do not apply to the SNAP portion of a CA/SNAP case or to non-cash assistance (NCA) SNAP cases. Therefore, all countable gross income must be determined and included in the SNAP budgeting process. SNAP households will continue to receive a 20% Earned Income Deduction from their gross earned income, which is intended to compensate for work-related expenses, union dues, taxes, transportation and other expenses. The CA grant, and increased income from either the one-time 100% employment income disregard or training income disregard, must both be counted in full in the SNAP budget and, in some cases, may cause the SNAP portion of the case to close due to excess income.

Households where all members are in receipt of either Supplemental Security Income (SSI) or CA benefits are categorically eligible for SNAP and are not subject to a resource or Net Income Test for SNAP, having already passed these tests for receipt of CA.

Households of one or two people who meet the categorical eligibility standards are automatically eligible for the minimum SNAP benefit for a household of one or two. There is no such standard for households of more than two individuals, and so the benefit calculation for a household of more than two people can yield a benefit of \$0. This is why it is possible to be “categorically eligible” for \$0 in SNAP benefits (and therefore ineligible for SNAP).

Medicaid
Implications

CA participants with either the training income or the one-time employment income disregard would remain eligible for MA.

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

Staff must obtain appropriate interpretation services for individuals who are Limited English Proficient (LEP) or deaf or hard-of-hearing. Please refer to **PD #18-10-OPE**, **PD #17-19-OPE** and **DSS-PB #2021-007 (R1)** for detailed instructions.

FAIR HEARING IMPLICATIONS

Avoidance/
Resolution

Ensure that all case actions are processed in accordance with current procedures and that electronic case files are kept up to date. Remember that applicants/participants must receive either adequate or timely and adequate notification of all actions taken on their case.

Conferences

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

The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the applicant/participant, review the case file and discuss the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker’s Supervisor. The AJOS/Supervisor I will explain the reason for the Agency’s action(s) to the applicant/participant.

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

Evidence Packets All Evidence Packets must contain a detailed history, e.g. copies of POS “Case Comments” and/or New York City Work, Accountability and You (NYCWAY) “Case Notes” screens, copies of relevant WMS screen printouts, notices sent, and other documentation relevant to the action taken.

REFERENCES [23-ADM-10](#)
[09-ADM-11](#)

RELATED ITEMS [PB#09-38-SYS](#)
[PD#14-02-SYS](#)
[PD#23-05-ELI](#)

ATTACHMENTS	Attachment A	One-Time Six Month 100% Earned Income Disregard Information
	Attachment B	CA Budget Calculation with End Effective Date in POS
	FIA-1269	200% FPL Check (12/22/2023)
	LDSS-4014A-NYC	Action Taken On Your Recertification: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (NYC) (Rev. 12/23)
	LDSS-4014B-NYC	Action Taken On Your Recertification: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (NYC) (Rev. 12/23)
	LDSS-4015A-NYC	Notice of Intent To Change Benefits: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Timely & Adequate) (NYC) (Rev. 12/23)
	LDSS-4015B-NYC	Notice of Intent To Change Benefits: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Timely & Adequate) (NYC) (Rev. 12/23)

LDSS-4016A-NYC	Notice of Intent To Change Benefits: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Adequate Only) (NYC) (Rev. 12/23)
LDSS-4016B-NYC	Notice of Intent To Change Benefits: Public Assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Coverage and Services (Adequate Only) (NYC) (Rev. 12/23)
WINR0750	PA/FS Cases with End of Month Expiring Authorizations Center Report
W-113K	Documentation Requirements and/or Assessment Follow-Up (Rev. 5/3/2023)

ATTACHMENT A

One-Time Six Month 100% Earned Income Disregard Information

Did you know that if you get a new job while you are receiving Cash Assistance (CA), your income from your new job will not be counted for six (6) months in a row while you keep getting CA benefits? This is called the *100% Earned Income Disregard (EID)*.

Here's what you need to know about this:

- ✓ You must be on CA at the time you start working.
- ✓ You can only receive this one time.
- ✓ Your income will still be counted for your SNAP benefits. You may receive less SNAP or be ineligible for SNAP.
- ✓ You must tell us about a new job within 10 days. If you don't do this, your CA benefits may be lowered or stopped.
- ✓ If your total income is more than 200% of the Federal Poverty Level (FPL) for your household size at any time during this six-month period, you will no longer be able to get the EID.
- ✓ The 6 months must be in a row (for example, from January 1st through June 30th).
- ✓ If you quit your job or reduce your hours by choice, you may no longer get the EID or be eligible for CA.
- ✓ If your job ends at any time during the six months, the six-month clock will continue to count down. This reduces the number of days that are left in the six-month period.
- ✓ If you find a new job before the 6-month period is up, and your total income is below 200% of the FPL for your household size, you can ask to receive the 100% EID for any time left in the 6-month period.

Example A:

David receives CA and gets a new job. David timely reports their updated income due to the new job to DSS/HRA. Staff reviews David's income and determines they are eligible for the 100% EID beginning July 1. Staff will not include David's income in their CA case for six months so they can save money and catch up on bills.

