Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING
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POLICY BULLETIN #21-37-OPE

(This Policy Bulletin Replaces PB #21-14-OPE)

REVISION TO OPERATIONAL REMINDERS AND INFORMATION DURING COVID-19

Date:	**Subtopic(s):**
June 3, 2021	Providing Interpretation Services, Telework, SAVE, ACCESS HRA Single Issuance Requests, Substance Abuse, Employment, Payment of Storage Fees

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Revisions to the Original Policy Bulletin

This policy bulletin is being revised to inform staff that when they are unable to use the softphone due to technological reasons they must create an Information Technology Services (ITS) ticket via the ITS Service Desk, to address the issue, and use a personal phone to make calls. Staff must also enter a case note in POS stating that a personal phone was used when recording date and time when call was made.

Purpose

The purpose of this policy bulletin is to inform Job Center staff of operational reminders during COVID-19. This policy bulletin is informational for all other staff.

Interpretation Services

Refer to PD#18-10-OPE

Applicants/Participants with limited or no ability to speak, read, write, or understand English, must be provided with communication assistance in their preferred language(s). All applicants and participants have the right to free interpretation services. When conducting a telephone interview, staff must utilize telephonic interpretation services if the applicant/participant prefers to communicate in a language other than English.

The Human Resource Administration's (HRA) telephonic interpretation is available 24 hours a day, 7 days a week. Staff do not need a supervisor's permission to access interpretation services. Staff should utilize the Infocard: How to Call for an Interpreter (**PALM-21**) for more information on accessing telephone interpretation services.

Refer to DSS-PB-2020-003

Staff conducting telephone interviews remotely will be using the Virtual Communications Express (VCE) Connect software to communicate with applicants/participants. Staff must use the three-way calling feature in order to successfully use the telephone interpretation services. Please refer to the **PALM-21** card and the Phone Usage Guidance procedure (DSS-PB-2020-003) for general guidance on conducting agency business while working from home. If staff members know that the applicant/participant speaks a language other than English prior to making the call, staff should contact interpretation services before calling the applicant/participant. Interpretation services will be able to do a three-way call with the applicant/participant on the staff's behalf. If not, further instructions on using the 3-way/conference call are described in Conferencing in a Third Party using the Softphone Technology (**Attachment A**).

Revised

New

Note: Staff unable to use the softphone due to technological reasons must create an Information Technology Services (ITS) ticket via the ITS Service Desk, to address the issue, and use a personal phone to make calls. Staff must also enter a case note in POS stating that a personal phone was used when recording the date and time when call was made.

If staff cannot determine the language that an applicant/participant speaks, they should call the telephonic interpretation services number (1-855-938-0533) and press 0 (zero) for a Customer Service Representative. The representative will assist in determining the appropriate language.

Redeployed non-Family Independence Administration (FIA) staff must utilize the telephone interpretation service using the COVID-19 specific CA code **3398**. Multiple users can use this code at the same time, so there should be no problems using one code for the program. For FIA staff, the telephone interpretation service codes for the respective Job Centers are listed on **Attachment B**.

Questions Regarding Immigration Status and Eligibility

Refer to PB#17-49-ELI

If the JOS/Worker has any questions regarding immigration status and eligibility, they must request a clearance from the ORIA to assist in determining benefit eligibility for non-citizens.

The JOS/Worker will fill out the Office of Refugee and Immigrant Affairs (ORIA) Clearance Request Form (**ORIA-195**) when:

- The documentation (or the results from the **SAVE** System) an applicant/participant submits is:
  - unclear, or
  - does not correspond with the Paperless Office System (POS) Alien Checklist, or
  - does not correspond directly to a non-citizen document identified on the Non-Citizen Eligibility Desk Aid (**LDSS-4579**) or Permanently Residing Under the Color of Law (**PRUCOL**) Desk Aid (**W-205JJ**).
- Prior to a case being denied for immigration status.

The **ORIA-195** is a form that can either be printed out and completed manually or completed electronically through DSS eDocs. After completion, staff must save the completed PDF document on their desktop and print it. The printed document must be scanned and indexed into the electronic case record of the applicant/participant for whom the request is being made. Staff must email the completed **ORIA-195** and all supporting documents to ORIA@dss.nyc.gov.

Note: A separate **ORIA-195** is required for each individual that a clearance is being requested for. However, a single email to ORIA@dss.nyc.gov may be sent for multiple individuals on the same case.

Once ORIA receives the **ORIA-195** and documents, a review of the documents will be conducted to ascertain benefit eligibility for the non-citizen. If the documents provided and/or the clearance request is unclear, ORIA will reach out to the requestor for additional information.

Revised

Once a decision is ready, ORIA will respond with an email to the requestor, either using the ORIA Clearance Response Form (**ORIA-195a**) or in the body of the email containing the full clearance information. The requestor must scan and index the clearance into the electronic case record.

SAVE Clearance and SAVE Liaison

Refer to PD#18-09-SYS

As a condition of eligibility, any applicant/participant household that has members applying for or in receipt of assistance who are not United States citizens, must provide documentation of their immigration status granted by the United States Citizenship and Immigration Services (USCIS), the Executive Office for Immigrant Review (EOIR), or any other part of the federal immigration agency. All documentation other than U.S. Certificates of Naturalization provided must be verified using the Systematic Alien Verification for Entitlement (SAVE) system.

The SAVE Liaison at the Job Center will conduct the SAVE clearance. The immigration status information obtained from the SAVE system verifies that a person has the immigration status that their documents indicate and can be used by JOS/Workers to determine a noncitizen applicant's/participant's eligibility for public benefits. The SAVE system does not provide information on a noncitizen's eligibility for benefits. It merely verifies that the immigration documentation is consistent with USCIS records.

The Job Opportunity Specialist (JOS)/Worker must request a SAVE clearance from the SAVE Liaison to verify immigration status for noncitizens in the following three situations:

- Noncitizen making an initial application for benefits;
- Noncitizen applying to be added to an existing Cash Assistance (CA) case; or
- Change in the immigration status of a noncitizen in receipt of CA benefits.

New

Refer to PD#18-09-SYS, PD#13-09-ELI, and CD#20-18

Note: If an individual identifies as undocumented (unknown to USCIS or any other part of the federal immigration agency) and claims to have no immigration status or pending applications before any branch of the federal immigration agency, the JOS/Worker should not request a SAVE referral. An ORIA clearance is required before denying benefits. Refer to PD#18-09-SYS for more information.

A SAVE clearance is not required if an individual has one or more of the following documents verifying U.S. Citizenship:

- U.S. Birth Certificate;
- U.S. Passport or U.S. Passport Card;
- Certificate of Naturalization form issued by USCIS (**N-550** or **N-570**);
- Enhanced Driver Licenses and Non-Driver Identification Cards For New York State Residents Who Are U.S. Citizens;
- Consular Report of Birth Abroad form (**FS-240**);
- Certification of Report of Birth form (**DS-1350**);
- U.S. Citizen I.D. Card (**I-197** or **I-179**);
- Certificate of U.S. Citizenship form (**N-560** or **N-561**);
- Document from a U.S. federal agency (such as the Social Security Administration) verifying the U.S. or U.S. territories as place of birth; or
- Religious document (such as baptismal record) verifying that the ceremony took place in the U.S. and that the document was registered within three months of the individual's birth.

SAVE Referral

Once it is determined that a SAVE clearance is necessary, the JOS/Worker must complete the Systematic Alien Verification for Entitlements (SAVE) Referral (**W-515X**) in the **Forms Data Entry** screen in the Paperless Office System (POS).

The completed **W-515X** must be printed and forwarded along with copies of the original immigration documentation (front and back), when available, to:

- The SAVE Liaison in Job Centers; or
- The Principal Administrative Associate (PAA) II/Center's Designee in the HIV/AIDS Services Administration (HASA) Centers.

SAVE Liaison

Revised

Note: Each Center should have a SAVE Liaison. If there is no SAVE Liaison, the Center Director will designate one. After a SAVE Liaison is identified, the Center Director will inform their region of the need for the new designated SAVE Liaison to have access to SAVE and training on how to complete the SAVE clearance and interpreting the relevant information. The Center Director will then submit a training request for the new SAVE liaison for the next available SAVE training. Upon completion of SAVE training, the SAVE liaison will receive SAVE credentials allowing the liaison to access the SAVE system.

Only one clearance may be requested on each **W-515X** submitted. A separate **W-515X** must be completed for each noncitizen (adults and minors) for whom a clearance is required. The **W-515X** should be scanned and indexed into the electronic case record for future review.

Refer to PB #17-49-ELI for information on requesting a clearance from ORIA

If all verification attempts for a SAVE clearance result in information that does not reflect the information that is on the immigration documentation, the SAVE Liaison must obtain a further clearance from ORIA.

Substance Use Screening and Follow Up

Refer to PD#12-14-EMP

All adult applicants/participants and heads of households must be screened for potential drug/alcohol use disorders. Failure to comply with substance use screening may result in the individual's denial of CA until compliance (non-durational sanction).

All adult applicants/participants and heads of households who screen positive for potential drug/alcohol use disorders must be formally assessed by a Credentialed Alcoholism Substance Abuse Counselor (CASAC). If determined by CASAC staff through formal assessment the need for treatment, the applicant/participant must participate in appropriate drug/alcohol rehabilitation treatment as a condition of eligibility.

The substance use questions in POS must be asked of applicants/participants during the application or recertification interview, even if they are pre-populated from an ACCESS HRA submission. Any positive answers to the substance use questions will place the case on a worklist and a CASAC will outreach to the applicant/participant to conduct a telephonic assessment. No substance use referrals should be made at this time by the Job Center.

Domestic Violence Follow Up

Refer to PD#19-08-ELI and PB#20-13-ELI

When a CA applicant/participant indicates that they are a victim of domestic violence (DV), every effort must be made to address the safety needs of these individuals and their children.

To promptly assist these individuals in obtaining safe and supportive services, a Domestic Violence Unit (DVU) was established that reports to the Office of Domestic Violence and Emergency Intervention Services (ODVEIS). Each Job Center is covered by a Domestic Violence Liaison (DVL) who:

- Conducts waiver assessments;
- Provides emergency safety planning;
- Informs participants and relevant staff about waiver decisions; and
- Develops service plans in collaboration with the victim.

All individuals applying/recertifying for assistance must be provided with information about the DVU, DV protection, and other services that are available. At the application/recertification interview, the JOS/Worker must read to the applicant/participant the information from the Desk Reference for Domestic Violence Screening Under the Family Violence Option (**LDSS-4813**) even if answers are already populated based on an ACCESS HRA submission; and

- Inform the applicant/participant that the completion of the Domestic Violence Screening Form (**LDSS-4583**) is not mandatory but may be in their best interest;
- Ensure that necessary interpretation services are obtained if an applicant/participant has limited English-speaking ability, as they must understand the questions on the **LDSS-4583**;
- Inform that applicant/participant that benefits and eligibility are not affected by a refusal to complete the form; and
- Reassure the applicant/participant that all information on the form is kept confidential.

If the applicant/participant answers “YES” to any of the six questions on the **LDSS-4583**, there is an indication of possible domestic abuse. The JOS/Worker should:

- Provide the individual with information about the DVU and its services;
- Encourage the individual to speak with the DVL and inform them that all referrals are voluntary and confidential (with the exception of child abuse and maltreatment).

If the applicant/participant agrees to speak with a DVL:

- Check “Yes” next to the “Client Referred to DVL?” question at the top of the **LDSS-4583** form; and
- inform the applicant/participant that a DVL will outreach to them to conduct a telephonic assessment.

If the applicant/participant indicates the existence of DV on the **LDSS-4583** and declines to speak with the DVL:

- Check “No” next to the “Client Referred to DVL?” question at the top of the **LDSS-4583** form, and enter “N” on the Assessment-Primary Questionnaire screen of the automated Employability Plan (EP); and
- Forward the **LDSS-4583** to the Deputy Director or their designee at the Job Center.

Referral for DV Assessment

Once individuals identify themselves as victims of DV and indicate they want to speak with the DVL, inform them that the DVL will conduct a Special Assessment. The DVL will be conducting assessments via telephone.

DV Assessment Outcomes and Follow Up

Upon receipt of the DV assessment outcome, the JOS/Worker will proceed to address the mandatory assessments and referrals that were postponed until the completion and outcome of DV assessment.

After the completion of the Special Assessment, if the CA applicant’s/participant’s claim of domestic violence is substantiated, the DVL may grant waivers from the following:

- Employment participation;
- Child support activity;
- Substance abuse treatment;
- Alien deeming;
- Spousal support;
- Teen (minor) parent educational requirement;
- Property liens; or
- Time limits.

Note: All waivers are granted for a minimum of six months and may only be granted by the DVL. At assessment, the DVL will also determine if a waiver must be extended or discontinued. The New York City Work Accountability and You (NYCWAY) system is programmed to only allow identified DVU staff to enter waiver determinations in the system.

Application/Recertification Closing Codes

Refer to PB#20-13-ELI

All CA eligibility and recertification interviews should currently be conducted by telephone, as opposed to in-person or "face-to-face". However, if the applicant/participant requests an in-person interview, it must be provided to them. Applicants/Participants with limited or no ability to speak, read, write, or understand English, must be provided with communication assistance in their preferred language(s). All applicants/participants have the right to free interpretation services.

Refer to PB#20-64-ELI

Two attempts must be made to contact the applicant/participant to conduct an application/recertification interview. If the second call attempt is not successful, staff must leave the applicant/participant the following voicemail message, using the interview rescheduling number:

"Hello, I am calling from the City of New York Human Resources Administration (HRA). We received [applicant/participant name]'s application [or recertification, based on interview type] and are calling to conduct your eligibility interview. This was our second attempt to contact you. If you would like to continue with your application [or recertification, based on interview type] please call us back at 212-835-7304 to let us know you want to have your interview. Thank you."

Two new Failed to Recertify (FTR) closing codes and two new associated Client Notices System (CNS) closing notices were created for FTR cases. These closing codes and closing notices are:

- **G69** (Participant submits the recertification form, but does not have the required recertification interview).

  CNS text: *You submitted your recertification form, but you did not complete a recertification interview. We tried to call you at the phone number provided but received no answer.*

- **G70** (Participant does not submit the recertification form AND does not have the required recertification interview).

  CNS text: *You did not send us your completed recertification form and you did not complete the required recertification interview.*

The **G69** and **G70** codes were activated in the Welfare Management System (WMS) on July 2, 2020. These new closing codes also can be used by Job Center #90 staff for homebound cases, as they would apply in the same way for regular Job Center cases. All necessary outreach to the participant must be completed prior to the initiation of the closing of the case, as per current procedure.

Refer to PB#21-09-ELI

Note: Staff must not enter the **G69** or **G70** before the 10th day of the 12th month of the certification period.

As a reminder, the currently used FTR closing code **G10** (Failure to Recertify on [Date]. CA has been discontinued because the client failed to appear for face-to-face recertification interview) is specific to the face-to-face scheduled appointments and is not appropriate for the telephone recertification interview during the COVID-19 emergency.

Note: The closing code **G10** must not be used to close any cases for failure to complete the recertification until further notice.

Single Issuance Grant Request Reminders

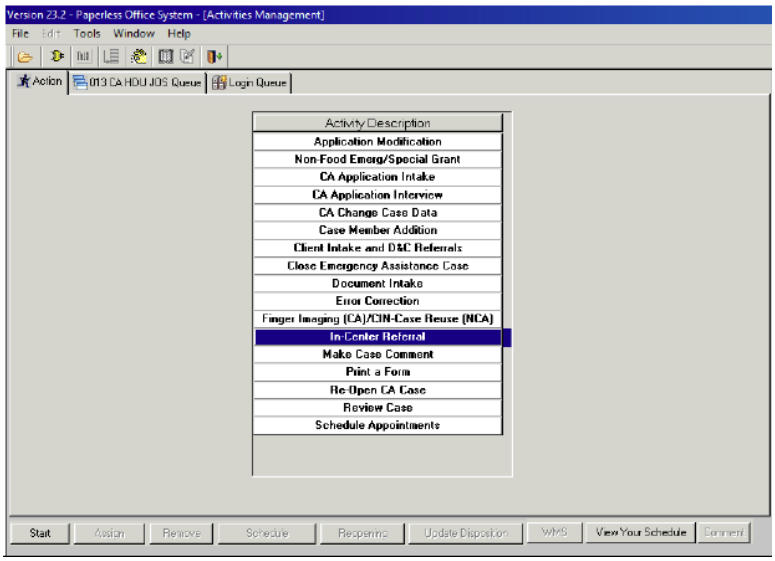
Refer to PB#19-44-SYS

CA participants with cases in active (**AC**) status can make an online request for assistance with rent arrears. Cases are assigned to the JOS/Worker to be processed timely.

This is a reminder to JOS/Workers to complete the decision on the rent arrears grant request. The Housing Diversion Unit (HDU) must close out any Rental Assistance Unit (RAU) / FHEPS Centralized Determination Unit (FCDU) denials using the Action Taken on Your Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (Participants Only) (**W-137B**) form. If the rent arrears grant request is not completed, the **W-137B** cannot be used to close out the denial.

This is a reminder to the JOS/Worker to not use rent supplementation, but to complete the decision on the rent arrears grant request. If when completing a new request for rent arrears, and the JOS/Worker finds a prior request for rent arrears, the JOS/Worker should not start another activity (i.e., rent supplementation). The JOS/Worker must finish the **W-137B** decision for prior rent arrears with a case note indicating that it was completed. If a decision is made manually, the JOS/Worker should go into the **Single Issuance (SI) Grant Request** Task 6 in the Paperless Office System (POS) to indicate that a manual decision was done. This will allow closing out the grant request when completing the **W-137B** form.

This is a reminder to the JOS/Worker that when they start an activity, and then move on to a different activity on the Activities Management screen in POS, the JOS/Worker needs to remove or close out the initial activity. For example, if the JOS/Worker started with the **CA Change Case Data** activity on the Activities Management screen in POS, then moved to complete a **Non-Food Emergency / Special Grant** activity, the JOS/Worker will need to remove the initial activity in order to reopen the **Non-Food Emergency / Special Grant** activity to enter the decision.



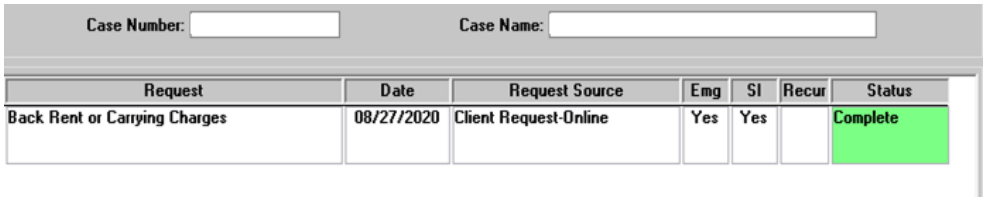
This is a reminder to ensure that the appropriate levels of approval are applied for the respective check or grant amounts:

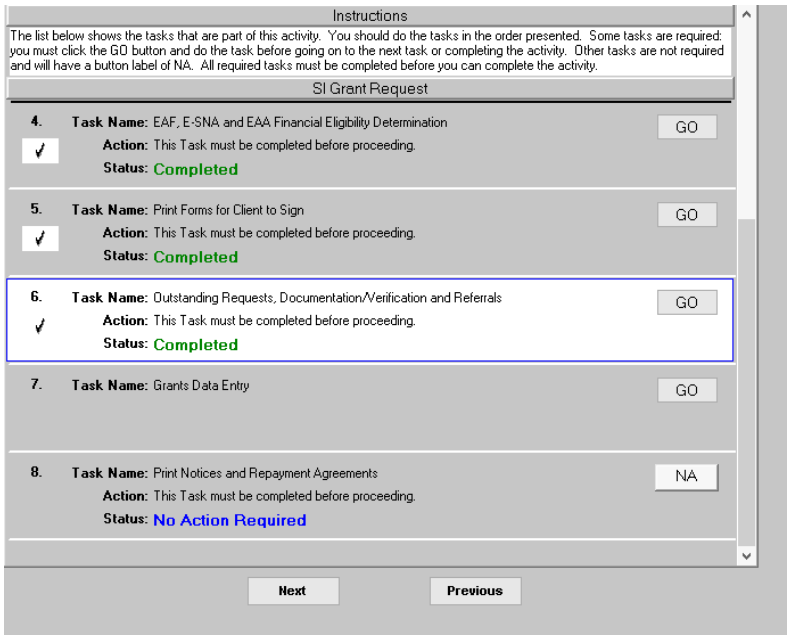
- Up to $999.99, can be approved by the Associate Job Opportunity Specialist (AJOS I) / Principal Administrative Associate (PAA I).
- $1,000 to $1,999.99 can be approved by the AJOS II / PAA II (Assistant Deputy Director).
- $2,000 and above can be approved by the Administrative Job Opportunity Specialist (Admin JOS I) [Deputy Director].
- All special grant code 99 must have approval from the Admin JOS II (Center Director).

The JOS/Worker sends the case to their Supervisor for approval. The Supervisor must approve the check/grant and print the **W-137B** form to notify the participant. It is also imperative that staff check the total check or grant amount. For example, if two checks are issued ($750 dollars and $733 dollars) for the total sum of $1,483 dollars, it should be the AJOS II signing off and approving the checks, not the AJOS I.

This is a reminder that Centers with Selective Case Review must address the **W-137B** located in the print queue in POS, and allow them to be produced from that print queue and issued via Print to Mail (PTM).

The JOS/Worker must ensure that the **SI Grant Request** Task 6 in POS shows a status of Complete. Please refer to the following screenshots.





Automated Storage Payments

Refer to PB#14-23-OPE

This is a reminder that a CA applicant/participant who places furniture and personal belongings in storage may be eligible for payment of storage fees. These circumstances include situations where the individual or family has to relocate, is evicted, or resides in temporary shelter/housing. The storage payments may be paid as long as eligibility for CA continues and circumstances necessitating the storage continue to exist.

Assistance to pay storage fees is not a benefit meant to continue for an indefinite period of time. Storage fees for applicants/participants must be applied for on a month-to-month basis.

Note: Street homeless individuals (those cases with shelter code 23 and those not in a shelter) should not have automated storage payments.

The JOS/Worker must enter all requests for Storage fees in the POS **Single Issuance Record Special Grant Requests** window. POS will log in the request for storage fees on the POS automated Participant Request Control Card (**W-111F**) to track the request. A determination must be made within seven business days of receipt of all relevant documentation supporting an applicant's/participant's request for storage fees.

Refer to PD#19-14-OPE

A storage allowance/grant may be made in accordance with the needs and size of the applying/requesting household. Generally, households with more members would require more storage space than a household with fewer people. All households are entitled to receive, if otherwise eligible, sufficient storage space to store their allowable furniture and personal belongings. However, the household's total furniture must not exceed the amount needed for the household size and is limited to the items allowed by regulation and personal belongings to be stored must not exceed the amount needed for the household size and must be reasonable in number and total volume.

Note: To qualify for automated storage payments, the household storage size and cost must fall within the agency guidelines depending on the initial request date, and there must be no change to the household's homeless situation.

Refer to PB#14-100-OPE

The Human Resources Administration (HRA) has an automated process to systematically pay storage fees (Issuance Code **21**) to storage vendors for households, as long as the household resides in a Department of Homeless Services (DHS) shelter. The Information Technology Systems (ITS) unit will conduct a file match with DHS to identify individuals or families who reside in participating homeless shelters. Once those households have been identified, ITS will pass a file to the Welfare Management System (WMS) on a monthly basis for the storage fees to be automatically paid to the storage vendor.

Note: In order for the identified household to have their storage fees paid, the case must be in active (AC) status on the first of the month, when the file match is run. If the case is closed for any reason on the first of the month, the case will not be part of the file match and will not get their storage fees paid. The applicant/participant will need to reopen their case and initiate a new storage request.

Refer to PD#19-14-OPE

Applicants/Participants will need to submit a current invoice when it is a new storage request, or when there is a change in the storage cost. The storage fee request should be recorded in POS. For active CA cases, POS will prefill the Request for Emergency Assistance or Additional Allowance (For Participants Only) (**W-137A**) when a participant requests a payment of storage fees. In the **Print Forms for Client to Sign** window, the JOS/Worker will print the **W-137A** form for participants and capture the participant's signature. The Supervisor must approve the grant request and will print the Action Taken on Your Request for Emergency Assistance or the Additional Allowance Form (For Participants Only) (**W-137B**) to notify a participant.

Note: The storage payment period should be within the same month (i.e., 10/1/20 to 10/31/20; not 10/2/20 to 11/1/20).

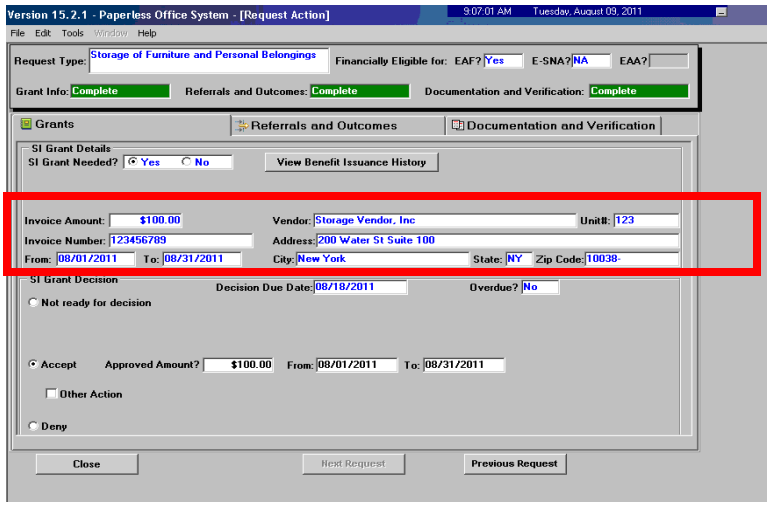
Staff must populate a monthly storage fee amount in the POS field for the initial storage request to get on the monthly storage file.

Staff must complete all fields in the new request window:

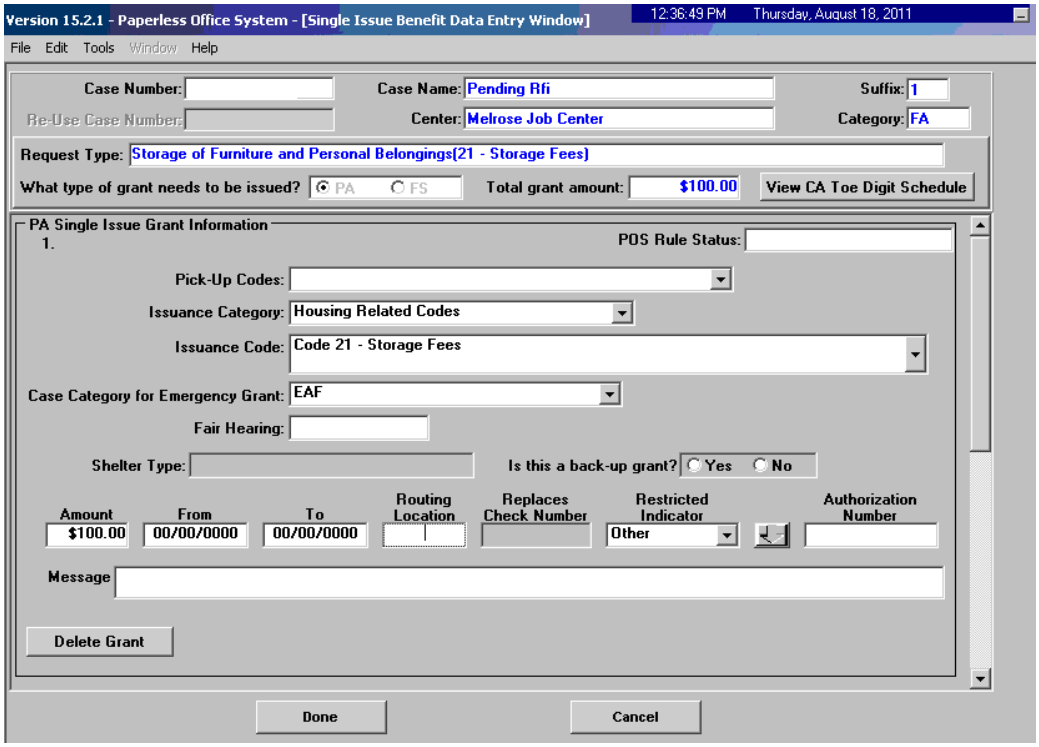
- Actual monthly storage cost;
- Storage company name;
- Storage company address;
- Invoice number;
- Cube or account number.

Note: It is recommended that staff include the participant's last name in the vendor name field, if space allows. For example, EXTRASPACE STORAGE FOR JONES in the vendor name field.

Note: For the Unit Number in POS, it is important to include the participant's storage unit number or the participant's account number.



Note: The Request Type and Issuance Code should not be "Other", as the case will not get to the monthly storage file. In the following screenshot, the Request Type lists storage fees and the Issuance Code is Code 21.



Staff must remember to not initiate multiple **W-137A** requests for storage, as it will prevent the case from getting to the monthly storage file. Staff can initiate one storage fees request to cover multiple months and late fees, as long as the "storage fee amount" field accurately states the monthly storage amount.

Fillable Forms

The following forms are available in fillable formats:

- Help for People with Disabilities (**HRA-102c**)
- New York State Application for Certain Benefits and Services (**LDSS-2921**)
- New York State Recertification Form for Certain Benefits and Services (**LDSS-3174**).

Effective Immediately

Related Items:

CD #20-18
DSS-PB-2020-003
PB #14-23-OPE
PB #14-100-OPE
PB #17-49-ELI
PB #19-44-SYS
PB #20-13-ELI
PB #20-64-ELI
PB #21-09-ELI
PD #12-14-EMP
PD #13-09-ELI
PD #18-09-SYS
PD #18-10-OPE
PD #19-08-ELI
PD #19-14-OPE

Attachments:

Attachment A	Conferencing in a Third Party Using the Softphone Technology
Attachment B	Telephone Interpretation Service Access Codes
HRA-102c	Help for People with Disabilities (Rev. 1/5/17)
HRA-102c (S)	Help for People with Disabilities (Spanish) (Rev. 1/5/17)
LDSS-2921	New York State Application for Certain Benefits and Services (Rev. 7/20)
LDSS-3174	New York State Recertification Form for Certain Benefits and Services (Rev. 7/20)
LDSS-4579	Non-Citizen Eligibility Desk Aid (Rev. 11/19)
LDSS-4583	Domestic Violence Screening Form (Rev. 9/07)
LDSS-4813	Desk Reference for Domestic Violence Screening Under the Family Violence Option
ORIA-195	Office of Refugee and Immigrant Affairs (ORIA) Clearance Request Form (Rev. 10/6/20)
ORIA-195a	Office of Refugee and Immigrant Affairs (ORIA) Clearance Response Form (Rev. 10/6/20)
PALM-21 (E)	Infocard: How to Call for an Interpreter (Rev. 6/18)
W-111F	Participant Request Control Card (Rev. 9/2/11)
W-137A	Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Rev. 3/16/20)

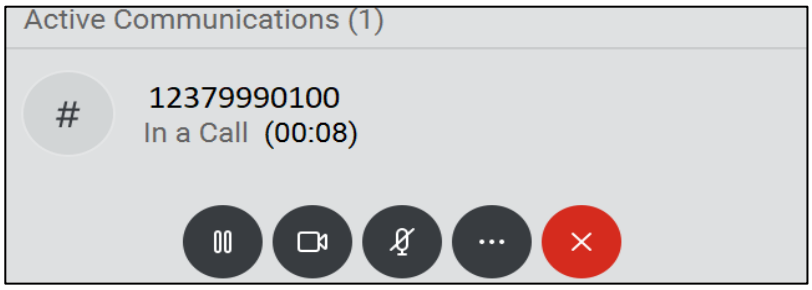
W-137A (S)	Request for Emergency Assistance, Additional Allowances, or to Add a Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 3/16/20)
W-137B	Action Taken on Your Request For Emergency Assistance, Additional Allowances, or to Add A Person to the Cash Assistance Case (For Participants Only) (Rev. 3/16/20)
W-137B (S)	Action Taken on Your Request For Emergency Assistance, Additional Allowances, or to Add A Person to the Cash Assistance Case (For Participants Only) (Spanish) (Rev. 3/16/20)
W-205JJ	Permanently Residing Under the Color of Law (PRUCOL) Desk Aid (Rev. 11/24/17)
W-515X	Systematic Alien Verification for Entitlements (SAVE) Referral (Rev. 10/11/13)

ATTACHMENT A

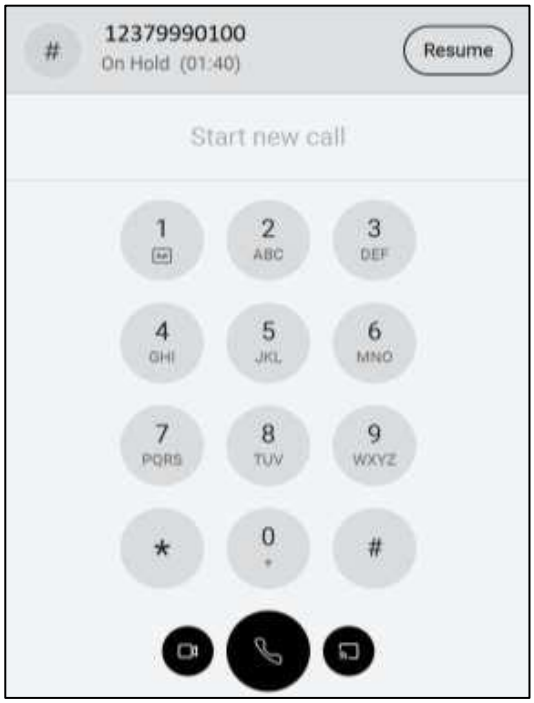
CONFERENCING IN A THIRD PARTY USING THE SOFTPHONE TECHNOLOGY

- To make a three-way/conference call, (i.e., to conference in a third party to help an applicant/participant with the interview), take the following steps once you are connected:

  - Click the  icon to pause the current call.

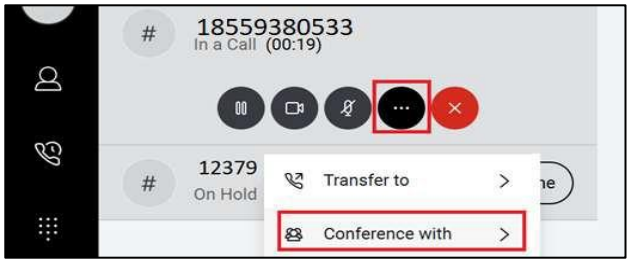


  - After clicking pause, you'll be automatically be prompted to start a new call as shown below. Use the dialer pad to dial the number (i.e., applicant's/participant's adult son) you wish to add to the call.

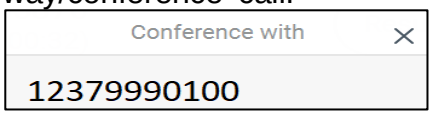


- Once connected to the 2nd line, tell them you are going to merge the calls.

  Click the  icon, then click “conference with.”

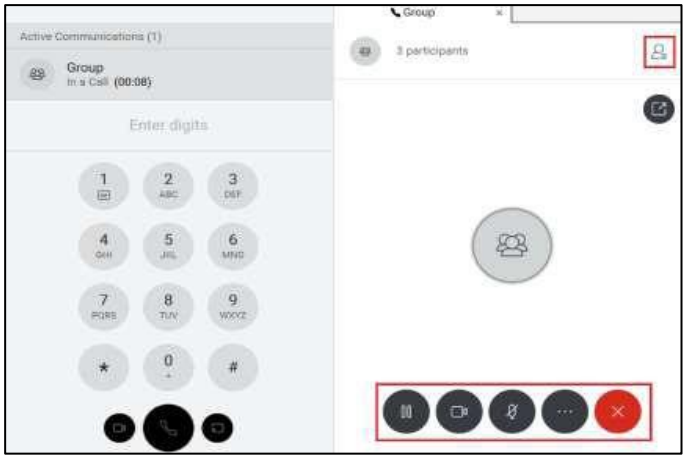


- In the pop-up box, select the phone number to add to the three-way/conference call.



- You will see the three-way/conference call has started. Use the controls on the right panel to view the individuals in the call, or to pause the call.

- Once done with the three-way/conference call, click the  icon to disconnect the group call (i.e., disconnect from the applicant’s/participant’s adult son) and return to your original call.



- Click “Resume” to take the original call off hold. Resume the conversation following the end of the three-way/conference call, if necessary and appropriate.

ATTACHMENT B

Telephone Interpretation Service Access Codes

Redeployed Non-FIA Staff

Redeployed Non-FIA staff must utilize the telephone interpretation service using the access code **3398**.

FIA Staff

For FIA staff, the telephone interpretation service codes for the respective Job Centers are listed below.

Job Center	Telephone Interpretation Service Access Code
Bronx Region	
Rider Job Center #38	3338
Hunts Point Job Center #40	3340
Fordham Job Center #44	3344
Concourse Job Center #45	3345
Crotona Job Center #46	3346
Brooklyn Region	
Coney Island Job Center #63	3363
Dekalb Job Center #64	3364
Bushwick Job Center #66	3366
Clinton Hill Job Center #67	3367
Southern Brooklyn Job Center #70	3370
Manhattan Region	
Waverly Job Center #13	3313
St. Nicholas Job Center #18	3318
East End Job Center #23	3323
Dyckman Job Center #35	3335
Queens/Staten Island Region	
Queens Job Center #53	3353
Jamaica Job Center #54	3354
Rockaway Job Center #79	3379
Richmond Job Center #99	3399

ATTACHMENT B

Job Center	Telephone Interpretation Service Access Code
Family Services Call Center (FSCC)	
FSCC Job Center #17	3317
Bronx Satellite FSCC	331729
Manhattan Satellite FSCC	331766
Queens Satellite FSCC	331776
Brooklyn Satellite FSCC	331725
Field Operations Support / Special Population / Special Needs Region /	
Union Square Job Center #39	3339
Refugee and Immigrant Job Center #47	3347
HRA Express Center #50	3350
Residential Treatment Job Center #52	3352
Veterans Job Center #62	3362
Special Project Job Center #80	3380
Home Visit Needed Job Center #90	3390

Human Resources Administration
Department of Social Services

HELP FOR PEOPLE WITH DISABILITIES

Do you have a disability, medical condition or mental health condition that makes it hard for you to apply for or get benefits from us?

For example:

- Does your condition make it hard for you to use public transportation?
- Do you need help to get to appointments?
- Does your condition make it hard for you to wait for long periods of time?
- Is it hard for you to read, understand or fill out forms?
- Do you need help because of a vision or hearing disability?
- Do you need other help because of your condition?

If you do, we may be able to help you. This help is called a reasonable accommodation.

HOW TO ASK FOR A REASONABLE ACCOMMODATION

ASK: You can ask for help when you come to an HRA office or center

CALL: 212-331-4640

You can also write us or fill out the request on the other side of this form and give it to us through:

FAX: 212-331-4685

EMAIL: ConstituentAffairs@hra.nyc.gov

MAIL: HRA
Office of Constituent Services
150 Greenwich Street, 35th Floor
New York, NY 10007

GET HELP WITH THIS FORM!

You can get help with this form or with your request.

CALL: 212-331-4640 or **VISIT:** your center or HRA office

Turn this page over to complete the Reasonable Accommodation Request Form.

HELP FOR PEOPLE WITH DISABILITIES
REASONABLE ACCOMMODATION REQUEST FORM

Do you have a disability, medical condition or mental health condition that makes it hard for you to apply for or get benefits from us? **If you do,** please fill out this form. **If you do not,** you don't need to fill out this form.

YOUR INFORMATION

Name: _____ Date: _____

Case Number: _____ Date of Birth: _____

Phone Number 1: _____ Phone Number 2 *(if any)*: _____

Address: _____

WHY DO YOU NEED HELP?

Tell us how your condition makes it hard to access HRA benefits and services *(If you need more space to write, please attach pages):* _____

_____

_____

_____

CHOOSE WHAT HELP YOU MIGHT NEED BECAUSE OF YOUR CONDITION:

- ☐ Help for people who are blind or low vision
  Explain: _____
- ☐ Making appointments when you can have someone come with you
- ☐ No appointments during certain days and times
- ☐ No appointments during rush hour
- ☐ No in-office appointments while you apply for Access-A-Ride
- ☐ Shorter wait times

Help for people who are deaf or hard of hearing :

- ☐ American Sign Language (ASL) interpretation
- ☐ Other forms of interpretation
  Explain: _____
- ☐ Help reading forms
- ☐ Help completing forms
- ☐ You need HRA to come to your home for appointments
- ☐ Transfer your case to center:
  _____
- ☐ Keep your case at your center:
  _____

☐ Accommodations (other than above) that you need to access services at HRA. *Explain:*

_____

_____

_____

You do not need to give us proof of your condition now.
We may ask you to give us some medical or clinical documents later.

To be completed by HRA worker if submitted at an HRA location *(Please give a copy to the client):*

Location	Date Received
Name of HRA worker (Print)	Signature

Center 90 Staff only: Homebound status was requested ☐ Yes ☐ No

Human Resources Administration
Department of Social Services

AYUDA PARA LAS PERSONAS CON DISCAPACIDADES

¿Padece usted una discapacidad, afección médica o de salud mental que le dificulte solicitar u obtener beneficios de parte nuestra?

Por ejemplo:

- ¿Le dificulta la afección servirse del transporte público?
- ¿Necesita usted ayuda para trasladarse a las citas?
- ¿Le dificulta la afección esperar por largos ratos?
- ¿Le cuesta trabajo leer, entender o llenar formularios?
- ¿Necesita usted ayuda debido a una discapacidad de la vista o de la audición?
- ¿Necesita usted ayuda de otra índole debido a su afección?

En caso afirmativo, tal vez podamos ayudarle. Esta ayuda se denomina arreglo razonable.

CÓMO SOLICITAR ARREGLO RAZONABLE

EN PERSONA: Usted puede pedir ayuda al presentarse a una oficina o centro de la HRA.

LLAME AL: 212-331-4640

Usted también nos puede escribir o llenar la solicitud al revés de este formulario y prensentárnosla por:

FAX: 212-331-4685

CORREO ELECTRÓNICO: ConstituentAffairs@hra.nyc.gov

CORREO POSTAL:
HRA
Office of Constituent Services
150 Greenwich Street, 35th Floor
New York, NY 10007

¡OBTENGA AYUDA PARA LLENAR ESTE FORMULARIO!

Usted puede obtener ayuda con este formulario o con su solicitud.

LLAME AL: 212-331-4640 o **VISITE:** su oficina o su centro de la HRA.

Pase esta página para llenar el Formulario de Solicitud de Arreglo Razonable.

AYUDA PARA LOS DISCAPACITADOS
FORMULARIO DE SOLICITUD DE ARREGLO RAZONABLE

¿Padece usted una discapacidad, afección médica o de salud mental que le dificulte solicitar u obtener beneficios de parte nuestra? **En caso afirmativo**, favor de llenar este formulario. **En caso negativo**, no necesita llenar este formulario.

SUS DATOS

Nombre y apellido: _____ Fecha: _____

Número del Caso: _____ Fecha de Nacimiento: _____

Núm. de Teléfono 1: _____ Núm. de Teléfono 2 *(de haberlo)*: _____

Dirección: _____

¿POR QUÉ NECESITA USTED AYUDA?

Explíquenos cómo su afección le dificulta el acceso a los beneficios y servicios de la HRA. *(Si necesita más espacio para escribir, favor de adjuntar páginas adicionales.)*:_____

_____

_____

_____

ELIJA LA AYUDA QUE USTED NECESITE DEBIDO A SU AFECCIÓN:

☐ Ayuda para los ciegos o con vista limitada
Detalle: _____

☐ Citas programadas para cuando usted desee que alguien le acompañe

☐ Ningunas citas durante ciertos días y horas

☐ Ninguna cita durante la hora punta

☐ Ninguna cita en oficinas mientras usted solicite Access-A-Ride

☐ Tiempo de espera más corto

Ayuda para los sordos o con audición limitada :

☐ Interpretación de Lenguaje de Señas Estadounidense (ASL)

☐ Otro modo de interpretación
Detalle: _____

☐ Ayuda para leer formularios

☐ Ayuda para llenar formularios

☐ Usted necesita que la HRA vaya a su casa para las citas

☐ Transferencia de su caso a centro:
_____

☐ Mantenimiento de su caso en su centro:
_____

☐ Arreglos (aparte de los de arriba) que usted necesite para acceder servicios de la HRA. *Detalle:*

_____

_____

_____

Usted no tiene que proporcionarnos ningún comprobante de su afección en este momento. Puede que le solicitemos documentos médicos o clínicos en una fecha posterior.

To be completed by HRA worker if submitted at an HRA location *(Please give a copy to the client):*

_____ _____
Location Date Received

_____ _____
Name of HRA worker (Print) Signature

Center 90 Staff only: Homebound status was requested ☐ Yes ☐ No

LDSS-2921 **Statewide** (Rev. 07/20)

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

CENTER/ OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	SERV. IND	CASE NUMBER	REGISTRY NUMBER	VERS	DISTRICT	SUFFIX	SNAP SUFFIX	CATEGORY	LANG	NUMBER REUSE INDICATOR

CASE NAME	EFFECTIVE DATE	DISPOSITION	SERVICES TRANSACTION TYPE
		☐ DENIAL ☐☐☐ REASON CODE ☐ WITHDRAWAL	☐ NEW OPENING 02 ☐ REOPEN 10 ☐ RECERTIFICATION 06

ELIGIBILITY DETERMINED BY (WORKER):	DATE	ELIGIBILITY APPROVED BY (SUPERVISOR):	DATE	FORM _____ 0F _____	SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION x _____	DATE

DATE RECEIVED BY AGENCY	EMPLOYED BY: ☐ SOCIAL SERVICES DISTRICT ☐ PROVIDER AGENCY SPECIFY: _____

PA AUTHORIZATION PERIOD		MA AUTHORIZATION PERIOD		SNAP AUTHORIZATION PERIOD		SERVICES AUTHORIZATION PERIOD	
FROM	TO	FROM	TO	FROM	TO	FROM	TO

NEW YORK STATE APPLICATION FOR CERTAIN BENEFITS AND SERVICES

If you are blind or seriously visually impaired and need this application in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request an application in an alternative format, see the instruction book (PUB-1301 Statewide), available at www.otda.ny.gov or https://www.health.ny.gov/.