On January 1 of the next year, David still has the same job. However, the six-month period of the 100% EID has expired. David's earned income is added to their CA case, and the standard EID and work expense disregard, is applied to determine David's continued eligibility for CA. Based on their income, David is no longer eligible for CA, and their case is closed.

The following July, David reapplies for CA because they are no longer working. David is determined eligible for CA and begins receiving benefits August 1. During the month of October, David reports that they are now employed again. Since David already received the one time, six-month 100% EID, they can't get it again. Staff will apply the standard EID and work expense disregard to determine David's continued eligibility for CA.

Example B:

Ana and Ana's three children receive CA benefits. Ana gets a new job and timely reports the updated information to DSS/HRA. Staff reviews Ana's income and determines they are eligible for the 100% EID beginning February 1.

On April 18, Ana reports to staff that they received a raise. Ana provides proof of this increased income. Staff reviews the income and determines that Ana's income is now over 200% of the FPL for their household size. Ana is no longer eligible for the 100% EID. Because Ana reported the change to staff in a timely manner, staff applies the standard EID and work expense disregard and determines that Ana remains eligible for a small CA grant. Ana has used three (3) months of their six-month period.

On June 1, Ana reports that their employer reduced the number of hours they work, and their earned income has gone down. Staff re-evaluates Ana's income and determines Ana's total income is now below 200% of the FPL and Ana can again receive the 100% EID for the remainder of the initial six-month period, which is June and July. Staff rebudgets the case and does not count the income for the remaining months.

ATTACHMENT B

CA Budget Calculation with End Effective Date in POS

- (1) When the user attempts to calculate a new budget, the following screen will first appear with the effective start date automatically filled-in by POS. User can click "OK" button to continue.

Click on the 'New Budget' button to calculate a new budget.

Case No.	POS	Author-	Authoriz-
Suf Bdgt No	Bdgt No	izable	able
1	10	Y	N
1	9	N	N
1	8	Y	N
1	7	N	N

Select Effective Date for Budget

Please enter the beginning Effective Date for this budget.

01A24

OK

Budget Required

Budget

Budget

Budget

Budget

Next Previous

- (2) In the Budget Household window, initially the user will only see the effective start date as seen in the below screen.

- (3) But user can enter the effective “To” date on the “Effective Dates” field as shown below:

(Example: Effective ‘To’ date of “05A24” is manually entered here)

(4) See below. The budget #5 is saved with an end effective date in the POS budget result screen.

Effective Dates
01A2405A24

Center ID: Worker: Type: Case No: Suffix No: Bdgt No: Client Name: Total # of People in PA Household: FR: WMS Budget No: 5

PA & FS

Monthly Food Stamp Budget Results

Suffix	No in HH	Catg. Eligibility	Adjusted Income	Shelter Amount	Net FS Income	Coupon Amount	Recoup	Adjusted Coupon	FS Rtg
1	1	Y			\$0.00				

Semi-Monthly Public Assistance Budget Results

Suffix	No in HH	Allowances:					Net PA Income	PA Grant	Recoup	Adjusted Grant
		Basic	Shelter	Energy	Fuel	Other				
1	1									

Retrieve Existing Budgets

(5) The budget #5 is saved with an end effective date in WMS.

```

MSBL80 [Z] PUBLIC ASSISTANCE/FOOD STAMPS BUDGET RESULTS 12/13/23
CASE/BUD # / 5 CTR UNIT/WORKER # PA HOUSEHOLD 1 FR S
***** MONTHLY FOOD STAMP BUDGET RESULTS *****
      ADJ  SHELTER  NET FS  COUPON
      INCOME  AMOUNT  INCOME  AMOUNT  RECOUP  ADJ  FS
      SUF  NO  CE  SUF  NO  CE  SUF  NO  CE  SUF  NO  CE  SUF  NO  CE
      01  1  Y  01  1  Y  01  1  Y  01  1  Y  01  1  Y
***** SEMI-MONTHLY PUBLIC ASSISTANCE BUDGET RESULTS *****
      BASIC  SHEL  ENER  FUEL  OTHER  NET PA  PA  ADJ
      ALLOW  ALLOW  ALLOW  ALLOW  ALLOW  INCOME  GRANT  RECOUP  GRANT
      SUF  NO  SUF  NO  SUF  NO  SUF  NO  SUF  NO  SUF  NO  SUF  NO  SUF  NO
      01  1  01  1  01  1  01  1  01  1  01  1  01  1  01  1
EFFECTIVE 01/A/24 - 05/A/24
PENDING/SAVED
CMD
  
```



200% FPL Check

Date	12/22/2023
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Household Composition	
Number of individuals in household receiving Cash Assistance (CA)	3

Monthly Gross Income Information			
Earned Income	Gross Amount	Frequency	Monthly Amount
Earned Income 1	525.00	Weekly	2274.83
Earned Income 2	0.00	--Select--	0.00
Earned Income 3	0.00	--Select--	0.00
Total Monthly Gross Earned Income			2274.83

Unearned Income	Gross Amount	Frequency	Monthly Amount
Unearned Income 1	0.00	--Select--	0.00
Unearned Income 2	0.00	--Select--	0.00
Unearned Income 3	0.00	--Select--	0.00
Unearned Income 4	0.00	--Select--	0.00
Total Monthly Gross Unearned Income			0.00

Total Individual Income	2274.83
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Below Or Above 200% FPL	Eligible for EID
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ACTION TAKEN ON YOUR RECERTIFICATION: PART A
PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP),
MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE	
CASE NUMBER	CIN NUMBER		
CASE NAME (And C/O Name if Present) AND ADDRESS			
<div style="border: 1px solid black; width: 100px; height: 100px; margin: auto;"></div>		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____	
		OR Agency Conference _____	
		Fair Hearing information and assistance _____	
		Record Access _____	
		Legal Assistance information _____	

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
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The action(s) taken on your recertification dated _____ is explained below and on Part B, next to the checked box(es) :
SEE PART B FOR SNAP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

RECERTIFIED for the period from _____ to _____.

The above grant is based on a reduced budget because:

_____ failed without good cause to cooperate with the Office of Child Support Enforcement (OCSE) on _____ by _____ [18NYCRR 352.3(d)].

To lift this sanction, call () _____ . Read the detailed instructions on the back of this notice.

_____ failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]:

screening assessment rehabilitation

or, has not provided consent or revoked consent to disclose treatment information to the agency.

REDUCE your monthly Public Assistance benefit for that period effective _____ from \$ _____ to \$ _____.

INCREASE your monthly Public Assistance benefit for that period effective _____ from \$ _____ to \$ _____.

[name(s)] _____ has been added to your case.

We cannot add the following individuals to your case:

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

CONTINUE your Public Assistance benefit unchanged at \$ _____.

A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance.

If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d).

DISCONTINUE your Public Assistance benefit effective _____.

The **REASON** for this action is _____

The above decision(s) is based on 18 NYCRR _____.

Your earnings from a new job, or a paid training or work activity are not being counted against your Public Assistance benefit. If you started a new job, for a one-time period of up to six months in a row, 100% of your income from a new job won't be counted against your Public Assistance benefit. Any income earned from participating in an eligible paid training or work activity is not counted against your Public Assistance benefit.

Your earnings from either a new job, or a paid training or work activity are now used in your Public Assistance benefit calculations. This is either because your earnings have increased above 200% of the federal poverty level for your household size, you are no longer in paid training or, because you have reached the end of the one-time six-month period for the employment disregard.

MEDICAL ASSISTANCE

CONTINUE the Medical Assistance coverage for [name(s)] _____ unchanged.

CONTINUE the Medical Assistance coverage for [name(s)] _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

CONTINUE the Medical Assistance coverage for [name(s)] _____ pending our review of eligibility. We will send you our decision within thirty days.

REDUCE the Medical Assistance coverage effective _____ for [name(s)] _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is \$ _____. Your total monthly deductions are \$ _____. The difference between these is your monthly net income for Medical Assistance. This is \$ _____. The allowable income standard for a family household your size is \$ _____. The difference between your net income and this standard (\$ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program.

DISCONTINUE Medical Assistance for [name(s)] _____ effective _____ because _____

Medical Assistance coverage will continue under Transitional Medical Assistance (See attached Medical Assistance Fact Sheet).

Medical Assistance coverage will continue until _____ due to receipt of/increase in child or spousal support payments.

The above decision(s) is based on _____.

SERVICES – If you are getting Social Services and lose your Public Assistance and Medical Assistance Benefits, we will need to see if you still can get Social Services at your next scheduled recertification. This does not necessarily mean that you will no longer be able to get Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any questions, please contact your Services worker or call the general phone number at the top of this notice.

BE SURE TO READ THE BACK OF PART B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

To Lift a Sanction for Non-cooperation with a Child Support Requirement

A sanction for non-cooperation with a child support requirement is open-ended and will continue until _____ contacts the Child Support Enforcement Unit and cooperates.

When _____ contacts the Child Support Enforcement Unit, they will be told what action(s) must be taken to end the sanction. The sanction will end when they take the required actions(s). If _____ did not cooperate but now wants to report a good reason for not cooperating with child support they should call (_____) _____.

Some examples of a good reason for not cooperating with child support are:

- fear of emotional or physical harm to you or the children in your family; or,
- the child was born due to rape or incest; or,
- the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three months.

To find out more information about how to end the sanction, call (_____) _____.

- Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.
Even if you are no longer eligible for Public Assistance or Medical Assistance, Social Services may provide information and education about family planning for up to 90 days from the effective date stated in this notice.
For further information, please contact your Services worker or call the general phone number on the front of this notice.
- If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
- Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.
- Although you may no longer be able to get Public Assistance, SNAP Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

**PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP),
MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)**

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE			
CASE NUMBER		CIN NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS					
<div style="border: 1px solid black; width: 100%; height: 100%; margin: 5px;"></div>				GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____	
				OR Agency Conference _____	
				Fair Hearing information and assistance _____	
				Record Access _____	
				Legal Assistance information _____	
OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME		TELEPHONE NUMBER

The action(s) taken on your recertification dated _____ is explained below and on Part A, next to the checked box(es) : **SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE, AND SERVICES INFORMATION.**

If you do not use your SNAP account for a period of 274 consecutive days, any SNAP benefit remaining in the account that is at least 274 days old will be expunged (removed) from the account. Expunged SNAP benefits cannot be reissued.