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

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

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

We are committed to assisting and supporting you in a professional and respectful manner. You are responsible for participating in activities, including work activities for Public Assistance and the Supplemental Nutrition Assistance Program, where required, so you can become self-sufficient. Whenever you see "Public Assistance" or "PA" on the application, it means "Family Assistance" and/or "Safety Net Assistance." We call both programs "Public Assistance." These PA programs are meant to assist you only until you can fully support yourself and your family. Please refer to the instruction book (PUB-1301 Statewide) and "What You Should Know" Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this application, and contact your social services district with any questions.

When you see "MA" on the application, it means "Medicaid." You may apply for MA using this application only if you are also applying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only apply for MA, you can go online at https://nystateofhealth.ny.gov/ and/or call 1-855-355-5777 for more information or to apply, or you may use the MA-only paper application - Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to apply only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH- 4220 MA application form.

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

LDSS-2921 Statewide (Rev. 07/20)

SECTION 1

CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE APPLYING FOR

☐ Public Assistance (PA) ☐ Child Care in lieu of PA ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Medicaid (MA) and SNAP
☐ Medicaid (MA) and PA ☐ Services (S), including Foster Care (FC) ☐ Child Care Assistance (CC) ☐ Emergency Assistance Only (EMRG)

SECTION 2

WHAT IS YOUR PRIMARY LANGUAGE? ☐ ENGLISH ☐ SPANISH ☐ OTHER (specify) _____

DO YOU WANT TO RECEIVE NOTICES IN: ☐ ENGLISH ONLY ☐ ENGLISH AND SPANISH

SECTION 3 APPLICANT INFORMATION PLEASE PRINT CLEARLY

FIRST NAME	M.I.	LAST NAME	MARITAL STATUS	PHONE NUMBER ( ) AREA CODE

STREET ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

IN CARE OF NAME (COMPLETE IF YOU RECEIVE YOUR MAIL IN CARE OF ANOTHER PERSON)

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?	YEARS	MONTHS	IS THIS A SHELTER? ☐YES ☐NO	ANOTHER PHONE WHERE YOU CAN BE REACHED	NAME	PHONE NUMBER ( ) AREA CODE

DIRECTIONS TO CURRENT ADDRESS

FORMER ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK HERE ☐

AGENCY HELPING APPLICANT/CONTACT PERSON	PHONE NUMBER ( ) AREA CODE

DO YOU NEED THE MEDICAID PORTION OF THIS APPLICATION AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL? ☐ YES ☐ NO

SECTION 5

DO ANY OF THESE APPLY TO YOU?

☐ Pregnant	1
☐ Victim of Domestic Violence	2
☐ Need to Establish Parentage	3
☐ Need Child Support	4
☐ Drug/Alcohol Problem	5
☐ Fuel or Utility Shutoff	6
☐ No Place to Stay/Homeless	7
☐ Fire or Other Disaster	8
☐ Have No Income	9
☐ Serious Medical Problem	10
☐ Pending Eviction	11
☐ No Food	12
☐ Need Foster Care	13
☐ Need Child Care	14
☐ Problems with English	15
☐ Reasonable Accommodations	16
☐ Other _____	17

SECTION 4 – If You Are Applying For SNAP: You can file an application the day you get it. In order to file a SNAP application, it must have, at minimum, your name, address (if you have one) and signature below. You must complete the application process, including signing the last page of the application and being interviewed. If eligible, you will get SNAP benefits back to the date you filed the application. You must be told, within 30 days of the date you turned in (filed) your application for SNAP benefits, if your application is approved or denied. If your household has little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources, you may be eligible to get SNAP benefits within five calendar days of the date you file. If you are a resident of an institution and are applying for both Supplemental Security Income (SSI) and SNAP benefits prior to leaving the institution, the filing date of the application is the date you leave the institution.

SNAP APPLICANT/REPRESENTATIVE SIGNATURE	DATE SIGNED
x	

SECTION 6 – HOUSEHOLD INFORMATION – List everybody who lives with you, even if they are not applying with you. List yourself on the first line.

RI	LN	First Name, Middle Initial, Last Name	This person is applying for: PA	SNAP	MA	CC	FC	S	EMRG	Date of Birth: (mm/dd/yyyy)	Sex: (M/F)	Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe])	Relationship to you:	Social Security Number of Applying Household Members *(See instruction book, PUB-1301 Statewide, or talk to your social services district)*	Highest School Grade Completed	Does This Person (Including Minor Children) Buy Food or Prepare Meals with You? YES	NO
	01												**SELF**				
	02																
	03																
	04																
	05																
	06																
	07																
	08																

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAVE BEEN KNOWN

Line No.	ONC	FIRST NAME	M.I.	LAST NAME

IS ANYONE SANCTIONED? ☐ YES ☐ NO | IF YES, WHO | REASON | END DATE

NON-APPLICANT INFORMATION

LN	FIRST NAME	LAST NAME	LEGALLY RESPONSIBLE YES	NO	FOR WHOM?	CONTRIBUTION/ DEEMED INCOME	CHECK IF MEMBER OF SNAP HOUSEHOLD

NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS INFORMATION

LN	NON-CITIZEN STATUS	STATUS ADJUSTED YES	NO	DATE OF ENTRY/STATUS MONTH	DAY	YEAR	APPLIED FOR CITIZENSHIP YES	NO	SPONSORED YES	NO

INDIVIDUAL EDUCATION

LN	DEGREE RECEIVED	LN	DEGREE RECEIVED
01		05	
02		06	
03		07	
04		08	

CONSIDER

✓ RCA/RMA REFERRAL

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 7 – RACE/ETHNICITY – Providing this information is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for requesting this information is to ensure that program benefits are distributed without regard to race, color, or national origin.

H HISPANIC OR LATINO
I NATIVE AMERICAN OR ALASKAN NATIVE
A ASIAN
B BLACK OR AFRICAN AMERICAN
P NATIVE HAWAIIAN OR PACIFIC ISLANDER
W WHITE
U UNKNOWN **(MA ONLY)**

LN	↓ ENTER Y (YES) OR N (NO) FOR HISPANIC OR LATINO / ENTER Y (YES) OR N (NO) FOR EACH RACE							CLIENT IDENTIFICATION NUMBER	ENTER APPROPRIATE CODES								
	H	I	A	B	P	W	U		REL	SSN	SFUI	MS	SI	LA	EM	CI	EL
01																	
02																	
03																	
04																	
05																	
06																	
07																	
08																	

ANTICIPATED FUTURE ACTION			CASE TYPE	RELATED CASE NUMBERS
LINE NO.	CODE	DATE		

SERVICE ELIGIBILITY PROCESS CODE			
SFUI	CODE	SFUI	CODE
SFUI	CODE	SFUI	CODE

NEEDED	REFERRALS	COMPLETED
	Legal	
	Services	
	SSA	
	NYSoH	
	Chronic Care/SSI-Related	
	MA-Only	
	Medicare Savings Program	

CONSIDER

- ✓ Relationship
- ✓ Filing Unit
- ✓ Legally Responsible Relative
- ✓ Single Economic Unit
- ✓ SNAP Household Composition
- ✓ SNAP Aged/Disabled Individual
- ✓ Photo ID
- ✓ AFIS (PA Only)
- ✓ CBIC/PIN
- ✓ RFI/OCA
- ✓ Health Insurance

REQUESTED	DOCUMENTATION	IN FILE
	Photo ID	
	Birth Verification	
	Marriage License	
	Social Security Card	
	Code 9 Resolution	
	Immigration Status	
	Multi-Suffix/Co-op Case Notice (Single Economic Unit Questionnaire)	

Please read this entire page carefully before completing it. If you have questions, see the instruction book (PUB-1301 Statewide) or talk to your social services district.

SECTION 8 – CITIZENSHIP/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS

LIST EVERYONE WHO IS APPLYING OR WHO IS REQUIRED TO APPLY.

You have to fill out Sections 8 and 9 if you are:

- Applying for Child Care Assistance only, but you need to fill out the information only for the children who would be receiving Child Care Services.
- Applying for Foster Care only, but you need to fill out the information only for the children who would be receiving Foster Care.
- Applying for other Services under certain circumstances.

SECTION 9 – CERTIFICATION

Some social services programs require that you certify that you are a United States citizen, Native American or national of the U.S., or a non-citizen with satisfactory immigration status. Other programs do not.

You MUST sign the Certification below only if you are a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status, and you are applying for:

- Public Assistance (where there are children in the household or a member of the household is pregnant), or
- The Supplemental Nutrition Assistance Program, or
- Medicaid (except if the applicant is pregnant), or
- Child Care Assistance (certification is needed for the children only), or
- Foster Care (certification is needed for the children only), or
- Other Services under certain circumstances;
- Emergency Payment Assistance

An adult household member or authorized representative may sign for all household members. Example: A parent without a satisfactory non-citizen status may sign for their child with a satisfactory non-citizen status.

NEEDED	REFERRALS	COMPLETED
	Systematic Alien Verification for Entitlements (SAVE)	

An application for SNAP must list all persons living in the SNAP household. An application for PA must list all children for whom you are applying, their siblings, and all parents of those children who live together. If you do not check whether a listed person is a United States citizen, national of the U.S. or an non-citizen with a satisfactory immigration status, or provide an U.S. Citizenship and Immigration Services (USCIS) number (Alien Registration Number) or a non-citizen number (if applicable), that person will not be given assistance and the remaining members of the household will receive reduced benefits. If you are a Native American, check citizen/national.

SIGN* AND DATE THE BOX BELOW FOR EACH APPLICANT.

In the case of an applying non-citizen with a satisfactory immigration status, check the program(s) for which each applying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1301 Statewide.)

LN	FIRST NAME	MI	LAST NAME	Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.	USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER (If Applicable)	CERTIFICATION	DATE	PA	SNAP	MA	CC	FC	S	EMRG
01				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								
02				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								
03				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								
04				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								
05				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								
06				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								
07				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								
08				☐ CITIZEN/ NATIONAL ☐ NON-CITIZEN	A	Sign Name X								

By checking a box above and by signing the certification in Section 9, I hereby certify, under penalty of perjury, that I, and/or the person(s) for whom I am signing, am a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status.
I understand that signing this Certification may result in information about applying members of my household being submitted to the United States Citizenship and Immigration Services for verification of non-citizen status, if applicable.
The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of citizenship status, and the administration or enforcement of the provisions of the Public Assistance, Supplemental Nutrition Assistance, Medicaid, Child Care Assistance, Foster Care and Services Programs.

*A person who wishes to sign the Certification but cannot write may make an "X" on the line in front of a witness. The witness must sign below.

I witnessed the marks made in lines: _____,_____,_____,_____,_____,_____ Signature of witness: _____ Date Signed: _____

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 10 – INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT

If you are applying only for child care assistance, you are not required to pursue child support and do not have to fill out this section. If you are applying for Medicaid in addition to Public Assistance or the Supplemental Nutrition Assistance Program, you may have to help us obtain medical support for yourself and your applying children. Answer the following questions to determine if you need to complete this section. Include yourself, as appropriate:

1. Are you applying for an individual under the age of 21 who was born out of wedlock and for whom legal parentage has not been established? ☐ Yes ☐ No
2. Are you applying for an individual under the age of 21 who has an absent parent (noncustodial parent)? ☐ Yes ☐ No

You do not need to complete this section if you answered "No" to both of these questions. Go to Section 11.

You must complete this section if you answered "Yes" to either or both of these questions. Provide the names of all individuals under the age of 21 for whom you are applying and any information you currently have about those individuals' noncustodial parents or alleged parents.

3. Are you under the age of 21? ☐ Yes ☐ No

If you answered "Yes" to this question, provide the information for your noncustodial parent(s) or alleged parent(s).

As a condition of obtaining assistance, you are required to assign certain rights related to support, as described in the Notices, Assignments, Authorizations, and Consents section at the end of this application. You will be provided with the LDSS-5145 form, "Referral for Child Support Services," to complete and return to the Child Support Enforcement Unit. Except in situations of domestic violence or other good cause, as a condition of obtaining assistance, you are required to cooperate with the Child Support Enforcement Unit to locate any noncustodial parent or alleged parent; establish legal parentage for each individual under the age of 21 born out of wedlock; and establish, modify, and/or enforce orders of support. You also will be provided with the LDSS-4279 form, "Notice of Responsibilities and Rights for Support," which explains your responsibilities and your rights if you do not cooperate with the Child Support Enforcement Unit.

REQUESTED	DOCUMENTATION	IN FILE
	Acknowledgment of Parentage or Paternity	
	Child Support Order	
	Good Cause Form (LDSS-4279)	
	IV-D Attestation (LDSS-4281)	
	Death Certificate	
	Divorce Decree	
	VA Benefits	
	Order of Filiation/Paternity/Parentage	
	Birth Certificate	
NEEDED	**REFERRALS**	**COMPLETED**
	CTHP	
	CAP	
	Referral for Child Support Services (LDSS-5145)	
	Parentage/Paternity	

CONSIDER

- ✓ Health Insurance of Non-custodial Parent/Absent Spouse
- ✓ Child Health Plus
- ✓ TASA
- ✓ Petition to Family Court
- ✓ SSI/SSA

NAME OF INDIVIDUAL UNDER AGE 21	NONCUSTODIAL PARENT OR ALLEGED PARENT'S NAME AND ADDRESS	NONCUSTODIAL PARENT OR ALLEGED PARENT'S DATE OF BIRTH			NONCUSTODIAL PARENT OR ALLEGED PARENT'S SOCIAL SECURITY NUMBER
		MONTH	DAY	YEAR	
A.					
B.					
C.					
D.					
E.					

SECTION 11 – TAX FILING/DEPENDENT STATUS - Please select the tax status for each individual living in the household.

			TAX STATUS						
FIRST NAME	MIDDLE INITIAL	LAST NAME	SINGLE	MARRIED FILING JOINTLY	MARRIED FILING SINGLE	HEAD OF HOUSEHOLD (WITH QUALIFYING INDIVIDUAL)	QUALFIYING WIDOW(ER) WITH DEPENDENT CHILD	DEPENDENT AND WILL BE FILING TAXES	WILL NOT BE FILING TAXES

Tax dependents not living in the household. Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip this question.

NAME OF TAX DEPENDENT			NAME OF TAX FILER		
FIRST NAME	MIDDLE INITIAL	LAST NAME	FIRST NAME	MIDDLE INITIAL	LAST NAME

SECTION 12 – ABSENT/DECEASED SPOUSE INFORMATION – If the spouse of anyone applying lives someplace else or is deceased, please indicate below.

NAME OF PERSON APPLYING	NAME OF SPOUSE	DATE OF SPOUSE'S BIRTH	DATE OF SPOUSE'S DEATH, IF APPLICABLE	SPOUSE'S SOCIAL SECURITY NUMBER

SPOUSE'S ADDRESS, IF APPLICABLE	CITY	COUNTY	STATE	ZIP CODE

SECTION 13 – ABSENT CHILD INFORMATION – If anyone applying has a child under the age of 21 living someplace else, please indicate below.

NAME OF PERSON APPLYING	NAME OF ABSENT CHILD	DATE OF BIRTH	ADDRESS OF CHILD (STREET, CITY, COUNTY, STATE, AND ZIP CODE)	LEGAL PARENTAGE ESTABLISHED?		DO YOU PAY CHILD SUPPORT?	
				Yes	No	Yes	No

SECTION 14 – TEEN PARENT INFORMATION

Is there a parent under the age of 18 ("teen parent") in the household? ☐ Yes ☐ No

Name _____

Does the teen parent's child live in the household? ☐ Yes ☐ No

Name of teen parent's child _____

TEEN PARENT

LN NO. _____ Marital Status _____

High School Diploma/High School Equivalent? _____

LN NO. _____ Marital Status _____

High School Diploma/High School Equivalent? _____

TEEN PARENT CHILDREN

LN NO. _____

LN NO. _____

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 15 – INCOME INFORMATION:

Indicate if you or anyone who lives with you receives money from:	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY	CD	INCOME LN No.	INCOME SOURCE CODE	INCOME AMOUNT	INCOME PERIOD
1 Unemployment Insurance Benefits							49				
2 Supplemental Security Income (SSI) Benefits (State and Federal Total)							45				
3 Social Security Disability (SSD) Benefits							42				
Social Security Dependent Benefits 4											
Social Security Survivor's Benefits 5							43				
Social Security Retirement Benefits 6							44				
Railroad Retirement Benefits 7							38				
Retirement Benefits (Pensions) 8							39				
Dividends/Interest from Stocks, Bonds, Savings, etc. 9							03				
Workers' Compensation 10							59				
NYS Disability Benefits 11							33				
Veteran's Pension/Benefits/Aid and Attendance 12							55				
Public Assistance Grant 13							37				
GI Dependency Allotments 14							10				
Education Grants or Loans 15											
Contributions/Gifts (Received) 16											
Foster Care Payments (Received) 17											
Child Support Payments (Received) Received From:_____ 18							06				
Spousal Support (Received) 19							02				
Private Disability Insurance - Health/Accident Insurance Policy Income 20											
No-Fault Insurance Benefits 21							50				
Union Benefits (including Strike Benefits) 22											
Loans, Other than Education (Received) 23											
Income from a Trust (including income you are currently entitled to receive, or were entitled to receive in the past, that has not been distributed) 24											
Training Allotments/Stipends 25							31				
Rental Income (Received) 26							14				
Boarders/Lodgers Income (Received) 27											
Other Income (Please Specify)											

CONSIDER

- ✓ Child Support Disregard/Pass-Through
  - ☐ Explained ☐ Budgeted
- ✓ SNAP Aged/Disabled Indicator
- ✓ Disability Review
- ✓ Reception and Placement Grant (SNAP Only)
- ✓ Refugee Matching Grant

Deductions: Certain types of Medicaid budgeting allow applicants/recipients to reduce their countable income with deductions that they take on their federal taxes. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Only record deductions here if you will claim them on the current year's tax return.		YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY
Educator expenses	1						
Individual Retirement Account (IRA) deduction	2						
Student loan interest deduction	3						
Tuition and fees	4						
Certain business expenses (reservists, artists, fee-based government officials)	5						
Health savings account deduction	6						
Job-related moving expenses	7						
Deductible part of self-employment (S/E) tax	8						
S/E, SIMPLE & qualified plans	9						
S/E health insurance deduction	10						
Penalty on early withdrawal of savings	11						
Alimony paid	12						
Domestic production activities deduction	13						
Additional adjustments added on line 36 (IRS Form 1040 only)	14						
Archer MSA deduction	15						
Other Adjustment (Please Specify)							

SECTION 16 – STEPPARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

Answer all questions listed below.

	YES	NO	WHO?
Does the stepparent of any children who live with you have any resources or receive income of any kind?			
Is anyone in your household a non-citizen with satisfactory immigration status who was sponsored for admission into the U.S.?			

NAME OF SPONSOR: PHONE NO.:

ADDRESS:

NEEDED	REFERRAL	COMPLETED
	UIB	

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 17 – EMPLOYMENT INFORMATION

I am currently: ☐ employed ☐ self-employed ☐ unemployed

Gross Income $ _____ Hours Worked Monthly _____

(Include wages, salary, overtime pay, commissions, and tips)

Paid: ☐ Weekly ☐ Biweekly ☐ Monthly Day of the week paid: _____

Employer's Name and Address: 1

_____ Phone No. _____

_____

Is anyone else who lives with you currently: ☐ employed ☐ self-employed

Who: _____

Gross Income $ _____ Hours Worked Monthly _____

Paid: ☐ Weekly ☐ Biweekly ☐ Monthly Day of the week paid: _____ 2

Employer's Name and Address:

_____ Phone No. _____

_____

Is health insurance available through your employer? ☐ Yes ☐ No

Does anyone who lives with you have health insurance with an employer? ☐ Yes ☐ No

Who: _____ 3

Name of Insurance Company: _____

Do you or anyone who lives with you have a child or dependent care expenses due to employment? ☐ Yes ☐ No

Who: _____ 4

Do you or anyone who lives with you have other employment-related expenses? ☐ Yes ☐ No

Who: _____ 5

REQUESTED	DOCUMENTATION	IN FILE
	CINTRAK/RFI/IRCS	
	1099	
	Employment Verification	
	Income Tax Return	
	Self-Employment Worksheet	
	Wage Stubs	
	Work Registration Form	
	Dependent/Child Care Form/Statement	
	Approval of Informal Child Care Provider	

NEEDED	REFERRALS	COMPLETED
	CAP	
	Disability	
	Employment	
	TPHI/COBRA	
	UIB	
	Workers' Compensation	
	Drug/Alcohol	
	Domestic Violence	
	Refugee Cash Assistance	

CONSIDER
✓ Limited English Proficiency
✓ Earned Income Tax Credit (see PUB-4786)
✓ Explaining Periodic Reporting Requirements
✓ Net Loss of Cash Income
✓ P.A.S.S. Income Amount and Sources
✓ Employment Sanctions
✓ Temporary Employment
✓ Disability Review
✓ Individual Development Account (IDA)
✓ Voluntary Quit

If not employed, when was the last time you or anyone who lives with you worked?

Who: _____ When: _____

Where: _____ 6

Why did you (or they) stop working? _____

Did you or anyone living with you file for unemployment? ☐ Yes ☐ No

If yes, who? _____ When?: _____

Status of filing: ☐ Approved ☐ Denied ☐ Pending

Are you or is anyone who lives with you participating in a strike? ☐ Yes ☐ No

Who: _____ 7

When the strike began: _____

Are you or is anyone who lives with you a migrant or seasonal farm worker? ☐ Yes ☐ No

Who: _____ 8

Do you or any other adult who lives with you have any medical conditions that limit the ability to work or the type of work that can be performed? ☐ Yes ☐ No

Who: _____

Describe Limitations: _____

_____ 9

Could you accept a job today? ☐ Yes ☐ No 10

If not, why? _____

What type of work would you like to do? _____

_____ 11

CHILD/DEPENDENT CARE EXPENSES

Who Pays	Amount	Name	Age	Care Provider
	$			
	$			
	$			
	$			
	$			
	$			
	$			
	$			

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 18 – EDUCATION/TRAINING

What is your highest level of education completed?