- APPROVED** for continued SNAP from _____ to _____ for [name(s)] _____
 - 1. You will get \$ _____ for the month of _____ because we must figure your first month's benefit from:
 - 1a. The date you applied to the end of the month. You may access your benefit on _____.
 - 1b. The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____.
 - 2. You will get \$ _____ which is a combined benefit for the months of _____ and _____. This is because you applied/provided proof after the 15th of the month. Your first month's benefit of \$ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of \$ _____ is for the entire month. You may access your combined benefit on _____.
 - 3. Beginning _____ you will get \$ _____ monthly in SNAP benefits. You may access these benefits on the _____ day of each month.
 - 3a. You will continue to get the benefit above until _____. This is because you are eligible for Transitional SNAP benefits. You are not required to report any changes until the end of this transition period. If you have changes during your transition period that may increase your benefits, you must contact your worker to file an early recertification application in order to receive any increase. Early recertifications that result in a benefit increase will end your transition period, otherwise, your transitional period and benefit will continue as described above.
 - 4. Beginning _____ you will get \$ _____ monthly in SNAP benefits. You may access these benefits on the _____ day of each month.
 - 5. So you could get SNAP benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: _____

You will **not** be able to get SNAP Benefits in the future unless you provide this proof. This proof will be used to determine the amount of SNAP benefits you can get. If your SNAP benefits change due to this proof, you will **not** be notified.

- 6. If you applied for Public Assistance and are approved, your SNAP Benefits might go down or might stop. If this happens, you will not get a notice about your SNAP.
 - Your earnings from a new job, or a paid training or work activity are not being counted against your Public Assistance benefit. This income is still being counted against your SNAP benefits; therefore your SNAP benefits might go down or might stop.
- 7. Other information: _____

- DENIED** for the following individuals:
 - Name(s): _____ Reason(s) _____
 - Name(s): _____ Reason(s) _____
 - Name(s): _____ Reason(s) _____
 - Name(s): _____ Reason(s) _____

You did not give us the proof we need to see if you can get SNAP. If you give us this proof we listed on the above lines by _____, you will not have to reapply. After that date, you will have to reapply for benefits.

- OTHER:** _____
- OVERPAYMENT INFORMATION**

- We are establishing a SNAP overpayment because you or your household got more in SNAP benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
- The benefit in line # 3 above reflects a _____% reduction (recoupment) of \$ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**
- The benefit in line # 4 above reflects a _____% reduction (recoupment) of \$ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

In the future if your case is closed, you will receive a separate notice providing repayment options and guidelines to ensure paying back the remaining balance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance.

The above decision(s) is based on 18 NYCRR: _____

BE SURE TO READ THE BACK OF THIS NOTICE FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

NAME:	ADDRESS:	CASE NUMBER:
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National School Lunch/or Breakfast Programs - The child(ren) listed below are approved to receive free lunch and/or breakfast if the child(ren) attend a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a copy of this notice to the school that your child(ren) attend.

This notice also entitles your child(ren) to free meals if they attend a program such as a school, club or camp that participates in the Summer Food Service Program. Make a copy for your records so you can provide it to the sponsor.

List Child(ren)'s name(s):

--

Responsibility To Report Changes – See enclosed LDSS-3151: “SNAP Change Report Form” for information on when to report changes.

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

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

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

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

1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.
If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See “Keeping Your Benefits The Same” below.)
2. **STATE FAIR HEARING** – You have the following number of days from the date of this notice to ask for a fair hearing:

BENEFIT AREA	TIME LIMIT
Public Assistance, Medical Assistance, Social Services	60 days
SNAP Benefits	90 days

If this notice is telling you that you owe a Public Assistance overpayment, and if you do not agree that you owe this overpayment, you must call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

KEEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance, Medical Assistance and Social Services Benefits to the same level they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing, your SNAP benefits **cannot be continued in the same amount as** before your recertification, but will be in the new amount shown in this notice. If you lose the fair hearing, you will have to pay back any Public Assistance benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

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

I do not want to “keep my benefits the same” until the Fair Hearing decision is issued:

Public Assistance Medical Assistance Social Services

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

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

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

Phone: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

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

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

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

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

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

At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong.

To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements.

At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

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

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

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

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

PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE) (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE			
CASE NUMBER	CIN NUMBER				
CASE NAME (And C/O Name if Present) AND ADDRESS					
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____			
		OR Agency Conference _____			
		Fair Hearing information and assistance _____			
		Record Access _____			
		Legal Assistance information _____			
OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER	
We are CHANGING your benefits as explained below and on <u>PART B</u> , next to the checked box(es) <input checked="" type="checkbox"/> : SEE PART B FOR SNAP AND FAIR HEARING INFORMATION.					
PUBLIC ASSISTANCE					
<input type="checkbox"/> REDUCE your Public Assistance Benefit effective _____ from \$ _____ to \$ _____ because: <input type="checkbox"/> _____ failed without good cause to cooperate with the Office of Child Support Enforcement (OCSE) on _____ by _____ [18NYCRR 352.3(d)]. To lift this sanction, call (_____) _____ . Read the detailed instructions on the back of this notice. <input type="checkbox"/> Other: _____					
<input type="checkbox"/> INCREASE your monthly Public Assistance benefit for that period effective _____ from \$ _____ to \$ _____. <input type="checkbox"/> [name(s)] _____ has been added to your case. <input type="checkbox"/> We cannot add the following individuals to your case: Name: _____ Reason(s) _____ Name: _____ Reason(s) _____					
<input type="checkbox"/> CONTINUE your Public Assistance Benefit unchanged at \$ _____ . <input type="checkbox"/> A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance. If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d).					
<input type="checkbox"/> DISCONTINUE your Public Assistance grant effective _____ The REASON for this action is _____ _____ The above decision(s) is based on 18 NYCRR _____ .					
<input type="checkbox"/> Your earnings from a new job, or a paid training or work activity are not being counted against your Public Assistance benefit. If you started a new job, for a one time-period of up to six months in a row, 100% of your income from a new job won't be counted against your Public Assistance benefit. Any income earned from participating in an eligible paid training or work activity is not counted against your Public Assistance benefit.					
<input type="checkbox"/> Your earnings from either a new job, or a paid training or work activity are now used in your Public Assistance benefit calculations. This is either because your earnings have increased above 200% of the federal poverty level for your household size; you are no longer in paid training; or, because you have reached the end of the one-time six-month period for the employment disregard.					
MEDICAL ASSISTANCE					
<input type="checkbox"/> CONTINUE the Medical Assistance coverage for [name(s)] _____ unchanged.					
<input type="checkbox"/> CONTINUE the Medical Assistance coverage for [name(s)] _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.					
<input type="checkbox"/> CONTINUE the Medical Assistance coverage for [name(s)] _____ pending our review of eligibility. We will send you our decision within thirty days.					
<input type="checkbox"/> REDUCE the Medical Assistance coverage effective _____ for [name(s)] _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is \$ _____. Your total monthly deductions are \$ _____. The difference between these is your monthly net income for Medical Assistance. This is \$ _____. The allowable income standard for a family household your size is \$ _____. The difference between your net income and this standard (\$ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program.					
<input type="checkbox"/> DISCONTINUE Medical Assistance for [name(s)] _____ effective _____ because _____ _____					
<input type="checkbox"/> Medical Assistance coverage will continue under Transitional Medical Assistance (See attached Medical Assistance Fact Sheet). <input type="checkbox"/> Medical Assistance coverage will continue until _____ due to receipt of/increase in child or spousal support payments.					
The above decision(s) is based on 18 NYCRR _____ .					
SERVICES - If you are getting Social Services and lose your Public Assistance and Medical Assistance Benefits, we will need to see if you still can get Social Services at your next scheduled recertification. This does not necessarily mean that you will no longer be able to get Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any questions, please contact your services worker or call the general phone number at the top of this notice.					

BE SURE TO READ THE BACK OF PART B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

Enclosure

DISTRIBUTION: White -CLIENT/FAIR HEARING COPY

Yellow - CLIENT COPY

Pink - AGENCY COPY

To Lift a Sanction for Non-cooperation with a Child Support Requirement

A sanction for non-cooperation with a child support requirement is open-ended and will continue until _____ contacts the Child Support Enforcement Unit and cooperates.

When _____ contacts the Child Support Enforcement Unit, they will be told what action(s) must be taken to end the sanction. The sanction will end when they take the required actions(s). If _____ did not cooperate but now wants to report a good reason for not cooperating with child support they should call (____)_____.

Some examples of a good reason for not cooperating with child support are:

- fear of emotional or physical harm to you or the children in your family; or,
- the child was born due to rape or incest; or,
- the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three months.

To find out more information about how to end the sanction, call (____)_____.

- Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.
Even if you are no longer eligible for Public Assistance or Medical Assistance, Social Services may provide information and education about family planning for up to 90 days from the effective date stated in this notice.
For further information, please contact your services worker or call the general phone number on the front of this notice.
- If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
- Regulations require that you immediately notify this department of any changes in needs, income, resources, living arrangements or address.
- Although you may no longer be able to get Public Assistance, SNAP Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

**PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP),
MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE) (NYC)**

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE				
CASE NUMBER	CIN NUMBER					
CASE NAME (And C/O Name if Present) AND ADDRESS						
<div style="border: 1px solid black; width: 100%; height: 100%; margin: 0 auto;"></div>		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____				
		OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____				
		OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
		We are CHANGING your benefits, as explained below and on <u>Part A</u> , next to the checked box(es) <input checked="" type="checkbox"/> : SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE AND SERVICES INFORMATION.				