__ Less than high school diploma
If so, last grade completed? _____
__ Completion of an Individualized Education Plan (IEP)
__ High school diploma or General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™) 1
__ Associate's Degree (2-year college degree)
__ Bachelor's Degree (4-year college degree) or higher

Does anyone else in the household have a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education? ☐ Yes ☐ No

If yes, who: _____ 2

Degree attained: _____

Date completed: _____

Indicate if you or anyone who lives with you who is applying for or getting assistance:

Is or has been in any training program? ☐ Yes ☐ No

Who _____

Where _____ 3

Program _____

Dates attended _____

Dates completed _____

Is 16 years of age or older and is attending school or college? ☐ Yes ☐ No

Who _____ 4

Where _____

Is under 16 years of age and is attending school? ☐ Yes ☐ No

Who _____

School _____

Who _____

School _____

Who _____

School _____ 5

Who _____

School _____

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Educational Grant Worksheet	
	Child Care Statement	

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

CONSIDER	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the SNAP student eligibility requirement?	☐	☐
Does anyone pay for child or dependent care to attend school or training?	☐	☐
Is there a 16-19 year-old parent who does not have a high school or equivalency diploma and who is not attending school?	☐	☐
Is anyone in training?	☐	☐
Are any other supportive services appropriate?	☐	☐
Are there any training related expenses?	☐	☐

SECTION 19 – RESOURCES INFORMATION

Indicate if you or anyone who lives with you who is applying:		YES	NO	WHO	AMOUNT/VALUE	WHO	AMOUNT/VALUE
Has cash available	1						
Has a checking account(s)	2						
Has a savings account(s) or certificate(s) of deposit	3						
Has a credit union account(s)	4						
Has life insurance	5						
Has title or registration to a motor vehicle(s) or other vehicle(s): Year _____ Make/Model _____ Year _____ Make/Model _____ Other_____	6						
Has stocks, bonds, certificates or mutual funds	7						
Has savings bonds	8						
Has an IRA, Keogh, 401(k) or deferred compensation account(s)	9						
Has an irrevocable burial trust	10						
Has a burial fund	11						
Has a burial space	12						
Has their own home	13						
Has real estate, including income-producing and non-income-producing property	14						
Is eligible for an income tax refund	15						
Has an annuity	16						
Is the beneficiary of a trust	17						
Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources	18						
Has an "in trust" account(s)	19						
Has a safe deposit box(es)	20						
Has resources other than those listed above	21						
Has anyone (including your spouse, even if not applying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months?	22						
Has anyone (including your spouse, even if not applying or living with you) ever created a trust in the past or transferred any assets to a trust within the past 60 months? If yes, when? _____	23						

VEHICLE INFORMATION

YR.	MAKE	MODEL	OWNER'S NAME	AMOUNT OWED	NADA VALUE	EXEMPT YES*	EXEMPT NO	LIEN HOLDER	ACCOUNT NO.
				$	$				
				$	$				

*IF EXEMPT, WHY?

NEEDED	REFERRAL	COMPLETED
	Legal	
	Resource	

LIFE INSURANCE

FACE AMOUNT	CASH VALUE

REQUESTED	DOCUMENTATION	IN FILE
	Resource Checklist	
	Market Value	
	DMV Clearance	
	Bank Statement	
	Assignment of Proceeds	
	Car/Vehicle Title	
	Car/Vehicle Registration (Older Models)	
	Bank Clearance	
	RFI/OCA	
	1099	

CONSIDER

- ✓ Children's Resources
- ✓ Lump Sum
- ✓ Boats, Campers, Snowmobiles
- ✓ Individual Development Account (IDA)
- ✓ Exempt Vehicles

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 20 – MEDICAL INFORMATION

Indicate if you or anyone who lives with you who is applying:		YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses	1			
Is on Medicaid with a spend-down	2			
Has health or hospital/accident insurance (including insurance from employer)	3			
Has health insurance available through an employer	4			
Has Medicare (red, white, and blue card)	5			
Has a health attendant/home health aide	6			
Is blind, sick or disabled	7			
Is a child with a developmental disability	8			
Is in a hospital, nursing home or other medical institution	9			
Has paid or unpaid medical bills within 3 months preceding the month of this application	10			
Is or was drug or alcohol dependent	11			
Needs home care/personal care	12			
Is on SSI or has ever applied for SSI	13			
Is pregnant If pregnant, due date: _____ Expected number of births: _____	14			
Receives treatment from a drug abuse or alcohol treatment program	15			
Has not been able to work for at least 12 months because of a disability or illness	16			
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months	17			
Has been in a car accident or work-related accident in the past two years	18			
Has had a government agency (public program) besides Medicaid or Medicare pay any of your medical bills If yes, what agency _____	19			
Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of Medicaid?	20			

POLICY NO.:

AMOUNT:

FREQUENCY OF PAYMENT:

INSURANCE COMPANY NAME:

WHO IS COVERED:

EFFECTIVE DATE:

Is the answer to question 7 in this section consistent with Section 17 asking if the applicant or any other adult who lives in the household have any medical conditions that limit their ability to work or the type of work that they can perform?

REQUESTED	DOCUMENTATION	IN FILE
	Pregnancy Statement	
	Med/Psych Statement	
	Drug/Alcohol Screening (LDSS-4571)	
	Drug/Alcohol Statement	
	Paid or Unpaid Medical Bills	
	SSI Application Verification (**PA ONLY)**	

CONSIDER

- ✓ AD/SSI Related
- ✓ SNAP Aged/Disabled Indicator
- ✓ SNAP Medical Deduction
- ✓ TPHI Reimbursement
- ✓ Buy-In Eligibility
- ✓ Kreiger (LDSS-3664)
- ✓ Domestic Violence
- ✓ SSI Referral
- ✓ Earned Income Credit

NEEDED	REFERRALS	COMPLETED
	SSI (D-CAP)	
	Disability Interview (LDSS-1151)	
	Medical Report (LDSS-486, 486t)	
	Disability Report	
	AD	
	TPHI	
	ACCES-VR	
	CTHP	
	Family Planning	
	SSA (RSDI)	
	Veteran's Benefits	
	Veteran's Counseling	
	Child Health Plus	
	COBRA Eligibility	
	Nurse's Aide Service	
	Home Care	
	NYSoH	
	MA-Only (DOH-4220)	
	SSI-Related/Chronic Care (DOH-4220 with Supplement A)	
	LDSS-4526 or local equivalent	

RETROACTIVE MEDICAID	WHO	DATE	RECURRING MEDICAL EXPENSES	WHO	AMOUNT $	

MEDICAL BILLS: ☐ YES ☐ NO **TPHI:** ☐ YES ☐ NO

HEALTH PLAN SELECTION

Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call 1-800-505-5678.

Name of Plan You Are Enrolling In	Last Name	First Name	Date of Birth mm/dd/yy	Sex M/F	ID# (from Medicaid Card if you have one)	Social Security # (optional if pregnant)	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID# of OB/GYN (check box if current provider)
							☐	☐
							☐	☐
							☐	☐
							☐	☐

SECTION 21 – SHELTER

WHAT IS YOUR LANDLORD'S NAME?

_____

WHAT IS YOUR LANDLORD'S ADDRESS?

_____

_____

_____

WHAT IS YOUR LANDLORD'S PHONE NUMBER?

( ) _____

	YES	NO	IF YES, AMOUNT
Do you or anyone who lives with you have a rent, mortgage or other shelter expense?			$
Do you or anyone who lives with you have a heat bill separate from your rent or other shelter expense?			$

SHELTER COSTS		MONTHLY ACTUAL COST
A. Room and Board		
B. Rent		
C. Trailer Lot Rent		
D. Mortgage Payment		
1.	Principal	
2.	Interest	
3.	Property Tax (including School Tax)	
4.	Homeowner's Insurance (incl. Fire Insurance)	
5.	Taxes Included in Mortgage (Escrow Payment)	
6.	Assessments (Sewer, etc.)	
E. Total Mortgage Payment (Line 1-6)		
TOTAL (Lines A - E)		

REQUESTED	DOCUMENTATION	IN FILE
	Landlord Statement	
	Rent Receipt	
	Tenant of Record	
	Customer of Record	
	Voluntary Restrict	
	Mandatory Restrict	
	Subsidized Housing	
	Mortgage/Title Search	
	Section 8 Lease or Statement from Section 8 Office	
	Property Lien	
	Shelter/Utility Repayment Agreement	

CONSIDER

- ✓ Utility and/or Fuel Restrict
- ✓ Utility Guarantee
- ✓ HEAP
- ✓ Subsidized Housing May Show Total Rent, NOT Client Amount
- ✓ Foster Care-Related Additional Allowances
- ✓ SNAP Household Composition Rules
- ✓ SNAP Aged/Disabled Indicator
- ✓ Real Property Tax Credit
- ✓ AIDS/HIV Emergency Shelter Allowance
- ✓ Property Lien
- ✓ If Shelter Expenses/Living Quarters Are Shared by More than One Household

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 21 – SHELTER (CONT.)

Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?	YES	NO	IF YES, AMOUNT
Electricity (for needs other than heat; example: lights, cooking, hot water, etc.) 1			$
Natural Gas (for needs other than heat; example: cooking, hot water, etc.) 2			$
Water 3			$
Air Conditioning 4			$
Propane (for needs other than heat) 5			$
Sewer 6			$
Trash 7			$
Other Utilities and Expenses 8 Specify _____			$
Do you live in public housing? 9			
Do you live in Section 8, HUD, or other subsidized housing? 10			
Do you live in a drug/alcohol treatment facility? 11			

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	ACCOUNT NUMBER	IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD)	WHO IS THE TENANT OF RECORD?
A. Heat*					
B. Electricity (for cooking, lights, hot water)					
C. Gas (for cooking, hot water)					
D. Liquid Propane Gas					
E. Other Utilities or Expenses					
F. Air Conditioning					
G. Utility Installation Fees					
H. Sewer					
I. Trash					
J. Water					

***Check Primary Heat Type:**

☐ Natural Gas ☐ Oil ☐ PSC Electric ☐ Coal ☐ Other _____

☐ Kerosene ☐ Propane ☐ Municipal Electric ☐ Wood

ADDITIONAL INFORMATION

SECTION 22 – OTHER EXPENSES

Indicate if you or anyone who lives with you who is applying:	YES	NO	IF YES, AMOUNT	HOW OFTEN PAID	LEGALLY OBLIGATED YES	LEGALLY OBLIGATED NO	CHILD IN SNAP HH YES	CHILD IN SNAP HH NO
Pays child support 1			$					
Pays spousal support 2			$					
Pays for child care 3			$					
Pays for dependent care 4			$					
Pays tuition, fees, or other educational expenses 5			$					
Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.) Specify: _____ 6			$					
Do you or anyone who lives with you who is applying owe at least four months of support for a child under the age of 21? 7	☐ YES	☐ NO						

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

SECTION 23 – OTHER INFORMATION

Do you buy or plan to buy meals from a home delivery or communal dining service? 8	☐ YES	☐ NO		
Are you able to cook or prepare meals at home? 9	☐ YES	☐ NO	VETERAN STATUS	VETERAN CODE
Have you or anyone in your household ever been in the U.S. military? Who? _____ 10	☐ YES	☐ NO		
Has your spouse ever been in the U.S. military? 11	☐ YES	☐ NO		
Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? _____ 12	☐ YES	☐ NO		

Do you or does anyone who lives with you receive assistance or services now? ☐ YES ☐ NO 13

IF YES, WHO	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED

Have you or anyone who lives with you received assistance or services in the past? ☐ YES ☐ NO 14

IF YES, WHO (Please list all previous names)	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ SNAP Dependent Care Deductions
	UIB		

OTHER INFORMATION (CONT.)	YES	NO	WHO
Have you or anyone who lives with you who is applying moved into this county from another New York State county within the past two months?			
Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Public Assistance and/or the Supplemental Nutrition Assistance Program (SNAP) because of fraud/an Intentional Program Violation?			
Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?			
Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive Public Assistance in two or more states?			
Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP Benefits in any state after September 22, 1996?			
Have you or any member of your household been convicted of buying or selling SNAP Benefits for a combined amount of over $500 or more after September 22, 1996?			
Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?			
Are you or any member of your household fleeing to avoid prosecution, custody or confinement after conviction of a felony or attempted felony and actively being pursued by law enforcement?			
Are you or any member of your household violating probation or parole according to a court order?			

PROPERTY TRANSFER STATUS

I have ☐ I have not ☐ sold, transferred or given away any of my property to anyone to get Public Assistance or SNAP Benefits.

REQUESTED	DOCUMENTATION	IN FILE
	Educational Grant Worksheet	
	Child/Dependent Care Statement	
	Recoupments	
	Outstanding Overpayment	
	Pending Disqualification	

DO NOT WRITE IN THE SHADED AREAS OF THIS APPLICATION

IF TOTAL EXPENSES (INCLUDING EXPENSES NOT USED IN THE BUDGET DETERMINATION) EXCEED INCOME (INCLUDING PA GRANT), EXPLORE HOW THE HOUSEHOLD IS MEETING ITS OBLIGATIONS.

Actual Expenses $

- Actual Income $

= Difference $

	YES	NO
Does Client Receive Contribution Towards Difference	☐	☐

If Yes, From Whom? _____

CONSIDER
✓ Actual Expenses, including: shelter, fuel/utility costs, telephone costs, etc.
✓ Actual Shelter
✓ Actual Fuel/Utility Costs
✓ Telephone Expenses
✓ Car Expenses
✓ Furniture/Appliance Rental
✓ Cable TV
✓ Tuition
✓ Out-of-Pocket Medical Expenses

EMERGENCY CASH ASSISTANCE

Is there an immediate need? If not, why not?

_____

_____

_____

NOTES/COMMENTS

NOTICES, ASSIGNMENTS, AUTHORIZATIONS, and CONSENTS

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS – The collection of Social Security Numbers (SSNs) is authorized for each household member with respect to the Supplemental Nutrition Assistance Program (SNAP), pursuant to the Food and Nutrition Act of 2008 (as amended). Anyone applying for SNAP must provide an SSN in order to receive benefits. If you or anyone applying does not have an SSN, that person must apply for an SSN with the Social Security Administration (visit www.SSA.gov or call 1-800-772-1213).

With respect to all other programs for which this application form requires an SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: Section 205(c) of the Social Security Act (42 U.S. Code 405), Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) and Section 7(a)(2) of the Privacy Act of 1974. See the instruction book (PUB-1301 Statewide) or talk to your social services district if you have questions.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. The information will be used to check identity, to verify earned and unearned income, to determine if absent parents can receive health insurance coverage for applicants or recipients, to determine if applicants or recipients can obtain child or spousal support, and to determine if applicants or recipients can receive money or other help. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. Besides using the information you give us in this way, the state will use the information to prepare statistics about all of the people receiving benefits from the Home Energy Assistance Program (HEAP) (see below).

This information may be disclosed to other state and federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. Information collected with respect to applicants for and recipients of Family Assistance and Safety Net Assistance, including SSNs, may be used to assist in the formation of jury pools. If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

SSNs of ineligible household members will also be used and disclosed in the manner above.

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

NONDISCRIMINATION NOTICE – This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

The United States Department of Agriculture (USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

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

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201, or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

New York State additionally prohibits discrimination based on gender identity, transgender status, gender dysphoria, sexual orientation, marital status, military status, domestic violence victim status, pregnancy-related conditions, predisposing genetic characteristics, prior arrest or conviction record, familial status, and retaliation for opposing unlawful discriminatory practices.

CONSENT FOR INVESTIGATION – I agree to any investigation to verify or confirm the information I have given in connection with my request for Public Assistance (PA), Medicaid, Supplemental Nutrition Assistance Program (SNAP) Benefits, Home Energy Assistance Program Benefits, Services or Child Care Assistance. If additional information is requested, I will provide it. I will also cooperate fully with state and federal personnel in any PA and/or SNAP Quality Control Review.

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

CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE INFORMATION – I authorize the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance (UI) purposes to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with state and local agency employees working in social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of, Public Assistance, Medicaid, Supplemental Nutrition Assistance Program Benefits, Home Energy Assistance Program Benefits or Child Care Assistance, applied for in this application and for investigations to determine whether I received benefits to which I was not entitled. OTDA may also share the information with the New York State Office of Children and Family Services (OCFS) and the New York State Department of Health (DOH). OCFS will use the information to monitor the Child Care Assistance program.

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

CHANGE REPORTING – I agree to inform the agency **promptly** of any change in my address, needs, income, and property, able-bodied adult without dependents (ABAWD) status, pregnancy status or living arrangements, to the best of my knowledge or belief.

If I am applying for Child Care Assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my home, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

PENALTIES – Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Public Assistance, Medicaid, Supplemental Nutrition Assistance Program, Services or Child Care Assistance (“Assistance, Benefits or Services”) or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Assistance, Benefits or Services. If you are an authorized representative, such Assistance, Benefits or Services must be used for the other person and not for yourself. Federal and state laws provide that any transfer of assets for less than fair market value made by an individual or an individual’s spouse, within 60 months prior to the first of the month in which the individual is

both in receipt of nursing facility services and has submitted an application for Medicaid, may render the individual ineligible for nursing facility services or home and community-based waivered services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM DISQUALIFICATION PENALTIES – Any information you provide in connection with your application for the Supplemental Nutrition Assistance Program (SNAP) will be subject to verification by federal, state and local officials. If any information is incorrect, you may be denied SNAP Benefits. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to $250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable federal and state laws. Anyone who is violating a condition of probation or parole, or anyone who is fleeing to avoid prosecution, custody or confinement of a felony and is actively being pursued by law enforcement, is not eligible to receive SNAP Benefits.

You may be found ineligible for SNAP or found to have committed an Intentional Program Violation (IPV) if you make a false or misleading statement, or misrepresent, conceal or withhold facts, in order to qualify for benefits or receive more benefits; purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or commit or attempt to commit any act that constitutes a violation of federal or state law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking SNAP Benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system. Additionally, the following is not allowed and you may be disqualified from receiving SNAP Benefits and/or be subject to penalties for actions that include:

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

Individuals found to have committed an IPV either through an administrative disqualification hearing or by a federal, State or local court, or have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution shall be ineligible to participate in SNAP for a period of:

- 12 months for the first SNAP IPV;
- 24 months for the second SNAP IPV;
- 24 months for the first SNAP IPV that is based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- 120 months if the individual is found to have made a fraudulent statement about who they are or where they live in order to get multiple SNAP Benefits simultaneously, unless permanently disqualified for a third SNAP IPV.
  Additionally, a court may bar an individual from participating in SNAP for an additional 18 months.

An individual can be permanently disqualified from receiving SNAP Benefits for:

- The first SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of firearms, ammunition or explosives;
- The first SNAP IPV based on a court conviction for trafficking SNAP Benefits for a combined amount of $500 or more (trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices);
- The second SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- A third SNAP IPV.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – Your household must report child care and utility expenses in order to get a Supplemental Nutrition Assistance Program (SNAP) deduction for these expenses. Your household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a SNAP deduction for these expenses. Failure to report/verify the above expenses will be seen as a statement by your household that you do not want to receive a deduction for these unreported/unverified expenses. A deduction for these expenses may make you eligible for SNAP or may increase your SNAP benefits. You may report/verify these expenses at any time in the future. The deduction would then be applied to the calculation of SNAP benefits in future months, in accordance with the rules for change reporting (see Change Reporting, above).

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to apply for Supplemental Nutrition Assistance Program (SNAP) Benefits for you. You can also authorize someone outside your household to get SNAP Benefits for you or to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may authorize someone by printing the person's name, address, and phone number immediately below, and having them sign in the signature section at the end of this application. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, both the Authorized Representative and a responsible adult member of the household must sign and date the signature section at the end of this application, unless the SNAP household has otherwise designated the Authorized Representative to do so in writing.

NAME, ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE (PLEASE PRINT):

STANDARD UTILITY ALLOWANCE – I understand that Public Assistance and Supplemental Nutrition Assistance Program (SNAP) recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). I also understand that if I have not received a HEAP benefit of greater than $20 in the current month or previous 12 months, or a similar energy assistance benefit, I must pay for heating or air conditioning separately from my rent in order to receive the heating/cooling standard utility allowance (i.e., a deduction) for SNAP. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

RELEASE OF MEDICAL INFORMATION – I consent to the release of any medical information about me and any members of my family for whom I can give consent by my primary care provider, any other health care provider or the New York State Department of Health (DOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to DOH and other authorized federal, state, and local agencies for purposes of administration of Medicaid; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I authorize the release of any health-related information about me and any members of my family for whom I can legally give authorization related to the provision of assistance and services and my ability to participate in work activities, including employment, to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services or the local social services district, as reasonably necessary for the provision of Public Assistance benefits; for services, including child welfare services; for determining appropriate work activity assignments; for determining the need to apply and for making application for Supplemental Security Income Benefits; for establishing appropriate treatment plans for restoring employability; and for determining eligibility for exemptions from the State sixty-month time limit on cash assistance receipt. If I am required to apply for benefits administered by the Social Security Administration, the information specified above may be shared with the Social Security Administration. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law, unless a box is checked below. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain information regarding treatment, diagnosis and procedures on their behalf.

_____ Do not disclose HIV/AIDS information _____ Do not disclose drug and alcohol information
_____ Do not disclose mental health information

RELEASE OF INFORMATION TO HEALTH SERVICE PROVIDERS – I give permission to the social services district and the State of New York to share information with health service providers, as designated by the social services district or the State of New York, regarding Public Assistance benefits that I or any member of my household for whom I can legally give authorization have received or are eligible to receive, for the purpose of improving the quality of my healthcare and overall well-being, and to facilitate receipt of additional benefits for which I, or members of my household, may be eligible.

RELEASE OF EDUCATIONAL RECORDS – I give permission to the New York State Department of Health and the social services district to:1) obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming Medicaid reimbursement for health-related educational services; and 2) provide the appropriate federal government agency access to this information for the sole purpose of audit.

RELEASE OF INFORMATION FOR THE EARLY INTERVENTION PROGRAM – If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the social services district and New York State to share my child's Medicaid eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medicaid.

CHILD/TEEN HEALTH PROGRAM – I understand that if my child is on Medicaid, they can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the social services district.

MEDICARE – I authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

MEDICAID – You have a right as part of your Medicaid application, or within two years from the date of your application, to request reimbursement of expenses you paid for covered medical care, services and supplies received during the three-month period prior to the month of your application. After the date of your application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

ASSIGNMENT OF INSURANCE/OTHER BENEFITS AND DIRECT PAYMENT – For Public Assistance and Medicaid, I agree to file any claims for health or accident insurance benefits, and to pursue any personal injury claims or any other resources to which I may be entitled, and do hereby assign any such resources to the social services district to whom this application is made. In addition, I will assist in making any assigned benefits available to the social services district to whom this application is made.

I authorize payments owed to me or members of my household for health or accident insurance benefits to be made directly to the appropriate social services district for medical and other health services furnished while we are eligible for Medicaid.

MEDICAID RECOVERIES – Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. MA paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. MA may also recover the cost of services and premiums incorrectly paid.

I understand that effective April 1, 2014, if I get Medicaid through New York State of Health:

- No lien will be placed on my real property prior to my death.
- Recovery from assets in my estate upon my death is limited to the amount Medicaid paid for the cost of nursing home care, home and community-based services, and related hospital and prescription drug services received on or after my 55th birthday.

PUBLIC ASSISTANCE RECOVERIES – Public Assistance (PA) you receive for yourself and for persons for whom you are legally responsible to support is recoverable from property or money you possess or may acquire. You may be required, as a condition of receiving PA, to execute a deed or mortgage of real property you own. Your tax refunds and portions of lottery winnings may be taken to repay your debt for PA.

AUTHORIZATION TO REPAY PUBLIC ASSISTANCE BENEFITS FROM RETROACTIVE SUPPLEMENTAL SECURITY INCOME – I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of Supplemental Security Income (SSI); i.e. my retroactive SSI payment) to reimburse the local social services district (SSD) for

Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for SSI. SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SSA can reimburse the SSD in two situations:

(1) It will repay the SSD if I apply for SSI and SSA finds me eligible.
(2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called "interim assistance." The period begins: 1) with the first month I become eligible for payment of SSI benefits; or 2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and that, if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

This authorization applies to any SSI application or appeal I now have pending before SSA. This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called "What You Should Know About Social Services Programs." I understand what it says about interim assistance.