If you do not use your SNAP account for a period of 274 consecutive days, any SNAP benefit remaining in the account that is at least 274 days old will be expunged (removed) from the account. Expunged SNAP benefits cannot be reissued.

SNAP

1. **INCREASE** your SNAP benefits from \$ _____ to \$ _____ effective _____ .
 [name(s)] _____ has been added to your case.
 Your SNAP certification period has been extended. Your benefits will now end in _____ .
2. **CONTINUE** your SNAP benefits at \$ _____ effective _____ for [name(s)] _____ .
 Your SNAP certification period has been extended. Your benefits will now end in _____ .
3. **REDUCE** your SNAP benefits from \$ _____ to \$ _____ effective _____ .
 Your SNAP certification period has been extended. Your benefits will now end in _____ .
4. **DISCONTINUE** your SNAP benefits as of _____ .
5. **OTHER:** _____
 Your earnings from a new job, or a paid training or work activity are not being counted against your Public Assistance benefits. This income is still being counted against your SNAP benefits; therefore, your SNAP benefits might go down or might stop.
6. **OVERPAYMENT INFORMATION (Check All That Apply)**
 We are establishing a SNAP overpayment because you or your household got more in SNAP benefits than you should have. See the Demand Letter (and also, if your case is closing the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
 The benefit above reflects a _____% reduction (Recoupment) of \$ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

In the future if your case is closed, you will receive a separate notice providing repayment options and guidelines to ensure paying back the remaining balance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance.

7. We cannot add the following individuals to your case:
 Name: _____ Reason(s) _____
 Name: _____ Reason(s) _____

8. If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.
9. **OTHER INFORMATION:**

The reason for this action is: _____

The above decision(s) is based on 18 NYCRR _____ .

Responsibility To Report Changes – See enclosed LDSS-3151: “SNAP Change Report Form” for information on when to report changes.

BE SURE TO READ THE BACK OF THIS NOTICE FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

NAME:	ADDRESS:	CASE NUMBER:
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CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

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

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

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

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

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

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

BENEFIT AREA	TIME LIMIT
Public Assistance, Medical Assistance, Social Services	60 days
SNAP Benefits	90 days

If this notice is telling you that you owe a Public Assistance overpayment, and if you do not agree that you owe this overpayment, you must call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

KEEPING YOUR BENEFITS THE SAME: We will not change your Public Assistance, SNAP, Medical Assistance and Social Services benefits, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any Public Assistance and SNAP benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

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

I do not want to "keep my benefits the same" until the Fair Hearing decision is issued:

- Public Assistance Medical Assistance SNAP Social Services

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

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

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

Phone: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

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

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

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

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

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

At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong.

To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements.

At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

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

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

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

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

PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY) (NYC)

PART A

Form header section containing fields for NOTICE DATE, CASE NUMBER, CIN NUMBER, CASE NAME AND ADDRESS, GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP, and OFFICE NO., UNIT NO., WORKER NUMBER, UNIT OR WORKER NAME, TELEPHONE NUMBER.

We are CHANGING your benefits as explained below and on UPART B U, next to the checked box(es) [X]:

SEE UPART BU FOR SNAP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

- Public Assistance options: REDUCE, INCREASE, CONTINUE, DISCONTINUE. Includes detailed instructions for each option, such as 'A RECOUPMENT at the rate of ___ percent (%) is being taken against your Public Assistance...' and 'Your earnings from either a new job, or a paid training or work activity are now used in your Public Assistance benefit calculations...'.

MEDICAL ASSISTANCE

- Medical Assistance options: CONTINUE, REDUCE, DISCONTINUE. Includes instructions for each option, such as 'CONTINUE the Medical Assistance coverage for [name(s)] ___ unchanged.' and 'REDUCE the Medical Assistance coverage effective ___ for [name(s)] ___ from full coverage to coverage with a SPENDDOWN...'.

SERVICES - If you are getting Social Services and lose your Public Assistance and Medical Assistance benefits, we will need to see if you still can get Social Services at your next scheduled recertification. This does not necessarily mean that you will no longer be able to get Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any questions, please contact your services worker or call the general phone number at the top of this notice.

BE SURE TO READ THE BACK OF PART B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

- Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.
Even if you are no longer eligible for Public Assistance or Medical Assistance, Social Services may provide information and education about family planning for up to 90 days from the effective date stated in this notice.
For further information, please contact your services worker or call the general phone number on the front of this notice.
- If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
- Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.
- Although you may no longer be able to get Public Assistance, SNAP or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

NOTICE OF INTENT TO CHANGE BENEFITS: PART B
PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP),
MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY) (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE				
CASE NUMBER	CIN NUMBER					
CASE NAME (And C/O Name if Present) AND ADDRESS						
<div style="border: 1px solid black; width: 100%; height: 100%; margin: 0 auto;"></div>		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____				
		OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____				
		OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
		We are CHANGING your benefits, as explained below and on <u>Part A</u> , next to the checked box(es) <input checked="" type="checkbox"/> : SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE AND SERVICES INFORMATION.				

If you do not use your SNAP account for a period of 274 consecutive days, any SNAP benefit remaining in the account that is at least 274 days old will be expunged (removed) from the account. Expunged SNAP benefits cannot be reissued.

SNAP

1. **INCREASE** your SNAP benefits from \$ _____ to \$ _____ effective _____.
 [name(s)] _____ has been added to your case.
 Your SNAP certification period has been extended. Your benefits will now end in _____.
 2. **CONTINUE** your SNAP benefits for at \$ _____ effective _____.
 Your SNAP certification period has been extended. Your benefits will now end in _____.
 3. **REDUCE** your SNAP benefits from \$ _____ to \$ _____ effective _____.
 Your SNAP certification period has been extended. Your benefits will now end in _____.
 4. **DISCONTINUE** your SNAP benefits as of _____.
 5. **OTHER** _____
- Your earnings from a new job, or a paid training or work activity are not being counted against your Public Assistance benefit. This income is still being counted against your SNAP benefits; therefore your SNAP benefits might go down or might stop.
6. **OVERPAYMENT INFORMATION** (Check All That Apply)
- We are establishing a SNAP overpayment because you or your household got more in SNAP benefits that you should have. See the Demand Letter and also, if your case is closing, the Repayment Agreement for more information on this overpayment. This decision is based on 18 NYCRR 387.19.
 - The benefit above reflects a _____% reduction (recoupment) of \$ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

In the future if your case is closed, you will receive a separate notice providing repayment options and guidelines to ensure paying back the remaining balance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance.

7. We cannot add the following individuals to your case:
- Name: _____ Reason(s) _____
- Name: _____ Reason(s) _____
- Name: _____ Reason(s) _____
- Name: _____ Reason(s) _____
8. If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.
9. Other Information: _____

The reason for this action is: _____

The above decision(s) is based on 18 NYCRR _____.

Responsibility To Report Changes – See enclosed LDSS-3151: “SNAP Change Report Form” for information on when to report changes.

BE SURE TO READ THE BACK OF THIS NOTICE FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

Enclosure

DISTRIBUTION: White -CLIENT/FAIR HEARING COPY Yellow – CLIENT COPY Pink – AGENCY COPY

NAME:	ADDRESS:	CASE NUMBER:
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CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

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

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

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

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

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

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

BENEFIT AREA	TIME LIMIT
Public Assistance, Medical Assistance, Social Services	60 days
SNAP Benefits	90 days

If this notice is telling you that you owe a Public Assistance overpayment, and if you do not agree that you owe this overpayment, you must call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

KEEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance, SNAP, Medical Assistance and Social Services benefits to the same level they were before this notice, if you ask for a fair hearing within 10 days of this notice. If you lose the fair hearing, you will have to pay back any Public Assistance and SNAP benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance benefits.

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

I do not want to "keep my benefits the same" until the Fair Hearing decision is issued:

- Public Assistance Medical Assistance SNAP Social Services

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

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

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

Phone: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

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

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

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

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

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

At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong.

To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor's statements.

At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

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

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

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

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

**WELFARE MANAGEMENT SYSTEM
NEW YORK CITY REPORTS MANUAL
WINR0750 - PA/FS CASES WITH END OF MONTH EXPIRING AUTHORIZATIONS
CENTER REPORT**

WINR0750 - PA/FS CASES WITH END OF MONTH EXPIRING AUTHORIZATIONS CENTER REPORT

REPORT-DATE 10/04/2008 **1** NEW YORK CITY HUMAN RESOURCES ADMINISTRATION PAGE 6
2 PA/FS CASES WITH END OF MONTH EXPIRING AUTHORIZATIONS
CENTER REPORT
WMS REPORT WINR0750
***** THIS REPORT CONTAINS *
* CONFIDENTIAL INFORMATION *
* FOR INTERNAL USE ONLY *