SUPPORT – Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or Title IV-E foster care operates as an assignment to the State and the social services district of any rights to support from any other person that the applicant or recipient may have in their own right or on behalf of any other family member for whom the applicant or recipient is applying for, or receiving, assistance (Social Services Law, Sections 158 and 348). This assignment is limited in certain situations. Other sections of this application contain additional assignments.

ASSIGNMENT OF SUPPORT RIGHTS – I assign to the state and social services district any rights I have to support from persons having legal responsibility for my support and any rights I have to support on behalf of any family member for whom I am applying for or receiving assistance. Where applying for or receiving Family Assistance or Safety Net Assistance, my assignment of support rights is limited to support which accrues during the period that I and/or any family member receives assistance. However, any support rights that I assigned to the state on behalf of myself or any family member prior to October 1, 2009, continue to be assigned to the state.

HOME ENERGY ASSISTANCE PROGRAM – I understand that by signing this application/certification, I consent to any investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this application to be used in referrals to available weatherization assistance programs and my utility company's low income programs.

I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

SEXUAL ASSAULT INFORMATION – If you are a victim of sexual assault, you have the right to request referral information from the social services district. If you request referral information, the social services district must provide you with the addresses and phone numbers of any: 1) local hospitals offering sexual assault forensic examiner services certified by

the NYS Department of Health; 2) local rape crisis centers; and 3) local advocacy, counseling, and hotline services appropriate for victims of sexual assault. In addition, the social services district must provide you with the NYS Hotline for Sexual Assault and Domestic Violence numbers: (800) 942-6906 and (800) 818-0656 (TTY).

CERTIFICATION FOR CHILD CARE ASSISTANCE – If I am applying for Child Care Assistance, I certify that my family resources do not exceed $1,000,000.

I have read and understand the notices above. I understand and agree to the assignments, authorizations and consents above. I swear and/or affirm under the penalties of perjury that the information I have given or will give to the social services district is complete and correct.			
APPLICANT SIGNATURE **x**	**DATE SIGNED**	**SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE** **x**	**DATE SIGNED**
AUTHORIZED REPRESENTATIVE SIGNATURE **x**	**DATE SIGNED**		

ONLY COMPLETE THE FOLLOWING IF YOU WANT TO WITHDRAW YOUR APPLICATION FOR ONE OR MORE PROGRAMS.

I Consent to <u>Withdraw</u> My Application For:

☐ Public Assistance (PA) ☐ Child Care in lieu of PA ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Medicaid and SNAP

☐ Medicaid and PA ☐ Services, including Foster Care ☐ Child Care Assistance ☐ Emergency Assistance Only

I understand that I may reapply at any time.

APPLICANT/AUTHORIZED REPRESENTATIVE SIGNATURE **DATE SIGNED**

x

NYS Agency-Based Voter Registration Form

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

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

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

Signature _____ Date ___/___/___

Please Print Name _____

Important!

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

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

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

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

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

যদি আপনি এই ফরমটি বাংলা ভাষায় চান , তাহলে 1-800-367-8683 নম্বরে ফন করুন

VOTER REGISTRATION APPLICATION (instructions on back)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1 **Are you a U.S. citizen?** ☐ YES ☐ NO
If you answered **NO**, do not complete this form

2 **A) Will you be 18 years old on or before election day?** ☐ YES ☐ NO
B) Are you at least 16 years of age and understand that you must be 18 years of age on or before election day to vote, and that until you will be eighteen years of age at the time of such election your registration will be marked "pending" and you will be unable to cast a ballot in any election? ☐ YES ☐ NO
If you answered **NO** to both of the prior questions, you cannot register to vote.

For Board Use Only

3 Last Name | First Name | Middle Initial | Suffix

4 Address where you live (do not give P.O. box) | Apt. No. | City/Town/Village | Zip Code | County

5 Address where you get your mail (if different than above) | P.O. Box, Star Route, etc. | Post Office | Zip Code

6 Date of Birth | **7** Gender (optional) | **8** Telephone (optional) | Email (optional)

10 The last year you voted | Your address was (give house number, street and city)
In county/state | Under the name (if different from your name now)

9 **ID Number** (Check the applicable box and provide your number)
- ☐ New York State DMV number — — — — — — — — —
- ☐ Last four digits of your Social Security number — — — —
- ☐ I do not have a New York State DMV or Social Security number

11 **Political Party**

I wish to enroll in a political party

- ☐ Democratic party
- ☐ Republican party
- ☐ Conservative party
- ☐ Working Families party
- ☐ Green party
- ☐ Libertarian party
- ☐ Independence party
- ☐ SAM party
- ☐ Other _____

I do not wish to enroll in any political party and wish to be an independent voter

- ☐ No party

12 **Affidavit: I swear or affirm that**

- I am a citizen of the United States.
- I will have lived in the county, city or village for at least 30 days before the election.
- I will meet all requirements to register to vote in New York State.
- This is my signature or mark on the line below.
- The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years.

Signature or Mark in ink _____ Date ___/___/___

(Optional) Register to donate your organs and tissues

Last Name		
First Name	Middle Initial	Suffix
Address		
Apt Number	City/Town/Village	Zip Code
Birth Date	Gender ☐ M ☐ F	
Eye Color	Height Ft. In.	
Email	DMV or ID NYC Number	

By signing below, you certify that you are:

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

DONATE LIFE New York State

Signature _____ Date ___/___/___

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment;
- pre-register to vote if you are 16 or 17 years of age.

To Register You Must:

- be a U.S. citizen;
- be 18 years old (you may pre-register at 16 or 17 but cannot vote until you are 18);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in prison or on parole for a felony conviction (unless parole pardoned or restored rights of citizenship);
- not claim the right to vote elsewhere; and
- not found to be incompetent by a court.

Important!

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

NYS Board of Elections
40 North Pearl St, Suite 5
Albany, NY 12207-2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.ny.gov

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

Verifying your identity

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

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

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

To complete this form:

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

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

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

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

LDSS-3174 **DD Statewide** (Rev. 07/20)

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

CENTER/ OFFICE	INTERVIEW DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NUMBER	DISTRICT	CATEGORY	LANG	NUMBER REUSE INDICATOR

CASE NAME	EFFECTIVE DATE	DISPOSITION
		☐ RECERTIFICATION ☐ CLOSE ☐☐☐ REASON CODE

ELIGIBILITY DETERMINED BY (WORKER):	DATE	ELIGIBILITY APPROVED BY (SUPERVISOR):	DATE	FORM _____ 0F _____	SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION x _____	DATE

DATE RECEIVED BY AGENCY	EMPLOYED BY: ☐ SOCIAL SERVICES DISTRICT ☐ PROVIDER AGENCY SPECIFY: _____

PA AUTHORIZATION PERIOD		MA AUTHORIZATION PERIOD		SNAP AUTHORIZATION PERIOD	
FROM	TO	FROM	TO	FROM	TO

NEW YORK STATE RECERTIFICATION FORM FOR CERTAIN BENEFITS AND SERVICES

If you are blind or seriously visually impaired and need this recertification form in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request a recertification form in an alternative format, see the instruction book (PUB-1313 Statewide), available at www.otda.ny.gov or https://www.health.ny.gov/.

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

If yes, check the type of format you would like: Large Print Data CD

Audio CD Braille, if you assert that none of the other alternative formats will be equally effective for you

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

We are committed to assisting and supporting you in a professional and respectful manner. You are responsible for participating in activities, including work activities for Public Assistance and the Supplemental Nutrition Assistance Program, where required, so you can become self-sufficient. Whenever you see "Public Assistance" or "PA" on the recertification form, it means "Family Assistance" and/or "Safety Net Assistance." We call both programs "Public Assistance." These PA programs are meant to assist you only until you can fully support yourself and your family. **Please refer to the instruction book (PUB-1313 Statewide) and "What You Should Know" Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this recertification form, and contact your social services district with any questions.**

When you see "MA" on the recertification form, it means "Medicaid." You may apply for MA using this recertification form only if you are also recertifying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only recertify for MA, you can go online at https://nystateofhealth.ny.gov/ and/or call 1-855-355-5777 for more information or to recertify, or you may use the MA-only paper application - Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to recertify only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH- 4220 MA application form.

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

LDSS-3174 DDStatewide (Rev. 07/20)

SECTION 1 CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE RECERTIFYING FOR	Public Assistance (PA)	Supplemental Nutrition Assistance Program (SNAP)	Medicaid (MA) and SNAP	Medicaid (MA) and PA

SECTION 2

WHAT IS YOUR PRIMARY LANGUAGE? ◯ ENGLISH ◯ SPANISH ◯ OTHER (specify) _____

DO YOU WANT TO RECEIVE NOTICES IN: ◯ ENGLISH ONLY ◯ ENGLISH AND SPANISH

SECTION 3 RECIPIENT INFORMATION — PLEASE PRINT CLEARLY

FIRST NAME	M.I.	LAST NAME	MARITAL STATUS	PHONE NUMBER ( ) AREA CODE

STREET ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

IN CARE OF NAME (COMPLETE IF YOU RECEIVE YOUR MAIL IN CARE OF ANOTHER PERSON)

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?	YEARS	MONTHS	IS THIS A SHELTER? ◯ YES ◯ NO	ANOTHER PHONE WHERE YOU CAN BE REACHED	NAME	PHONE NUMBER ( ) AREA CODE

DIRECTIONS TO CURRENT ADDRESS

FORMER ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK HERE

AGENCY HELPING APPLICANT/CONTACT PERSON	PHONE NUMBER ( ) AREA CODE

DO YOU NEED THE MEDICAID PORTION OF THIS RECERTIFICATION FORM AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL? ◯ YES ◯ NO

LIST THE THINGS THAT HAVE CHANGED SINCE YOUR APPLICATION OR LAST RECERTIFICATION (such as moved, had a baby, income, etc.) _____

SECTION 5 DO ANY OF THESE APPLY TO YOU?

Pregnant	1
Victim of Domestic Violence	2
Need to Establish Parentage	3
Need Child Support	4
Drug/Alcohol Problem	5
Fuel or Utility Shutoff	6
No Place to Stay/Homeless	7
Fire or Other Disaster	8
Have No Income	9
Serious Medical Problem	10
Pending Eviction	11
No Food	12
Need Foster Care	13
Need Child Care	14
Problems with English	15
Reasonable Accommodations	16
Other _____	17

SECTION 4 – If You Are Reapplying For SNAP: You can file a recertification form the day you get it. In order to file a SNAP recertification, it must have, at minimum, your name, address (if you have one) and signature below. You must complete the recertification process, including signing the last page of the recertification and being interviewed. If eligible, you will get SNAP benefits back to the date you filed the recertification. You must be told, within 30 days of the date you turned in (filed) your recertification for SNAP benefits, if your recertification is approved or denied. If your household has little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources, you may be eligible to get SNAP benefits within five calendar days of the date you file. If you are a resident of an institution and are recertifying for both Supplemental Security Income (SSI) and SNAP benefits prior to leaving the institution, the filing date of the recertification is the date you leave the institution.

SNAP RECIPIENT/REPRESENTATIVE SIGNATURE	DATE SIGNED
x	

SECTION 6 – HOUSEHOLD INFORMATION – List everybody who lives with you, even if they are not recertifying with you. List yourself on the first line.

RI	LN	First Name, Middle Initial, Last Name	This person is recertifying for: PA	SNAP	MA	Date of Birth: (mm/dd/yyyy)	Sex: (M/F)	Gender Identity (Optional): (Male, Female, Non-Binary, X, Transgender, Different Identity [please describe])	Relationship to you:	Social Security Number of Recertifying Household Members *(See instruction book, PUB-1313 Statewide, or talk to your social services district)*	Highest School Grade Completed	Does This Person (Including Minor Children) Buy Food or Prepare Meals with You? YES	NO
	01								**SELF**			○	○
	02											○	○
	03											○	○
	04											○	○
	05											○	○
	06											○	○
	07											○	○
	08											○	○

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAVE BEEN KNOWN

Line No.	ONC	FIRST NAME	M.I.	LAST NAME

SECTION 7

HAS ANYONE MOVED **INTO** THE HOUSEHOLD IN THE PAST YEAR? ○YES ○NO
IF YES, INCIDATE BELOW.

NAME	DID THEY EVER LIVE IN NEW YORK STATE BEFORE NOW?
	○YES ○NO
	○YES ○NO

HAS ANYONE MOVED **OUT** OF THE HOUSEHOLD IN THE LAST YEAR?
○YES ○NO IF YES, INCIDATE BELOW.

NAME	WHEN?

IS ANYONE SANCTIONED?	☐ YES ☐ NO	IF YES, WHO	REASON	END DATE

NON-APPLICANT INFORMATION

LN	FIRST NAME	LAST NAME	LEGALLY RESPONSIBLE YES	NO	FOR WHOM?	CONTRIBUTION/ DEEMED INCOME	CHECK IF MEMBER OF SNAP HOUSEHOLD

NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS INFORMATION

LN	NON-CITIZEN STATUS	STATUS ADJUSTED YES	NO	DATE OF ENTRY/STATUS MONTH	DAY	YEAR	APPLIED FOR CITIZENSHIP YES	NO	SPONSORED YES	NO

INDIVIDUAL EDUCATION

LN	DEGREE RECEIVED	LN	DEGREE RECEIVED
01		05	
02		06	
03		07	
04		08	

CONSIDER

✓ RCA/RMA REFERRAL

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 8 – RACE/ETHNICITY – Providing this information is voluntary. It will not affect the eligibility of the persons recertifying or the level of benefits received. The reason for requesting this information is to ensure that program benefits are distributed without regard to race, color, or national origin.

H HISPANIC OR LATINO
I NATIVE AMERICAN OR ALASKAN NATIVE
A ASIAN
B BLACK OR AFRICAN AMERICAN
P NATIVE HAWAIIAN OR PACIFIC ISLANDER
W WHITE
U UNKNOWN **(MA ONLY)**

LN	↓ ENTER Y (YES) OR N (NO) FOR HISPANIC OR LATINO / ENTER Y (YES) OR N (NO) FOR EACH RACE						
	H	**I**	**A**	**B**	**P**	**W**	**U**
01							
02							
03							
04							
05							
06							
07							
08							

ANTICIPATED FUTURE ACTION			CASE TYPE	RELATED CASE NUMBERS
LINE NO.	CODE	DATE		

NEEDED	REFERRALS	COMPLETED
	Legal	
	Services	
	SSA	
	NYSoH	
	Chronic Care/SSI-Related	
	MA-Only	
	Medicare Savings Program	

CONSIDER

- ✓ Relationship
- ✓ Filing Unit
- ✓ Legally Responsible Relative
- ✓ Single Economic Unit
- ✓ SNAP Household Composition
- ✓ SNAP Aged/Disabled Individual
- ✓ Photo ID
- ✓ AFIS (PA Only)
- ✓ CBIC/PIN
- ✓ RFI/OCA
- ✓ Health Insurance
- ✓ Child Support Pass-Through

REQUESTED	DOCUMENTATION	IN FILE
	Photo ID	
	Birth Verification	
	Marriage License	
	Social Security Card	
	Code 9 Resolution	
	Immigration Status	
	Multi-Suffix/Co-op Case Notice (Single Economic Unit Questionnaire)	

Please read this entire page carefully before completing it. If you have questions, see the instruction book (PUB-1313 Statewide) or talk to your social services district.

SECTION 9 – CITIZENSHIP/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS

LIST EVERYONE WHO IS RECERTIFYING OR WHO IS REQUIRED TO RECERTIFY.

SECTION 10 – CERTIFICATION

Some social services programs require that you certify that you are a United States citizen, Native American or national of the U.S., or a non-citizen with satisfactory immigration status. Other programs do not.

You MUST sign the Certification below only if you are a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status, **and** you are recertifying for:

- Public Assistance (where there are children in the household or a member of the household is pregnant), or
- The Supplemental Nutrition Assistance Program, or
- Medicaid (except if the applicant is pregnant)

An adult household member or authorized representative may sign for all household members. Example: A parent without a satisfactory non-citizen status may sign for their child with a satisfactory non-citizen status.

NEEDED	REFERRALS	COMPLETED
	Systematic Alien Verification for Entitlements (SAVE)	

A recertification for SNAP must list all persons living in the SNAP household. A recertification for PA must list all children for whom you are recertifying, their siblings, and all parents of those children who live together. If you do not check whether a listed person is a United States citizen, national of the U.S. or an non-citizen with a satisfactory immigration status, or provide an U.S. Citizenship and Immigration Services (USCIS) number (Alien Registration Number) or a non-citizen number (if applicable), that person will not be given assistance and the remaining members of the household will receive reduced benefits. If you are a Native American, check citizen/national.

SIGN* AND DATE THE BOX BELOW FOR EACH APPLICANT.

In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)

LN	FIRST NAME	MI	LAST NAME	Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.		USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER (If Applicable)	CERTIFICATION	DATE	PA	SNAP	MA
01				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				
02				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				
03				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				
04				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				
05				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				
06				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				
07				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				
08				○ CITIZEN/ NATIONAL	○ NON-CITIZEN	A	Sign Name X				

By checking a box above and by signing the certification form in Section 10, I hereby certify, under penalty of perjury, that I, and/or the person(s) for whom I am signing, am a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status.
I understand that signing the above Certification may result in information about recertifying members of my household being submitted to the United States Citizenship and Immigration Services for verification of non-citizen status, if applicable.
The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of citizenship status, and the administration or enforcement of the provisions of the Public Assistance, Supplemental Nutrition Assistance, and Medicaid.

***A person who wishes to sign the Recertification Form but cannot write may make an "X" on the line in front of a witness. The witness must sign below.**

I witnessed the marks made in lines: _____,_____,_____,_____,_____,_____ Signature of witness: _____ Date Signed: _____

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 11 – INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT

If you are recertifying for Medicaid in addition to Public Assistance or the Supplemental Nutrition Assistance Program, you may have to help us obtain medical support for yourself and your recertifying children. Answer the following questions to determine if you need to complete this section. Include yourself, as appropriate:

1. Are you recertifying for an individual under the age of 21 who was born out of wedlock and for whom legal parentage has not been established? ◯Yes ◯No
2. Are you recertifying for an individual under the age of 21 who has an absent parent (noncustodial parent)? ◯Yes ◯No

You do not need to complete this section if you answered "No" to both of these questions. Go to the next section.

You must complete this section if you answered "Yes" to either or both of these questions. Provide the names of all individuals under the age of 21 for whom you are recertifying and any information you currently have about those individuals' noncustodial parents or alleged parents.

3. Are you under the age of 21? ◯Yes ◯No

If you answered "Yes" to this question, provide the information for your noncustodial parent(s) or alleged parent(s).

As a condition of obtaining assistance, you are required to assign certain rights related to support, as described in the Notices, Assignments, Authorizations, and Consents section at the end of this recertification. You will be provided with the LDSS-5145 form, "Referral for Child Support Services," to complete and return to the Child Support Enforcement Unit. Except in situations of domestic violence or other good cause, as a condition of obtaining assistance, you are required to cooperate with the Child Support Enforcement Unit to locate any noncustodial parent or alleged parent; establish legal parentage for each individual under the age of 21 born out of wedlock; and establish, modify, and/or enforce orders of support. You also will be provided with the LDSS-4279 form, "Notice of Responsibilities and Rights for Support," which explains your responsibilities and your rights if you do not cooperate with the Child Support Enforcement Unit.

REQUESTED	DOCUMENTATION	IN FILE
	Acknowledgment of Parentage or Paternity	
	Child Support Order	
	Good Cause Form (LDSS-4279)	
	IV-D Attestation (LDSS-4281)	
	Death Certificate	
	Divorce Decree	
	VA Benefits	
	Order of Filiation/Paternity/Parentage	
	Birth Certificate	
NEEDED	**REFERRALS**	**COMPLETED**
	CTHP	
	CAP	
	Referral for Child Support Services (LDSS-5145)	
	Parentage/Paternity	

CONSIDER

- ✓ Health Insurance of Non-custodial Parent/Absent Spouse
- ✓ Child Health Plus
- ✓ TASA
- ✓ Petition to Family Court
- ✓ SSI/SSA

	NAME OF INDIVIDUAL UNDER AGE 21	NONCUSTODIAL PARENT OR ALLEGED PARENT'S NAME AND ADDRESS	NONCUSTODIAL PARENT OR ALLEGED PARENT'S DATE OF BIRTH			NONCUSTODIAL PARENT OR ALLEGED PARENT'S SOCIAL SECURITY NUMBER
			MONTH	DAY	YEAR	
A.						
B.						
C.						
D.						
E.						

SECTION 12 – TAX FILING/DEPENDENT STATUS - Please select the tax status for each individual living in the household.

			TAX STATUS						
FIRST NAME	MIDDLE INITIAL	LAST NAME	SINGLE	MARRIED FILING JOINTLY	MARRIED FILING SINGLE	HEAD OF HOUSEHOLD (WITH QUALIFYING INDIVIDUAL)	QUALFIYING WIDOW(ER) WITH DEPENDENT CHILD	DEPENDENT AND WILL BE FILING TAXES	WILL NOT BE FILING TAXES
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○
			○	○	○	○	○	○	○

Tax dependents not living in the household. Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip this question.

NAME OF TAX DEPENDENT			NAME OF TAX FILER		
FIRST NAME	MIDDLE INITIAL	LAST NAME	FIRST NAME	MIDDLE INITIAL	LAST NAME

SECTION 13 – ABSENT/DECEASED SPOUSE INFORMATION – If the spouse of anyone recertifying lives someplace else or is deceased, please indicate below.

NAME OF PERSON RECERTIFYING	NAME OF SPOUSE	DATE OF SPOUSE'S BIRTH	DATE OF SPOUSE'S DEATH, IF APPLICABLE	SPOUSE'S SOCIAL SECURITY NUMBER

SPOUSE'S ADDRESS, IF APPLICABLE	CITY	COUNTY	STATE	ZIP CODE

SECTION 14 – ABSENT CHILD INFORMATION – If anyone recertifying has a child under the age of 21 living someplace else, please indicate below.