EXPIRING AUTHORIZATION DATE 10/31/2008
CENTER 099 **3**
UNIT/WORKER 00602 **4**

CASE NAME **5**
CXXXXX JEANETTE

CASE TYPE **6** CASE NO.-SFX **7**
HR 002451178E-01

TOTAL FOR WORKER IS 1 **8**
TOTAL FOR LOCAL OFFICE IS 6 **9**

<< report edited for formatting >>

REPORT ENDED

WINR0750 Report Sample - Center Report

**WELFARE MANAGEMENT SYSTEM
NEW YORK CITY REPORTS MANUAL**

**WINR0750 – PA/Fs CASES WITH END OF MONTH EXPIRING AUTHORIZATIONS
CENTER REPORT**



Office of Temporary and Disability Assistance

DECEMBER 29, 2014

WINR0750 – PA/Fs CASES WITH END OF MONTH EXPIRING AUTHORIZATIONS CENTER REPORT

REPORT TITLE PA/Fs Cases with End of Month Expiring Authorizations Center Report	REPORT NUMBER WINR0750	FILE NAME PRD080P50*** *** = PA Center Code
PURPOSE – NOTES This report lists the PA/Fs cases for a center with authorizations that are due to expire at the end of the report month.		
SOURCE RunID = PRD080	REFERENCE	AUDIENCE / GENERAL DISTRIBUTION PA Centers staff via DEPCON (center-specific report)
SEQUENCE Center/Unit/Worker/Case Name		BREAKS
FREQUENCY / SCHEDULE Monthly		RETENTION 30 Days
REPORT ITEM		DEFINITION (IF NEEDED)
1. Standard WMS Headings		-
2. Expiring Authorization Date		Date when authorizations for cases are due to expire.
3. Center		PA Center number responsible for the case.
4. Unit/Worker		Worker ID responsible for the case.
5. Case Name		Name of payee of the case.
6. Case Type		Case category code
7. Case No.-Sfx		Number that uniquely identifies the case / Number identifying the unit of assistance that received benefits.
8. Total for Worker is		Total number of cases expiring for this worker
9. Total for Local Office is		Total number of cases expiring for this center



Date: _____
 Case Number: _____
 Case Name: _____
 Center Number: _____
 SNAP Filing Date: _____
 Subject: _____

Documentation Requirements and/or Assessment Follow-Up

To see if you can get, or keep getting, benefits, you must give us the required documents by the due date on this form.

Please see the Eligibility Factors and Suggested Documentation Guide (**W-119D**) sent with this letter for some of the types of documents you can give us.

If you need more time or help getting the documents call the number on page 3 of this notice.

SAMPLE

Due Date: _____

Forms Reminder

(Please return the following Agency form(s), completed and signed where necessary.)

- | | |
|--|--|
| <input type="checkbox"/> LDSS-2474 SSI Referral and Certification of Contact
<input type="checkbox"/> W-146E Request to Pay Rent Arrears in Excess of PA Maximum Shelter Allowance
<input type="checkbox"/> W-146W Verification of Tenant's Rent in Section 8 Housing
<input type="checkbox"/> W-147CC Certification of Move Statement
<input type="checkbox"/> W-147M Landlord's Statement (Regarding Broker's Fee)
<input type="checkbox"/> W-147Q Verification of Secondary Tenant's Residence and Housing Costs | <input type="checkbox"/> M-15 Inquiry Regarding Veteran's Benefits/Allotment
<input type="checkbox"/> W-274U Attestation of Employment as an Informal Child Care Provider
<input type="checkbox"/> W-299 Notice to Applicants and Participants Regarding Third Party Health Insurance
<input type="checkbox"/> W-451 NYPD – New York Police Department Report/Referral
<input type="checkbox"/> W-582A Family Care Assessment
<input type="checkbox"/> W-700E School Attendance Verification Letter |
|--|--|

(Turn page)

CA Appointment Reminder

<input type="checkbox"/> BEV – Bureau of Eligibility Verification Appointment <input type="checkbox"/> OCSS – Office of Child Support Services Appointment <input type="checkbox"/> Career Services Vendor Appointment <input type="checkbox"/> CASAC – Credentialed Alcoholism/and Substance Abuse Counselor Appointment	<input type="checkbox"/> WeCARE – Wellness, Comprehensive Assessment, Rehabilitation and Employment Medical Provider Appointment <input type="checkbox"/> ACS – Agency for Children’s Services Appointment
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The following household member(s) must contact HRA for the reason indicated below:

Name of Household Member	<input type="checkbox"/> For an employability assessment	<input type="checkbox"/> To sign the cash assistance application
Name of Household Member	<input type="checkbox"/> For an employability assessment	<input type="checkbox"/> To sign the cash assistance application
Name of Household Member	<input type="checkbox"/> For an employability assessment	<input type="checkbox"/> To sign the cash assistance application
Name of Household Member	<input type="checkbox"/> For an employability assessment	<input type="checkbox"/> To sign the cash assistance application

SAMPLE

Outstanding documentation – see the **W-119D** for a list of documents that can be used to verify the Eligibility Factors listed.

Name	Eligibility Factor

(Turn page)

You may submit any required documents/information by:



UPLOAD (*easiest!*) — use your mobile phone or tablet with our ACCESS HRA mobile app at: www.nyc.gov/accesshramobile



IN PERSON — bring copies of the documents to your Center



FAX — send documents to _____



MAIL copies using envelope provided



CALL _____ if you need help getting documents or more time to get documents

Failure to submit verification/documentation or failure to contact your HRA worker on or before the due date may make you ineligible for Cash Assistance and/or SNAP, or may cause a reduction in your Cash Assistance and/or SNAP benefits for a specific period of time.

SAMPLE

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 718-557-1399. 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.

(Turn page)

THINGS TO REMEMBER



Pay Stubs: for each person working, you must provide pay stubs to cover the last 4 weeks they were paid.



Employer Letter: If you don't get pay stubs, have your employer write a letter stating the amount and frequency you get paid, and the company name and telephone number, and your employer must **sign and date** it.



Landlord or Primary Tenant Letter: must be signed, dated and include:

- amount of rent you are charged;
- whether you pay the landlord or primary tenant for heating/cooling or other utilities separate from your rent, and if so, how much;
- how many people are in your household; and
- the landlord's name and telephone number.

SAMPLE