NAME OF PERSON RECERTIFYING	NAME OF ABSENT CHILD	DATE OF BIRTH	ADDRESS OF CHILD (STREET, CITY, COUNTY, STATE, AND ZIP CODE)	LEGAL PARENTAGE ESTABLISHED?		DO YOU PAY CHILD SUPPORT?	
				Yes	No	Yes	No
				○	○	○	○
				○	○	○	○
				○	○	○	○

SECTION 15 – TEEN PARENT INFORMATION

Is there a parent under the age of 18 ("teen parent") in the household? ○ Yes ○ No

Name _____

Does the teen parent's child live in the household? ○ Yes ○ No

Name of teen parent's child _____

TEEN PARENT

LN NO. _____ Marital Status _____

High School Diploma/High School Equivalent? _____

LN NO. _____ Marital Status _____

High School Diploma/High School Equivalent? _____

TEEN PARENT CHILDREN

LN NO. _____

LN NO. _____

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 16 – INCOME INFORMATION:

Indicate if you or anyone who lives with you receives money from:	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY	INCOME LN No.	INCOME SOURCE CODE	INCOME AMOUNT	INCOME PERIOD
Unemployment Insurance Benefits 1	○	○								
Supplemental Security Income (SSI) Benefits (State and Federal Total) 2	○	○								
Social Security Disability (SSD) Benefits 3	○	○								
Social Security Dependent Benefits 4	○	○								
Social Security Survivor's Benefits 5	○	○								
Social Security Retirement Benefits 6	○	○								
Railroad Retirement Benefits 7	○	○								
Retirement Benefits (Pensions) 8	○	○								
Dividends/Interest from Stocks, Bonds, Savings, etc. 9	○	○								
Workers' Compensation 10	○	○								
NYS Disability Benefits 11	○	○								
Veteran's Pension/Benefits/Aid and Attendance 12	○	○								
Public Assistance Grant 13	○	○								
GI Dependency Allotments 14	○	○								
Education Grants or Loans 15	○	○								
Contributions/Gifts (Received) 16	○	○								
Foster Care Payments (Received) 17	○	○								
Child Support Payments (Received) Received From:_____ 18	○	○								
Spousal Support (Received) 19	○	○								
Private Disability Insurance - Health/Accident Insurance Policy Income 20	○	○								
No-Fault Insurance Benefits 21	○	○								
Union Benefits (including Strike Benefits) 22	○	○								
Loans, Other than Education (Received) 23	○	○								
Income from a Trust (including income you are currently entitled to receive, or were entitled to receive in the past, that has not been distributed) 24	○	○								
Training Allotments/Stipends 25	○	○								
Rental Income (Received) 26	○	○								
Boarders/Lodgers Income (Received) 27	○	○								
Other Income	○	○								
(Please Specify)	○	○								

CONSIDER

- ✓ Child Support Disregard/Pass-Through
  - ☐ Explained ☐ Budgeted
- ✓ SNAP Aged/Disabled Indicator
- ✓ Disability Review
- ✓ Reception and Placement Grant (SNAP Only)
- ✓ Refugee Matching Grant
- ✓ Change in Income from Last Budget

Deductions: Certain types of Medicaid budgeting allow applicants/recipients to reduce their countable income with deductions that they take on their federal taxes. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Only record deductions here if you will claim them on the current year's tax return.	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY
Educator expenses 1	○	○				
Individual Retirement Account (IRA) deduction 2	○	○				
Student loan interest deduction 3	○	○				
Tuition and fees 4	○	○				
Certain business expenses (reservists, artists, fee-based government officials) 5	○	○				
Health savings account deduction 6	○	○				
Job-related moving expenses 7	○	○				
Deductible part of self-employment (S/E) tax 8	○	○				
S/E, SIMPLE & qualified plans 9	○	○				
S/E health insurance deduction 10	○	○				
Penalty on early withdrawal of savings 11	○	○				
Alimony paid 12	○	○				
Domestic production activities deduction 13	○	○				
Additional adjustments added on line 36 (IRS Form 1040 only) 14	○	○				
Archer MSA deduction 15	○	○				
Other Adjustment (Please Specify)	○	○				
	○	○				

SECTION 17 – STEPPARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

Answer all questions listed below.

	YES	NO	WHO?
Does the stepparent of any children who live with you have any resources or receive income of any kind?	○	○	
Is anyone in your household a non-citizen with satisfactory immigration status who was sponsored for admission into the U.S.?	○	○	

NAME OF SPONSOR: PHONE NO.:

ADDRESS:

NEEDED	REFERRAL	COMPLETED
	UIB	

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 18 – EMPLOYMENT INFORMATION

I am currently: ◯ employed ◯ self-employed ◯ unemployed

Gross Income $ _____ Hours Worked Monthly _____

(Include wages, salary, overtime pay, commissions, and tips)

Paid: ◯ Weekly ◯ Biweekly ◯ Monthly Day of the week paid: _____

Employer's Name and Address: 1

_____ Phone No. _____

_____

Is anyone else who lives with you currently: ◯ employed ◯ self-employed

Who: _____

Gross Income $ _____ Hours Worked Monthly _____

Paid: ◯ Weekly ◯ Biweekly ◯ Monthly Day of the week paid: _____ 2

Employer's Name and Address:

_____ Phone No. _____

_____

Is health insurance available through your employer? ◯ Yes ◯ No

Does anyone who lives with you have health insurance with an employer? ◯ Yes ◯ No

Who: _____ 3

Name of Insurance Company: _____

Do you or anyone who lives with you have a child or dependent care expenses due to employment? ◯ Yes ◯ No

Who: _____ 4

Do you or anyone who lives with you have other employment-related expenses? ◯ Yes ◯ No

Who: _____ 5

REQUESTED	DOCUMENTATION	IN FILE
	CINTRAK/RFI/IRCS	
	1099	
	Employment Verification	
	Income Tax Return	
	Self-Employment Worksheet	
	Wage Stubs	
	Work Registration Form	
	Dependent/Child Care Form/Statement	
	Approval of Informal Child Care Provider	

NEEDED	REFERRALS	COMPLETED
	CAP	
	Disability	
	Employment	
	TPHI/COBRA	
	UIB	
	Workers' Compensation	
	Drug/Alcohol	
	Domestic Violence	
	Refugee Cash Assistance	

CONSIDER
✓ Limited English Proficiency
✓ Earned Income Tax Credit (see PUB-4786)
✓ Explaining Periodic Reporting Requirements
✓ Net Loss of Cash Income
✓ P.A.S.S. Income Amount and Sources
✓ Employment Sanctions
✓ Temporary Employment
✓ Disability Review
✓ Individual Development Account (IDA)
✓ Voluntary Quit

If not employed, when was the last time you or anyone who lives with you worked?

Who: When:

Where: _____ 6

Why did you (or they) stop working? _____

Did you or anyone living with you file for unemployment? ◯Yes ◯No

If yes, who? _____ When?: _____

Status of filing: ◯Approved ◯Denied ◯Pending

Are you or is anyone who lives with you participating in a strike? ◯Yes ◯No

Who: _____ 7

When the strike began: _____

Are you or is anyone who lives with you a migrant or seasonal farm worker? ◯Yes ◯No

Who: _____ 8

Do you or any other adult who lives with you have any medical conditions that limit the ability to work or the type of work that can be performed? ◯Yes ◯No

Who: _____

Describe Limitations: _____

_____ 9

Could you accept a job today? ◯Yes ◯No 10

If not, why? _____

What type of work would you like to do? _____

_____ 11

CHILD/DEPENDENT CARE EXPENSES

Who Pays	Amount	Name	Age	Care Provider
	$			
	$			
	$			
	$			
	$			
	$			
	$			
	$			

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 19 – EDUCATION/TRAINING

What is your highest level of education completed?

- ◯ Less than high school diploma
  - If so, last grade completed? _____
- ◯ Completion of an Individualized Education Plan (IEP)
- ◯ High school diploma or General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™)
- ◯ Associate's Degree (2-year college degree)
- ◯ Bachelor's Degree (4-year college degree) or higher

1

Does anyone else in the household have a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education? ◯ Yes ◯ No

If yes, who: _____

Degree attained: _____

Date completed: _____

2

Indicate if you or anyone who lives with you who is recertifying for or getting assistance:

Is or has been in any training program **in the last 12 months**? ◯ Yes ◯ No

Who _____

Where _____

Program _____

Dates attended _____

Dates completed _____

3

Is 16 years of age or older and is attending school or college? ◯ Yes ◯ No

Who _____

Where _____

4

Is getting a Training Allowance? ◯ Yes ◯ No

Who _____ Amt. $ _____

5

Is getting Educational Grants or Loans? ◯ Yes ◯ No

Who _____ Amt. $ _____

6

Is under 16 years of age and is attending school? ◯ Yes ◯ No

Who _____

School _____

Who _____

School _____

7

Who _____

School _____

Who _____

School _____

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Educational Grant Worksheet	
	Child Care Statement	

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

CONSIDER	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the SNAP student eligibility requirement?	☐	☐
Does anyone pay for child or dependent care to attend school or training?	☐	☐
Is there a 16-19 year-old parent who does not have a high school or equivalency diploma and who is not attending school?	☐	☐
Is anyone in training?	☐	☐
Are any other supportive services appropriate?	☐	☐
Are there any training related expenses?	☐	☐

SECTION 20 – RESOURCES INFORMATION

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	WHO	IF YES, AMOUNT/VALUE	WHO	IF YES, AMOUNT/VALUE
Has cash available 1	○	○		$		$
Has a checking account(s) 2	○	○				
Has a savings account(s) or certificate(s) of deposit 3	○	○				
Has a credit union account(s) 4	○	○				
Has life insurance 5	○	○				
Has title or registration to a motor vehicle(s) or other vehicle(s): Year _____ Make/Model _____ Year _____ Make/Model _____ Other_____ 6	○	○				
Has stocks, bonds, certificates or mutual funds 7	○	○				
Has savings bonds 8	○	○				
Has an IRA, Keogh, 401(k) or deferred compensation account(s) 9	○	○				
Has an irrevocable burial trust 10	○	○				
Has a burial fund 11	○	○				
Has a burial space 12	○	○				
Has their own home 13	○	○				
Has real estate, including income-producing and non-income-producing property 14	○	○				
Is eligible for an income tax refund 15	○	○				
Has an annuity 16	○	○				
Is the beneficiary of a trust 17	○	○				
Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources 18	○	○				
Has an "in trust" account(s) 19	○	○				
Has a safe deposit box(es) 20	○	○				
Has resources other than those listed above 21	○	○				
Has anyone (including your spouse, even if not recertifying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months? 22	○	○				
Has anyone (including your spouse, even if not recertifying or living with you) ever created a trust in the past or transferred any assets to a trust within the past 60 months? If yes, when? _____ 23	○	○				

VEHICLE INFORMATION

YR.	MAKE	MODEL	OWNER'S NAME	AMOUNT OWED	NADA VALUE	EXEMPT YES*	EXEMPT NO	LIEN HOLDER	ACCOUNT NO.
				$	$				
				$	$				

*IF EXEMPT, WHY?

NEEDED	REFERRAL	COMPLETED
	Legal	
	Resource	

LIFE INSURANCE

FACE AMOUNT	CASH VALUE

REQUESTED	DOCUMENTATION	IN FILE
	Resource Checklist	
	Market Value	
	DMV Clearance	
	Bank Statement	
	Assignment of Proceeds	
	Car/Vehicle Title	
	Car/Vehicle Registration (Older Models)	
	Bank Clearance	
	RFI/OCA	
	1099	

CONSIDER

- ✓ Children's Resources
- ✓ Lump Sum
- ✓ Boats, Campers, Snowmobiles
- ✓ Individual Development Account (IDA)
- ✓ Exempt Vehicles
- ✓ EIC
- ✓ Change in Resources from Last Budget

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 21 – MEDICAL INFORMATION

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses 1	○	○	
Is on Medicaid with a spend-down 2	○	○	
Has health or hospital/accident insurance (including insurance from employer) 3	○	○	
Has health insurance available through an employer 4	○	○	
Has Medicare (red, white, and blue card) 5	○	○	
Has a health attendant/home health aide 6	○	○	
Is blind, sick or disabled 7	○	○	
Is a child with a developmental disability 8	○	○	
Is in a hospital, nursing home or other medical institution 9	○	○	
Has paid or unpaid medical bills within 3 months preceding the month of this recertification 10	○	○	
Is or was drug or alcohol dependent 11	○	○	
Needs home care/personal care 12	○	○	
Is on SSI or has ever applied for SSI 13	○	○	
Is pregnant If pregnant, due date: _____ Expected number of births: _____ 14	○	○	
Receives treatment from a drug abuse or alcohol treatment program 15	○	○	
Has not been able to work for at least 12 months because of a disability or illness 16	○	○	
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months 17	○	○	
Has been in a car accident or work-related accident in the past two years 18	○	○	
Has had a government agency (public program) besides Medicaid or Medicare pay any of your medical bills If yes, what agency _____ 19	○	○	
Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of Medicaid? 20	○	○	

POLICY NO.:

AMOUNT:

FREQUENCY OF PAYMENT:

INSURANCE COMPANY NAME:

WHO IS COVERED:

EFFECTIVE DATE:

Is the answer to question 7 in this section consistent with Section 18 asking if the applicant or any other adult who lives in the household have any medical conditions that limit their ability to work or the type of work that they can perform?

REQUESTED	DOCUMENTATION	IN FILE
	Pregnancy Statement	
	Med/Psych Statement	
	Drug/Alcohol Screening (LDSS-4571)	
	Drug/Alcohol Statement	
	Paid or Unpaid Medical Bills	
	SSI Application Verification (**PA ONLY**)	

CONSIDER

- ✓ AD/SSI Related
- ✓ SNAP Aged/Disabled Indicator
- ✓ SNAP Medical Deduction
- ✓ TPHI Reimbursement
- ✓ Buy-In Eligibility
- ✓ Kreiger (LDSS-3664)
- ✓ Domestic Violence
- ✓ SSI Referral
- ✓ Earned Income Credit
- ✓ Change in Resources

NEEDED	REFERRALS	COMPLETED
	SSI (D-CAP)	
	Disability Interview (LDSS-1151)	
	Medical Report (LDSS-486, 486t)	
	Disability Report	
	AD	
	TPHI	
	ACCES-VR	
	CTHP	
	Family Planning	
	SSA (RSDI)	
	Veteran's Benefits	
	Veteran's Counseling	
	Child Health Plus	
	COBRA Eligibility	
	Nurse's Aide Service	
	Home Care	
	NYSoH	
	MA-Only (DOH-4220)	
	SSI-Related/Chronic Care (DOH-4220 with Supplement A)	
	LDSS-4526 or local equivalent	

RETROACTIVE MEDICAID	WHO	DATE	RECURRING MEDICAL EXPENSES	WHO	AMOUNT $	

MEDICAL BILLS: ☐ YES ☐ NO **TPHI:** ☐ YES ☐ NO

HEALTH PLAN SELECTION

Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call 1-800-505-5678.

Name of Plan You Are Enrolling In	Last Name	First Name	Date Of Birth mm/dd/yy	Sex M/F	ID# (from Medicaid Card if you have one)	Social Security # (optional if pregnant)	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID# of OB/GYN (check box if current provider)

SECTION 22 – SHELTER

WHAT IS YOUR LANDLORD'S NAME?

_____

WHAT IS YOUR LANDLORD'S ADDRESS?

_____

_____

_____

WHAT IS YOUR LANDLORD'S PHONE NUMBER?

( ) _____

	YES	NO	IF YES,
Do you or anyone who lives with you have a rent, mortgage or other shelter expense?	○	○	$
Do you or anyone who lives with you have a heat bill separate from your rent or other shelter expense?	○	○	$

SHELTER COSTS		MONTHLY ACTUAL COST
A. Room and Board		
B. Rent		
C. Trailer Lot Rent		
D. Mortgage Payment		
1.	Principal	
2.	Interest	
3.	Property Tax (including School Tax)	
4.	Homeowner's Insurance (incl. Fire Insurance)	
5.	Taxes Included in Mortgage (Escrow Payment)	
6.	Assessments (Sewer, etc.)	
E. Total Mortgage Payment (Line 1-6)		
TOTAL (Lines A - E)		

REQUESTED	DOCUMENTATION	IN FILE
	Landlord Statement	
	Rent Receipt	
	Tenant of Record	
	Customer of Record	
	Voluntary Restrict	
	Mandatory Restrict	
	Subsidized Housing	
	Mortgage/Title Search	
	Section 8 Lease or Statement from Section 8 Office	
	Property Lien	
	Shelter/Utility Repayment Agreement	

CONSIDER

- ✓ Utility and/or Fuel Restrict
- ✓ Utility Guarantee
- ✓ HEAP
- ✓ Subsidized Housing May Show Total Rent, NOT Client Amount
- ✓ Foster Care-Related Additional Allowances
- ✓ SNAP Household Composition Rules
- ✓ SNAP Aged/Disabled Indicator
- ✓ Real Property Tax Credit
- ✓ AIDS/HIV Emergency Shelter Allowance
- ✓ Property Lien
- ✓ If Shelter Expenses/Living Quarters Are Shared by More than One Household

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

SECTION 22 – SHELTER (CONT.)

Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?	YES	NO	IF YES, AMOUNT
Electricity (for needs other than heat; example: lights, cooking, hot water, etc.) 1	○	○	$
Natural Gas (for needs other than heat; example: cooking, hot water, etc.) 2	○	○	$
Water 3	○	○	$
Air Conditioning 4	○	○	$
Propane (for needs other than heat) 5	○	○	$
Sewer 6	○	○	$
Trash 7	○	○	$
Other Utilities and Expenses 8 Specify _____	○	○	$
Do you live in public housing? 9	○	○	
Do you live in Section 8, HUD, or other subsidized housing? 10	○	○	
Do you live in a drug/alcohol treatment facility? 11	○	○	

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	ACCOUNT NUMBER	IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD)	WHO IS THE TENANT OF RECORD?
A. Heat*					
B. Electricity (for cooking, lights, hot water)					
C. Gas (for cooking, hot water)					
D. Liquid Propane Gas					
E. Other Utilities or Expenses					
F. Air Conditioning					
G. Utility Installation Fees					
H. Sewer					
I. Trash					
J. Water					

***Check Primary Heat Type:**

☐ Natural Gas ☐ Oil ☐ PSC Electric ☐ Coal ☐ Other _____

☐ Kerosene ☐ Propane ☐ Municipal Electric ☐ Wood

ADDITIONAL INFORMATION

SECTION 23 – OTHER EXPENSES

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES, AMOUNT	HOW OFTEN PAID	LEGALLY OBLIGATED YES	LEGALLY OBLIGATED NO	CHILD IN SNAP HH YES	CHILD IN SNAP HH NO
Pays child support 1	○	○	$					
Pays spousal support 2	○	○	$					
Pays for child care 3	○	○	$					
Pays for dependent care 4	○	○	$					
Pays tuition, fees, or other educational expenses 5	○	○	$					
Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.) Specify: _____ 6	○	○	$					
Do you or anyone who lives with you who is recertifying owe at least four months of support for a child under the age of 21? 7	○ YES	○ NO						

SECTION 24 – OTHER INFORMATION

Do you buy or plan to buy meals from a home delivery or communal dining service? 8	○ YES	○ NO		
Are you able to cook or prepare meals at home? 9	○ YES	○ NO	VETERAN STATUS	VETERAN CODE
Have you or anyone in your household ever been in the U.S. military? Who? _____ 10	○ YES	○ NO		
Has your spouse ever been in the U.S. military? 11	○ YES	○ NO		
Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? _____ 12	○ YES	○ NO		

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	WHO
Have you or anyone who lives with you who is recertifying moved into this county from another New York State county within the past two months?	○	○	
Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Public Assistance and/or the Supplemental Nutrition Assistance Program (SNAP) because of fraud/an Intentional Program Violation?	○	○	
Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?	○	○	
Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive Public Assistance in two or more states?	○	○	
Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP Benefits in any state after September 22, 1996?	○	○	
Have you or any member of your household been convicted of buying or selling SNAP Benefits for a combined amount of over $500 or more after September 22, 1996?	○	○	
Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?	○	○	
Are you or any member of your household fleeing to avoid prosecution, custody or confinement after conviction of a felony or attempted felony and actively being pursued by law enforcement?	○	○	
Are you or any member of your household violating probation or parole according to a court order?	○	○	

PROPERTY TRANSFER STATUS

I have ○ **I have not** ○ sold, transferred or given away any of my property to anyone to get Public Assistance or SNAP Benefits.

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ SNAP Dependent Care Deductions
	UIB		✓ District of Fiscal Responsibility (SSL 62.5)

REQUESTED	DOCUMENTATION	IN FILE
	Child/Dependent Care Statement	
	Recoupments	
	Outstanding Overpayment	
	Pending Disqualification	

IF TOTAL EXPENSES (INCLUDING EXPENSES NOT USED IN THE BUDGET DETERMINATION) EXCEED INCOME (INCLUDING PA GRANT), EXPLORE HOW THE HOUSEHOLD IS MEETING ITS OBLIGATIONS.

Actual Expenses $

Actual Income $

= Difference $

CONSIDER
✓ Actual Expenses, including: shelter, fuel/utility costs, telephone costs, etc.
✓ Actual Shelter
✓ Actual Fuel/Utility Costs
✓ Telephone Expenses
✓ Car Expenses
✓ Furniture/Appliance Rental
✓ Cable TV
✓ Tuition
✓ Out-of-Pocket Medical Expenses

Does Client Receive Contribution Towards Difference ☐ Yes ☐ No

If Yes, From Whom? _____

Based on the information contained in this recertification, make sure you reconsider the category. For PA, especially, consider the following:

- Eligible Child Status
- Essential Persons Status
- Family Assistance Extensions

Category is _____

Documented by _____

NOTES/COMMENTS

NOTICES, ASSIGNMENTS, AUTHORIZATIONS, and CONSENTS

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS – The collection of Social Security Numbers (SSNs) is authorized for each household member with respect to the Supplemental Nutrition Assistance Program (SNAP), pursuant to the Food and Nutrition Act of 2008 (as amended). Anyone applying for SNAP must provide an SSN in order to receive benefits. If you or anyone applying does not have an SSN, that person must apply for an SSN with the Social Security Administration (visit www.SSA.gov or call 1-800-772-1213).

With respect to all other programs for which this recertification form requires an SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: Section 205(c) of the Social Security Act (42 U.S. Code 405), Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) and Section 7(a)(2) of the Privacy Act of 1974. See the instruction book (PUB-1313 Statewide) or talk to your social services district if you have questions.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. The information will be used to check identity, to verify earned and unearned income, to determine if absent parents can receive health insurance coverage for applicants or recipients, to determine if applicants or recipients can obtain child or spousal support, and to determine if applicants or recipients can receive money or other help. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. Besides using the information you give us in this way, the state will use the information to prepare statistics about all of the people receiving benefits from the Home Energy Assistance Program (HEAP) (see below).

This information may be disclosed to other state and federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. Information collected with respect to applicants for and recipients of Family Assistance and Safety Net Assistance, including SSNs, may be used to assist in the formation of jury pools. If a SNAP claim arises against your household, the information on this recertification, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

SSNs of ineligible household members will also be used and disclosed in the manner above.

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

NONDISCRIMINATION NOTICE – This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

The United States Department of Agriculture (USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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

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

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201, or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

New York State additionally prohibits discrimination based on gender identity, transgender status, gender dysphoria, sexual orientation, marital status, military status, domestic violence victim status, pregnancy-related conditions, predisposing genetic characteristics, prior arrest or conviction record, familial status, and retaliation for opposing unlawful discriminatory practices.

CONSENT FOR INVESTIGATION – I agree to any investigation to verify or confirm the information I have given in connection with my request for Public Assistance (PA), Medicaid, Supplemental Nutrition Assistance Program (SNAP) Benefits, Home Energy Assistance Program Benefits, Services or Child Care Assistance. If additional information is requested, I will provide it. I will also cooperate fully with state and federal personnel in any PA and/or SNAP Quality Control Review.

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

CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE INFORMATION – I authorize the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance (UI) purposes to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with state and local agency employees working in social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of, Public Assistance, Medicaid, Supplemental Nutrition Assistance Program Benefits, Home Energy Assistance Program Benefits or Child Care Assistance, applied for in this application/recertification and for investigations to determine whether I received benefits to which I was not entitled. OTDA may also share the information with the New York State Office of Children and Family Services (OCFS) and the New York State Department of Health (DOH). OCFS will use the information to monitor the Child Care Assistance program.

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

CHANGE REPORTING – I agree to inform the agency **promptly** of any change in my needs, residency/address, living arrangements, household size, income, employment, property/resources, dependent care costs, health insurance, non-citizen with satisfactory immigration status/citizenship status, able-bodied adult without dependents (ABAWD) status, pregnancy status or living arrangements, to the best of my knowledge or belief.

If I am applying for Child Care Assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my home, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

PENALTIES – Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you recertify for Public Assistance, Medicaid, Supplemental Nutrition Assistance Program, Services or Child Care Assistance ("Assistance, Benefits or Services") or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your recertification or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have recertified to obtain or continue to receive Assistance, Benefits or Services. If you are an authorized representative, such Assistance, Benefits or Services must be used for the other person and not for yourself. Federal and state laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within 60 months prior to the first of the month in which the individual is both in receipt of nursing facility services and has submitted an application for Medicaid, may render the individual ineligible for nursing facility services or home and community-based waivered services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM DISQUALIFICATION PENALTIES – Any information you provide in connection with your application for the Supplemental Nutrition Assistance Program (SNAP) will be subject to verification by federal, state and local officials. If any information is incorrect, you may be denied SNAP Benefits. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to $250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable federal and state laws. Anyone who is violating a condition of probation or parole, or anyone who is fleeing to avoid prosecution, custody or confinement of a felony and is actively being pursued by law enforcement, is not eligible to receive SNAP Benefits.

You may be found ineligible for SNAP or found to have committed an Intentional Program Violation (IPV) if you make a false or misleading statement, or misrepresent, conceal or withhold facts, in order to qualify for benefits or receive more benefits; purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or commit or attempt to commit any act that constitutes a violation of federal or state law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking SNAP Benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system. Additionally, the following is not allowed and you may be disqualified from receiving SNAP Benefits and/or be subject to penalties for actions that include:

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

Individuals found to have committed an IPV either through an administrative disqualification hearing or by a federal, State or local court, or have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution shall be ineligible to participate in SNAP for a period of:

- 12 months for the first SNAP IPV;
- 24 months for the second SNAP IPV;
- 24 months for the first SNAP IPV that is based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- 120 months if the individual is found to have made a fraudulent statement about who they are or where they live in order to get multiple SNAP Benefits simultaneously, unless permanently disqualified for a third SNAP IPV.
  Additionally, a court may bar an individual from participating in SNAP for an additional 18 months.

An individual can be permanently disqualified from receiving SNAP Benefits for:

- The first SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of firearms, ammunition or explosives;
- The first SNAP IPV based on a court conviction for trafficking SNAP Benefits for a combined amount of $500 or more (trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices);
- The second SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- A third SNAP IPV.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – Your household must report child care and utility expenses in order to get a Supplemental Nutrition Assistance Program (SNAP) deduction for these expenses. Your household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a SNAP deduction for these expenses. Failure to report/verify the above expenses will be seen as a statement by your household that you do not want to receive a deduction for these unreported/unverified expenses. A deduction for these expenses may make you eligible for SNAP or may increase your SNAP benefits. You may report/verify these expenses at any time in the future. The deduction would then be applied to the calculation of SNAP benefits in future months, in accordance with the rules for change reporting (see Change Reporting, above).

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to recertify for Supplemental Nutrition Assistance Program (SNAP) Benefits for you. You can also authorize someone outside your household to get SNAP Benefits for you or to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may authorize someone by printing the person's name, address, and phone number immediately below, and having them sign in the signature section at the end of this recertification. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, both the Authorized Representative and a responsible adult member of the household must sign and date the signature section at the end of this recertification, unless the SNAP household has otherwise designated the Authorized Representative to do so in writing.

NAME, ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE (PLEASE PRINT):

STANDARD UTILITY ALLOWANCE – I understand that Public Assistance and Supplemental Nutrition Assistance Program (SNAP) recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). I also understand that if I have not received a HEAP benefit of greater than $20 in the current month or previous 12 months, or a similar energy assistance benefit, I must pay for heating or air conditioning separately from my rent in order to receive the heating/cooling standard utility allowance (i.e., a deduction) for SNAP. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

RELEASE OF MEDICAL INFORMATION – I consent to the release of any medical information about me and any members of my family for whom I can give consent by my primary care provider, any other health care provider or the New York State Department of Health (DOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to DOH and other authorized federal, state, and local agencies for purposes of administration of Medicaid; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I authorize the release of any health-related information about me and any members of my family for whom I can legally give authorization related to the provision of assistance and services and my ability to participate in work activities, including employment, to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services or the local social services district, as reasonably necessary for the provision of Public Assistance benefits; for services, including child welfare services; for determining appropriate work activity assignments; for determining the need to apply and for making application for Supplemental Security Income Benefits; for establishing appropriate treatment plans for restoring employability; and for determining eligibility for exemptions from the State sixty-month time limit on cash assistance receipt. If I am required to apply for benefits administered by the Social Security Administration, the information specified above may be shared with the Social Security Administration. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law, unless a box is checked below. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult

applying is necessary for consent to release information. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain information regarding treatment, diagnosis and procedures on their behalf.

_____ Do not disclose HIV/AIDS information _____ Do not disclose drug and alcohol information
_____ Do not disclose mental health information

RELEASE OF INFORMATION TO HEALTH SERVICE PROVIDERS – I give permission to the social services district and the State of New York to share information with health service providers, as designated by the social services district or the State of New York, regarding Public Assistance benefits that I or any member of my household for whom I can legally give authorization have received or are eligible to receive, for the purpose of improving the quality of my healthcare and overall well-being, and to facilitate receipt of additional benefits for which I, or members of my household, may be eligible.

RELEASE OF EDUCATIONAL RECORDS – I give permission to the New York State Department of Health and the social services district to:1) obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming Medicaid reimbursement for health-related educational services; and 2) provide the appropriate federal government agency access to this information for the sole purpose of audit.

RELEASE OF INFORMATION FOR THE EARLY INTERVENTION PROGRAM – If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the social services district and New York State to share my child's Medicaid eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medicaid.

CHILD/TEEN HEALTH PROGRAM – I understand that if my child is on Medicaid, they can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the social services district.

MEDICARE – I authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

MEDICAID – You have a right as part of your Medicaid **application**, or within two years from the date of your **application**, to request reimbursement of expenses you paid for covered medical care, services and supplies received during the three-month period prior to the month of your **application**. After the date of your application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

ASSIGNMENT OF INSURANCE/OTHER BENEFITS AND DIRECT PAYMENT – For Public Assistance and Medicaid, I agree to file any claims for health or accident insurance benefits, and to pursue any personal injury claims or any other resources to which I may be entitled, and do hereby assign any such resources to the social services district to whom this recertification is made. In addition, I will assist in making any assigned benefits available to the social services district to whom this recertification is made.

I authorize payments owed to me or members of my household for health or accident insurance benefits to be made directly to the appropriate social services district for medical and other health services furnished while we are eligible for Medicaid.

MEDICAID RECOVERIES – Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. MA paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. MA may also recover the cost of services and premiums incorrectly paid.
I understand that effective April 1, 2014, if I get Medicaid through New York State of Health:

- No lien will be placed on my real property prior to my death.

- Recovery from assets in my estate upon my death is limited to the amount Medicaid paid for the cost of nursing home care, home and community-based services, and related hospital and prescription drug services received on or after my 55th birthday.

PUBLIC ASSISTANCE RECOVERIES – Public Assistance (PA) you receive for yourself and for persons for whom you are legally responsible to support is recoverable from property or money you possess or may acquire. You may be required, as a condition of receiving PA, to execute a deed or mortgage of real property you own. Your tax refunds and portions of lottery winnings may be taken to repay your debt for PA.

AUTHORIZATION TO REPAY PUBLIC ASSISTANCE BENEFITS FROM RETROACTIVE SUPPLEMENTAL SECURITY INCOME – I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of Supplemental Security Income (SSI); i.e. my retroactive SSI payment) to reimburse the local social services district (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for SSI. SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SSA can reimburse the SSD in two situations:

(1) It will repay the SSD if I apply for SSI and SSA finds me eligible.
(2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called “interim assistance.” The period begins: 1) with the first month I become eligible for payment of SSI benefits; or 2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and that, if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

This authorization applies to any SSI application or appeal I now have pending before SSA. This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called “What You Should Know About Social Services Programs.” I understand what it says about interim assistance.

SUPPORT – Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or Title IV-E foster care operates as an assignment to the State and the social services district of any rights to support from any other person that the applicant or recipient may have in their own right or on behalf of any other family member for whom the applicant or recipient is applying for, or receiving, assistance (Social Services Law, Sections 158 and 348). This assignment is limited in certain situations. Other sections of this recertification contain additional assignments.

ASSIGNMENT OF SUPPORT RIGHTS – I assign to the state and social services district any rights I have to support from persons having legal responsibility for my support and any rights I have to support on behalf of any family member for whom I am applying for or receiving assistance. Where applying for or receiving Family Assistance or Safety Net Assistance, my assignment of support rights is limited to support which accrues during the period that I and/or any family member receives assistance. However, any support rights that I assigned to the state on behalf of myself or any family member prior to October 1, 2009, continue to be assigned to the state.

HOME ENERGY ASSISTANCE PROGRAM – I understand that by signing this application/certification, I consent to any investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this recertification to be used in referrals to available weatherization assistance programs and my utility company's low income programs.

I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

SEXUAL ASSAULT INFORMATION – If you are a victim of sexual assault, you have the right to request referral information from the social services district. If you request referral information, the social services district must provide you with the addresses and phone numbers of any: 1) local hospitals offering sexual assault forensic examiner services certified by the NYS Department of Health; 2) local rape crisis centers; and 3) local advocacy, counseling, and hotline services appropriate for victims of sexual assault. In addition, the social services district must provide you with the NYS Hotline for Sexual Assault and Domestic Violence numbers: (800) 942-6906 and (800) 818-0656 (TTY).

CERTIFICATION FOR CHILD CARE ASSISTANCE – If I am applying for Child Care Assistance, I certify that my family resources do not exceed $1,000,000.

I have read and understand the notices above. I understand and agree to the assignments, authorizations and consents above. I swear and/or affirm under the penalties of perjury that the information I have given or will give to the social services district is complete and correct.			
APPLICANT SIGNATURE **x**	**DATE SIGNED**	**SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE** **x**	**DATE SIGNED**
AUTHORIZED REPRESENTATIVE SIGNATURE **x**	**DATE SIGNED**		

ONLY COMPLETE THE FOLLOWING IF YOU WANT TO CLOSE YOUR CASE FOR ONE OR MORE PROGRAMS.

I REQUEST THAT MY CASE BE CLOSED FOR:

Public Assistance **Supplemental Nutrition Assistance Benefits** **Medical Assistance**

I understand that I may reapply at any time.

Give Reason: _____

Signature x _____ **Date** _____

NYS Agency-Based Voter Registration Form

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

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

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

Signature _____ Date ___/___/___

Please Print Name _____

Important!

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

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

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

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

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

যদি আপনি এই ফরমটি বাংলা ভাষায় চান , তাহলে 1-800-367-8683 নম্বরে ফন করুন

VOTER REGISTRATION APPLICATION (instructions on back)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1 **Are you a U.S. citizen?** ◯ YES ◯ NO
If you answered **NO**, do not complete this form

2 **A) Will you be 18 years old on or before election day?** ◯ YES ◯ NO
B) Are you at least 16 years of age and understand that you must be 18 years of age on or before election day to vote, and that until you will be eighteen years of age at the time of such election your registration will be marked "pending" and you will be unable to cast a ballot in any election? ◯ YES ◯ NO
If you answered **NO** to both of the prior questions, you cannot register to vote.

For Board Use Only

3 Last Name | First Name | Middle Initial | Suffix

4 Address where you live (do not give P.O. box) | Apt. No. | City/Town/Village | Zip Code | County

5 Address where you get your mail (if different than above) | P.O. Box, Star Route, etc. | Post Office | Zip Code

6 Date of Birth | **7** Gender (optional) | **8** Telephone (optional) | Email (optional)

10 The last year you voted | Your address was (give house number, street and city)
In county/state | Under the name (if different from your name now)

9 **ID Number** (Check the applicable box and provide your number)
- ◯ New York State DMV number — — — — — — — — —
- ◯ Last four digits of your Social Security number — — — —
- ◯ I do not have a New York State DMV or Social Security number

11 **Political Party**

I wish to enroll in a political party

- ◯ Democratic party
- ◯ Republican party
- ◯ Conservative party
- ◯ Working Families party
- ◯ Green party
- ◯ Libertarian party
- ◯ Independence party
- ◯ SAM party
- ◯ Other _____

I do not wish to enroll in any political party and wish to be an independent voter

- ◯ No party

12 **Affidavit: I swear or affirm that**

- I am a citizen of the United States.
- I will have lived in the county, city or village for at least 30 days before the election.
- I will meet all requirements to register to vote in New York State.
- This is my signature or mark on the line below.
- The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years.

Signature or Mark in ink _____ Date ___/___/___

(Optional) Register to donate your organs and tissues

Last Name

First Name | Middle Initial | Suffix

Address

Apt Number | City/Town/Village | Zip Code

Birth Date | Gender ◯ M ◯ F

Eye Color | Height Ft. In.

Email | DMV or ID NYC Number

By signing below, you certify that you are:

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

DONATE LIFE New York State

Signature _____ Date ___/___/___

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment;
- pre-register to vote if you are 16 or 17 years of age.

To Register You Must:

- be a U.S. citizen;
- be 18 years old (you may pre-register at 16 or 17 but cannot vote until you are 18);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in prison or on parole for a felony conviction (unless parole pardoned or restored rights of citizenship);
- not claim the right to vote elsewhere; and
- not found to be incompetent by a court.

Important!

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

NYS Board of Elections
40 North Pearl St, Suite 5
Albany, NY 12207-2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.ny.gov

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

Verifying your identity

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

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

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

To complete this form:

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

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

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

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

NON-CITIZEN ELIGIBILITY DESK AID

IMPORTANT! This desk aid does not include every form of acceptable documentation to support a non-citizen status that would be satisfactory for benefit eligibility. If an individual presents a document not listed below, follow your social services district policy/ procedure for further guidance.

Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes[1]	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
Lawful Permanent Resident (LPR) without 40 Qualifying Quarters	K	I-551 Permanent Resident Card: workers must check category code; [2] or Temporary I-551 stamp in foreign passport or on I-94 Arrival/Departure Record; or Immigrant visa with the notation "upon endorsement serves as temporary I-551 permanent resident for one year;" or I-797 Notice of Action indicating approval of an I-485 Application to Register Permanent Residence or Adjust Status; or I-327 Permit to Reenter the United States; or I-181 Memorandum of Creation of Record of Lawful Permanent Residence with approval stamp; or Any other authoritative document that identifies the non-citizen[3] as an LPR	DOS is the date status was obtained	Yes	Yes if: Entered the U.S. on or after 8/22/96, and after five years in U.S. in a qualified status; or Entered the U.S. before 8/22/96, have continuously resided in the U.S., and are in a qualified status	Yes if: In a qualified status and in receipt of certain disability benefits [7 USC 2012(j)(2)-(7)]; or In a qualified status and under age 18; or After five years in U.S. in a qualified status; or Currently in a qualified status and was age 65 or older on 8/22/96 and was lawfully residing in the U.S. on that date
LPR with 40 Qualifying Quarters	S	Same LPR documentation as above and Proof of 40 qualifying quarters[4] Note: No quarters earned after 12/31/96 may be counted in which a non-citizen has received a federal means-tested public benefit, including but not limited to FA, SSI and SNAP.	DOS is the date status was obtained			Yes

[1]The Date of Status (DOS) field in the Welfare Management System (WMS) identifies the date a non-citizen obtained qualified status, which is indicated by the appropriate Alien Citizenship Indicator (ACI) code, and is used to calculate when a qualified non-citizen reaches five years in a qualified status and then becomes eligible for federally funded assistance, if otherwise eligible. Non-citizens that are considered Permanently Residing Under Color of Law (PRUCOL) are not qualified non-citizens, therefore, their time in a status that is considered PRUCOL does not count towards the five years. For non-citizens that are PRUCOL, the DOS field is left blank. If a non-citizen who is PRUCOL later adjusts to a qualified status, the date that the qualified status is obtained is the date that is entered in the DOS field.

The Date Entered Country (DEC) field in WMS indicates when the non-citizen physically entered the United States (U.S.). This is necessary so as not to deny federal benefits to certain qualified non-citizens who entered the U.S. prior to August 22, 1996 but have been in a qualified status for less than five years.

[2]Workers must check the "Category" code on the documentation provided to make the correct eligibility determination for federal benefits (FA, SNAP). This code is used to describe the category that was used to admit a non-citizen to the U.S. as a permanent resident. It is located on the front side of the I-551 Permanent Resident Card next to the cardholder's A-number. This field is also known as a class of admission (COA), as seen on the Systematic Alien Verification for Entitlements (SAVE) report. As illustrated on this desk aid, certain non-citizens who have an I-551 Permanent Resident Card, often referred to as a "green card," may not be subject to the "five-year bar" on federal benefits depending on the category code on the I-551.

Additionally, it is essential that the category codes included in the qualified battered non-citizen section on page 3 of the desk aid are identified. This is because, for qualified battered non-citizens, the DOS is often prior to the "Resident Since" date on the I-551 Permanent Resident Card.

[3]As used in this desk aid, the term "non-citizen" means a person who is not a citizen or national of the U.S. The term "qualified non-citizen" means a person who is a "qualified alien" as that term is defined in 8 U.S.C. §1641.

Note: Individuals born in certain territories of the U.S. are U.S. citizens at birth. These include: Puerto Rico, U.S. Virgin Islands, Guam, Commonwealth of the Northern Mariana Islands, and the Panama Canal Zone (if born between 2/26/1904 and 10/1/1979). In addition, individuals who are born outside of the U.S. may be U.S. citizens at birth if one or both parents were U.S. citizens at their time of birth. Districts must verify citizenship status for these individuals. Individuals who are not U.S. citizens at birth may become U.S. citizens through naturalization. Naturalization is the conferring of U.S. citizenship after birth by any means whatsoever. Individuals born in American Samoa or Swains Island are nationals of the U.S. and for purposes of benefit eligibility should be treated as citizens, ACI code "C."

[4]40 qualifying quarters as defined under Title II of the Social Security Act, or can be credited with such qualifying quarters. An LPR may earn qualifying quarters by working, or may be credited with qualifying quarters from a parent, stepparent, or adoptive parent for any quarter earned prior to the LPR turning 18. An LPR may also be credited with quarters earned by a spouse during his/her marriage. A widow or widower retains credit for all qualifying quarters earned by a deceased spouse during the marriage. When a marriage ends in divorce, however, any quarters earned by the spouse during the marriage are forfeited.

IMPORTANT! This desk aid does not include every form of acceptable documentation to support a non-citizen status that would be satisfactory for benefit eligibility. If an individual presents a document not listed below, follow your social services district policy/ procedure for further guidance.

Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
• Refugee • Conditional Entrant (A status granted to Refugees prior to 1980) • Iraqi or Afghan Special Immigrant Visa Holder • Amerasian Immigrant • Certain Hmong or Highland Laotian *Also explore eligibility for Refugee Cash Assistance (RCA). See 16-ADM-02	R	I-551 Permanent Resident Card, or I-94 Arrival/Departure Record or Passport stamped/coded: AM1, AM2, AM3, AM6, AM7, AM8, AR1, AR6, R8-6, RE1, RE2, RE3, RE4, RE5, RE6, RE7, RE8, RE9, SI-1, SI-2, SI-3, SI-6, SI-7, SI-8, SI-9, SQ1, SQ2, SQ3, SQ6, SQ7, SQ8 or SQ9; or I-766 Employment Authorization Card coded: A3 or A03; or I-94 Arrival/Departure Record or Passport stamped: "admitted under Section 207 or 203(a)(7) (as in effect prior to 4/1/80) of the Immigration and Nationality Act (INA)," or "Refugee," or Iraq or Afghanistan national stamped: "admitted under Section 101(a)(27) of the INA;" or I-797 Notice of Action indicating approval of an I-730 "Refugee;" or I-571 Refugee Travel Document	DOS is the date the non-citizen entered the U.S.	Yes	Yes	Yes
Asylum Granted[5] *Also explore eligibility for RCA. See 16-ADM-02	A	I-551 Permanent Resident Card coded: AS1, AS2, AS3, AS6, AS7, or AS8; or I-766 Employment Authorization Card coded: A5 or A05; or I-94 Arrival/Departure Record stamped: "Granted asylum under Section 208 of the INA;" or I-797 Notice of Action indicating approval of an I-730 "Asylee;" or Grant letter from the United States Citizenship and Immigration Services (USCIS) Asylum Office; or Order of an immigration judge granting asylum	DOS is the date status was obtained	Yes	Yes	Yes

[5]If the non-citizen has not been granted asylum, but is an asylum applicant with employment authorization, refer to page 8 to determine SNA eligibility.

IMPORTANT! This desk aid does not include every form of acceptable documentation to support a non-citizen status that would be satisfactory for benefit eligibility. If an individual presents a document not listed below, follow your social services district policy/ procedure for further guidance.

Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
Qualified Battered Non-Citizen[6] A U.S. citizen's or LPR's battered spouse, or child, or parent or child of such battered person, who: Obtains "Notice of Prima Facie" Case from the USCIS under the Violence Against Women Act (VAWA); or Has an I-360 self-petition under VAWA that is approved; or Has a pending I-360 self-petition and is determined to be a credible victim of domestic violence by the district's Domestic Violence Liaison (DVL); or Is determined to be a credible victim of domestic violence by the district's DVL with a pending or approved I-130 petition; or Has an application for VAWA cancellation of removal or suspension of deportation that has been granted or is pending and the immigration court finds that the applicant has a prima facie case for this relief	B	I-551 Permanent Resident Card coded: B11, B12, B16, B17, B20, B21, B22, B23, B24, B25, B26, B27, B28, B29, B31, B32, B33, B36, B37, B38, BX1, BX2, BX3, BX6, BX7, BX8, IB1, IB2, IB3, IB6, IB7, IB8 or Z14; or I-766 Employment Authorization Card coded: A09, A15 or C31; or I-94 Arrival/Departure Record coded: K3, K4, V1, V2 or CR -1-7 and a pending or approved I-130; or I-797 Notice of Action indicating prima facie eligibility of an I-360 self-petition under Section 204(a)(1)(A)(iii) or (iv), or Section 204(a)(1)(B)(ii) or (iii) of the INA; or I-797 Notice of Action indicating approval or pending I-360 self-petition under Section 204(a)(1)(A)(ii) or (iii) or (iv), or Section 204(a)(1)(B)(ii) or (iii) of the INA; or I-797 Notice of Action indicating approval or pending I-130 visa petition under Section 204(a)(1)(A)(i) of the INA (spouse or child of a U.S. citizen), or Section 204(a)(1)(B)(i) (spouse or child of a lawful permanent resident); or Any other document from the USCIS indicating the non-citizen has a K or V visa and a pending or approved I-130; or Order from the Executive Office of Immigration Review (EOIR) under Section 240A(b)(2) of the INA or if the application is pending documentation that the court finds that the applicant has a prima facie case for this relief	DOS is the date status was obtained[7]	Yes	Yes if: Entered the U.S. on or after 8/22/96, and after five years in U.S. in a qualified status; or Entered the U.S. before 8/22/96, have continuously resided in the U.S., and are in a qualified status	Yes if: In a qualified status and in receipt of certain disability benefits [7 USC 2012(j)(2)-(7)]; or In a qualified status and under age 18; or In a qualified status and have 40 qualifying quarters; or After five years in U.S. in a qualified status; or Currently in a qualified status and was age 65 or older on 8/22/96 and was lawfully residing in the U.S. on that date

[6]For non-citizens to be treated as qualified battered non-citizens, they must meet four requirements:

1. Be a credible victim of battery or extreme cruelty; and
2. Have appropriate immigration documentation; and
3. Be able to show a substantial connection between the need for benefits and the battery or extreme cruelty; and
4. No longer reside in the same household as the abuser.

Districts should refer to 06-INF-14 for additional information about qualified battered non-citizens and eligibility.

[7]In general, the DOS for TA and SNAP is when all four of the criteria in footnote 6 are met. Exception for SNAP: Per current United States Department of Agriculture (USDA) guidance, for non-citizens with an approved I-360; or a prima facie determination on a pending I-360; the DOS for SNAP is the date the I-360 petition was approved, or the date the prima facie determination was made by USCIS, whichever is earlier.

WMS only records one DOS. If the DOS for TA and SNAP are different, enter the earlier of the two dates in WMS so that the non-citizen can receive the federal benefits they are eligible for; the later date must be noted, and tracked manually in the case record so that the federal benefits for that benefit program are also issued appropriately. See GIS 19 TA/DC038 "SNAP and TA Date of Status (DOS) Determination for Qualified Battered Non-Citizens," for further information.

Note: Non-citizens who file for VAWA related immigration relief often later adjust their immigration status to become LPRs. The "residence since" date on the I-551 Permanent Resident Card indicates the date LPR status was obtained, not the date the non-citizen was determined to be a qualified battered non-citizen. For both TA and SNAP, use the earliest appropriate date as the DOS for benefit eligibility. If a non-citizen presents an I-551 with one of the codes noted above, review the case record, and/or ask the non-citizen if they have additional documentation, to determine if an earlier DOS would be appropriate.

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Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
Victim of Human Trafficking *Also explore eligibility for RCA. See 16-ADM-02	D	I-551 Permanent Resident Card coded: ST0, ST6, ST7, ST8 or ST9; or I-766 Employment Authorization Card coded: A16 or C25; or I-94 Arrival/Departure Record coded: T1, T2, T3, T4, T5 or T6 stating admission under Section 212(d)(5) of the INA if status granted for at least one year; or I-797 Notice of Action indicating approval of an I-914 or I-914A coded: T1, T2, T3, T4, T5 or T6; or Certification Document (for adults) or Eligibility Letter (for children) from the Administration for Children and Families (ACF), Office on Trafficking in Persons (OTIP); Must call 1-866-401-5510 for verification	DOS is the date of certification or eligibility by OTIP See 03-ADM-01	Yes	Yes	Yes
Deportation or Removal Withheld	J	I-766 Employment Authorization Card coded: A10; or Order from an Immigration Judge showing the date deportation was withheld under Section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under Section 241(b)(3) of the INA	DOS is the date status was obtained	Yes	Yes	Yes
Parolee (for at least one year) (A parolee is a non-citizen who has been allowed to enter the U.S. for humanitarian or public interest reasons)	G	I-766 Employment Authorization Card coded: A04 or C11 and I-94 Arrival/Departure Record indicating admitted for at least one year; or I-94 Arrival/Departure Record stamped: "Paroled pursuant to Section 212(d)(5)," or "parole," or "PIP" with date of entry and date of expiration indicating one year Note: See Cuban/Haitian Entrant section on page 5 if non-citizen is a Cuban or Haitian national.	DOS is the date status was obtained	Yes	Yes if: Entered the U.S. on or after 8/22/96, and after five years in U.S. in a qualified status; or Entered the U.S. before 8/22/96, have continuously resided in the U.S., and are in a qualified status	Yes if: In a qualified status and in receipt of certain disability benefits [7 USC 2012(j)(2)-(7)]; or In a qualified status and under age 18; or In a qualified status and have 40 qualifying quarters; or After five years in U.S. in a qualified status; or Currently in a qualified status and was age 65 or older on 8/22/96 and was lawfully residing in the U.S. on that date
Parolee (for less than one year)	T	I-766 Employment Authorization Card coded: A04 or C11; or I-94 Arrival/Departure Record stamped: "Paroled pursuant to section 212(d)(5)," or "parole," or "PIP" Note: See Cuban/Haitian Entrant section on page 5 if non-citizen is a Cuban or Haitian national.	DOS is left blank	Yes	No	No

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Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
Cuban/Haitian Entrant *Also explore eligibility for RCA. See 16-ADM-02	H	I-551 Permanent Resident Card or Temporary I-551 stamp in foreign passport coded: CU6, CU7, CH6, HA6 or HB6; or I-94 Arrival/Departure Record stamped: "Cuban/Haitian Entrant (status pending)" or coded CU6, CU7, HF, HP0, HP1 or HPD; or Any other document from the USCIS indicating parole under the Haitian Family Reunification Parole Program (HFRP) coded "HF;" or Reasonable evidence of being a Cuban or Haitian national (citizen) and one of the following: I-766 Employment Authorization Card coded: C8, C08, or C11; or I-766 Employment Authorization Card coded: C18 (Order of Supervision) with additional documentation to support previous or current parole status into the U.S.; or I-94 Arrival/Departure Record stamped: "Form I-589 filed;" or I-94 Arrival/Departure Record stamped: "paroled under Section 212(d)(5) of the INA," or "Section 212(d)(5) of the INA," or stamp showing parole in U.S. on or after 10/10/80;[8] or I-797C Notice of Action confirming USCIS's receipt of the non-citizen's Form I-589 (Application for Asylum and Withholding of Removal); or Documentation issued by the Department of Homeland Security (DHS) or the Department of Justice's EOIR showing that the non-citizen is in removal proceedings (this includes Notice to Appear (DHS Form I-862) or Order of Supervision (DHS I-220B) if there is also evidence of parole into the U.S.)	DOS is the date status was obtained	Yes	Yes	Yes
Active Military: a qualified non-citizen who is on active duty, other than active duty for training, in the United States Armed Forces, or their spouse, surviving spouse, or unremarried surviving spouse, or unmarried dependent child if such spouse or dependent child is also a qualified non-citizen	M	Proof of qualified non-citizen status and Military Identification Card (Active) that lists an expiration date of more than one year from the date of determination. If ID card is due to expire within one year from the date of determination, use a copy of current military orders.	DOS is the date status was obtained	Yes	Yes	Yes

[8]Exception: This guideline does not apply when the non-citizen was paroled solely to testify as a witness in a judicial, administrative or legislative proceeding or when the parolee is in legal custody pending criminal prosecution.

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Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
Veteran: a veteran who is a qualified non-citizen and who has received a discharge from the United States Armed Forces characterized as honorable and not on account of alienage and who fulfilled the minimum active duty requirement (two years); or their spouse, unremarried surviving spouse, or unmarried dependent child if such spouse or dependent child is also a qualified non-citizen	V	Proof of qualified non-citizen status and DD Form 214 Discharge Certificate that states "Honorable." A character of discharge "Under Honorable Conditions" is not an "Honorable Discharge" for these purposes. Narrative Reason for Separation block must not state that discharge was for reason of "alienage" or lack of U.S. citizenship.	DOS is the date status was obtained	Yes	Yes	Yes
North American Indian born in Canada	C	I-551 Permanent Resident Card coded: S13 or temporary I-551 stamp in a Canadian passport; or I-94 Arrival/Departure Record stamped: S13; or Tribal document certifying at least 50% American Indian blood, as required by Section 289 of the INA and School records, or, a birth or baptismal certificate issued on a reservation, or, other satisfactory evidence of birth in Canada	N/A	Yes	Yes	Yes
Member of federally recognized tribe born outside U.S.	C	Membership card or other tribal document demonstrating membership in a federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act	N/A	Yes	Yes	Yes
Permanent nonimmigrant, pursuant to P.L. 99-239, as amended (applicable to citizens of the Federated States of Micronesia and Marshall Islands) or P.L. 99-658 (applicable to citizens of Palau)	O	I-766 Employment Authorization Card coded: A08; or I-94 Arrival/Departure Record stamped: CFA/MIS "DS" (Duration of Status), D/S; or, CFA/PAL "DS" (Duration of Status), D/S	DOS is left blank	Yes	No	No
Continuous entry and residence in the U.S. prior to January 1, 1972	O	I-766 Employment Authorization Card coded: C16; or Any other document from the EOIR or USCIS indicating Registry Application is pending; or Any documentary proof establishing entry and continuous residence	DOS is left blank	Yes	No	No

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Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
Subject to an Order of Supervision	O	I-766 Employment Authorization Card coded: C18; or I-220B Order of Supervision; or Any other authoritative document indicating an Order of Supervision Note: Cuban or Haitian nationals under an Order of Supervision are deemed to retain their Cuban-Haitian Entrant status for benefit eligibility purposes if they can document they are a national of Cuba or Haiti with a previous or current parole status into the U.S.[9]	DOS is left blank	Yes	No	No
Cancellation of Removal	O	Order from the EOIR granting cancellation of removal; or Any other document from the EOIR indicating cancellation of removal granted	DOS is left blank	Yes	No	No
Deferred Action Status	O	I-766 Employment Authorization Card coded: C14 or C33; or I-797 Notice of Action indicating approved "Deferred Action for Childhood Arrivals" (DACA) application; or Any document from the USCIS granting deferred action to a "U" visa applicant; or Any other document from the EOIR or USCIS indicating deferred action including any documentation that a DACA application has been approved	DOS is left blank	Yes	No	No
"U" Visa	O	I-766 Employment Authorization Card coded: A19 or A20; or I-94 Arrival/Departure Record stamped: U1, U2, U3, U4, or U5; or I-797 Notice of Action indicating that a petition for "U" nonimmigrant status was approved; or Any other document from the USCIS indicating "U" nonimmigrant status	DOS is left blank	Yes	No	No
"S" Visa	O	I-766 Employment Authorization Card coded: C21; or I-94 Arrival/Departure Record stamped: S5, S6, or S7; or Any other document from the USCIS indicating "S" visa status	DOS is left blank	Yes	No	No
"K3" or "K4" or "V" Visa Granted Under the Legal Immigration Family Equity Act (LIFE Act)	O	I-766 Employment Authorization Card coded: A9, A09, A14, or A15; or I-94 Arrival/Departure Record stamped: K3, K4, V1, V2, or V3; or Unexpired "K3," "K4," or "V" visa in passport Note: If an expired "K" or "V" visa is submitted, then proof that an I-539 (Application to Extend/Change Nonimmigrant Status) was filed with USCIS, and, proof that a Form I-130, I-485, or an immigrant visa application is still pending, must also be submitted.	DOS is left blank	Yes	No	No

[9]Refer to GIS 16 TA/DC048 "Eligibility to Participate in SNAP by Certain Cuban Nationals Under an Order of Supervision," for additional information regarding SNAP eligibility for these non-citizens.

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Description of Status	WMS ACI Code	Common Documentation	WMS DOS and DEC Codes	Safety Net Assistance (SNA)	Family Assistance (FA)	Supplemental Nutrition Assistance Program (SNAP)
Temporary Protected Status (TPS)	O	I-766 Employment Authorization Card coded: A12; or I-797 Notice of Action indicating TPS granted	DOS is left blank	Yes	No	No
Asylum Applicant with Employment Authorization	O	I-766 Employment Authorization Card coded: C8 or C08; or I-797 Notice of Action indicating Asylum application received or pending, and that the non-citizen is authorized to work in the U.S.; or Any other document from the USCIS indicating an asylum application is pending and that the non-citizen is authorized to work in the U.S. Note: Cuban or Haitian nationals who have an application for asylum pending with the USCIS and are not subject to a final, non-appealable, and legally enforceable removal order have Cuban-Haitian Entrant status for benefit eligibility purposes. See Cuban/Haitian Entrant section on page 5.	DOS is left blank	Yes	No	No
Deferred Enforced Departure	O	I-766 Employment Authorization Card coded: A11	DOS is left blank	Yes	No	No
Non-citizen, not otherwise included on this desk aid, who the USCIS has officially determined is legitimately present in the U.S. and who the USCIS is allowing to reside in the country for an indefinite period of time	O	Districts must contact the Office of Temporary and Disability Assistance (OTDA) Temporary Assistance (TA) Bureau for additional guidance if the district believes they have a non-citizen that fits this description.	DOS is left blank	Yes	No	No
Other status not eligible for TA or SNAP	E	Non-citizen that is unable to provide sufficient documentation to support their inclusion in any of the above statuses.	N/A	No[10]		

For any questions related to TA benefit eligibility for non-citizens, please contact the OTDA TA Bureau at: otda.sm.cees.tabureau@otda.ny.gov or: (518) 474-9344.

For any questions related to SNAP benefit eligibility for non-citizens, please contact the OTDA SNAP Bureau at: otda.sm.cees.snap@otda.ny.gov or: (518) 473-1469.

[10]If it is determined that a non-citizen is ineligible for TA and/or SNAP because of his/her non-citizen status, the non-citizen must be denied using the appropriate denial code (F92 - Failure to Provide Proof of Citizenship or Eligible Alien Status (TA) or F92 – Ineligible Alien (SNAP)) and ACI code "E." Use of the appropriate denial and ACI codes is necessary so that a Medicaid Separate Determination (MSD) is conducted.

CIN NUMBER/APP REG LINE #	CASE NUMBER	OFFICE/UNIT #	WORKER NAME/#
CLIENT NAME	**CLIENT REFERRED TO DVL?** ☐ **YES** ☐ **NO**		
	CRED DETERMINATION ONLY? ☐ **YES** ☐ **NO**		

DOMESTIC VIOLENCE SCREENING FORM

Under the Family Violence Option

***Completing this form is voluntary*:** You do not have to fill out this form to receive public assistance. It will not impact your eligibility for assistance[1], the amount of assistance you receive or the length of time it takes to process your application.

If you are a victim of domestic violence and you think that meeting certain program requirement(s) will put you or your children at risk or make it harder for you to escape an abusive situation, you may ask for a temporary delay (waiver) of that requirement by filling out this form and meeting with a Domestic Violence Liaison (DVL). You may decide not to fill out this form right now but you are free to do so at any time. You may ask to see the DVL at any time.

Anything you disclose to the DVL, including your relationship with the person who has abused you, will be kept confidential, with the exception of child abuse and neglect.

You may complete this form and request to see a DVL regardless of your gender, sexual orientation or marital status. You do not have to have children or have left the abusive situation to meet with the DVL. You are not required to provide any information or details about the abusive situation to any worker before you are referred to the DVL.

Are you in danger of a family member, your partner or ex partner doing any of the following:

- Hitting, slapping, kicking, choking or in any way hurting you physically?
- Isolating you; making you feel like a prisoner, controlling what you can do?
- Threatening to harm you, your children, or someone close to you?
- Stalking you, following you or checking up on you?
- Shaming or belittling you, constantly putting you down and telling you that you are worthless?
- Forcing you to have sex when you don't want to or into sexual acts that you do not want to participate in?
- Making you feel afraid?

☐ **Yes:** I would like to meet with a DVL to discuss my situation.
☐ **Yes:** But I do not want to meet with a DVL at this time.
☐ **No:** None of the situations described above apply to me or I do not wish to answer these questions at this time.

In signing this form I affirm that the information I have given or will give to the Department of Social Services is correct.

Signature: _____ **Date:**_____
*This form must not remain in the client's TA case Record. It must be forwarded to the DVL for confidential filing if any part of it has been completed.

[1] If you are an immigrant victim of domestic violence who has not yet obtained legal permanent residency you may be required to meet with a DVL as part of determining your eligibility for assistance.

(Spanish On Reverse / español en el reverso)

LDSS-4583 SP (Rev. 9/07) (REVERSO) **NYSOTDA**

CIN NUMBER/APP REG LINE #	CASE NUMBER	OFFICE/UNIT #	WORKER NAME/#

CLIENT NAME			
	CLIENT REFERRED TO DVL?	☐ **YES**	☐ **NO**
	CRED DETERMINATION ONLY?	☐ **YES**	☐ **NO**

FORMULARIO PARA DETECTAR A VÍCTIMAS DE VIOLENCIA DOMÉSTICA

Bajo el Programa de Opciones en Violencia Familiar *(Family Violence Option - FVO)*

Responder a estas preguntas es voluntario: usted no tiene que rellenar este formulario para recibir asistencia pública. Su decisión de rellenar o no este formulario no afectará su habilitación para recibir asistencia[1], el monto a recibir, ni tampoco el tiempo que tardará en procesar su solicitud.

Si es víctima de violencia doméstica y cree que cumplir con cierto(s) requisito(s) del programa le pone a usted o sus hijos en riesgo, o le hará(n) más difícil evitar la situación de abuso, usted puede solicitar una demora temporal (dispensa) del requisito o de los requisitos; si desea hacerlo, rellene este formulario y comuníquese con el Enlace del Centro de Violencia Doméstica (*Domestic Violence Liaison – DVL*) para hacer una cita con uno de los representantes. Usted puede decidir no rellenar este formulario en esta ocasión, pero está en libertad de hacerlo después. Se le puede solicitar en cualquier momento que se reúna con un representante del Centro de Violencia Doméstica.

La información que usted revele, incluyendo su relación con la persona que le ha abusado, permanecerá confidencialmente, exceptuando asuntos relacionados con abuso y abandono infantil.

Rellene este formulario y solicite presentar su caso a un representante del Enlace del Centro de Violencia Doméstica (*DVL*); no importa cual sea su sexo, orientación sexual o estado civil. Usted no tiene que tener niños o haber dejado la situación de abuso para que se le conceda una cita con un representante del *DVL.* Antes de que usted sea referido al *DVL*, no es necesario que suministre, a ningún trabajador, información o detalles relacionados con la situación de abuso.

¿Está usted en peligro de que un miembro de la familia, su compañero(a) o ex compañero(a) haga lo siguiente?

- ¿Le pegue, abofetee, patee, trate de estrangularle o le cause daño físico de alguna manera?
- ¿Le mantenga aislado(a), le haga sentirse como prisionero(a), le controle todo lo que hace?
- ¿Le amenace con hacerle daño a usted, a los niños o a un ser querido?
- ¿Le aceche, le persiga o le vigile?
- ¿Le abochorne o denigre, le humille constantemente y le diga que no vale nada?
- ¿Le fuerce a tener relaciones sexuales aunque usted no quiera o le fuerce a participar en actos sexuales que usted no quiera?
- ¿Le atemorice?

☐ **Sí: quiero** reunirme con un representante de DVL para exponerle mi situación.

☐ **Sí:** pero no quiero reunirme con un representante de DVL en esta oportunidad.

☐ **No:** nada de lo planteado arriba se aplica a mí, o no deseo responder esas preguntas en esta oportunidad.

Al firmar este formulario, yo afirmo que la información que he dado o daré al Departamento de Servicios Sociales es correcta.

Firma _____**Fecha:**_____

***Este formulario no puede guardarse en el archivo de Asistencia Temporal del cliente. Si el solicitante rellena alguna de las partes de este formulario, éste debe enviarse al Enlace del Centro de Violencia Doméstica *(Domestic Violence Liaison – DVL)* para archivamiento confidencial.**

[1] Si usted es un inmigrante victima de violencia doméstica que todavía no ha obtenido la residencia permanente, tiene que reunirse con un representante del *DVL* como parte de los requisitos necesarios para determinar si habilita para recibir asistencia.

(English On Front/ inglés en el anverso)

LDSS-4813

Desk Reference for Domestic Violence Screening under the Family Violence Option

Under the Family Violence Option, all applicants and recipients of Temporary Assistance must be screened for domestic violence using the Domestic Violence Screening Form (LDSS - 4583) at:

Application • Recertification • Any time client requests

Completing the domestic violence screening form is voluntary and answers are confidential.

Screening process:

The following provides a sample guide for workers to use when explaining the Family Violence Option to clients:

Guide for Staff Responsible for Domestic Violence Screening

As part of your interview, I need to discuss domestic violence and a program called the Family Violence Option. We discuss this with everyone who applies or recertifies for temporary assistance. As part of the application/recertification packet, you should have received a copy of the **Handout to All Applicants for Welfare**. Please read this handout which will give you information about domestic violence. A person may be a victim of domestic violence if their partner or ex-partner does any of the following:

- physically harms or threatens harm
- forces sex or sexual activities
- constantly insults or puts someone down
- follows, harasses or stalks someone and/or
- makes someone feel afraid

Also, please read the **Domestic Violence Screening Form**. You are not required to fill out this screening form. Answering the questions on this form is voluntary. It is NOT an eligibility requirement and will NOT affect your temporary assistance grant. Answers are confidential.

The purpose of the **Domestic Violence Screening Form** is to determine if you want a referral to meet with the Domestic Violence Liaison (DVL). Since you are applying for temporary assistance, you must meet certain requirements which will be explained to you during your eligibility interview.

The meeting with the specially trained DVL will help you figure out whether meeting any of the requirements would make it more difficult for you or your children to escape from domestic violence or subject you to further risk. You may be able to get a temporary delay (waiver) from the requirement(s) because of domestic violence. Some of the requirements are that you:

- look for work
- attend programs to help you get a job
- give information about the parent/step-parent of your children
- appear in court to get child support

If you only need to get information on domestic violence services, you may not need to see the DVL. You may contact the domestic violence service provider(s) directly. I can give you the domestic violence information for our county or you may meet with the DVL for more information.

Any information that you share with the DVL is voluntary and confidential. However, information about neglect or abuse of children will be reported to child protective services.

You may decide not to fill out this form right now, but you are free to do so at any time. You could first find out about the requirements and then, if you decide to meet with the DVL, you could fill out the screening form. You can ask to see the DVL at any time.

If you wish to meet with the DVL, check "Yes" on the form and sign your name.

Developed by the NYS Office of Temporary and Disability Assistance in conjunction with the NYS Office of Children & Family Services, the NYS Office for the Prevention of Domestic Violence and the Professional Development Program, Rockefeller College, University at Albany.

Notes to Worker:

- If a client only needs information on domestic violence (DV) services, you should provide the client with information/brochures on the DV services in your county, or refer to the DVL.
- This guide is for screening applicants who are applying for temporary assistance. When assistance is needed for emergency situations due to DV, such as needing a place to stay, follow your agency's policy on how to handle these situations.
- Take extra precautions conducting the screening when other people are present. Clients may be reluctant to talk in the presence of other people. Do whatever possible to screen people privately due to safety and confidentiality concerns.
- Be careful not to make assumptions about the client's sexual orientation. Use gender neutral language when the sex of the client's partner is unknown. For instance, use the term "your partner" rather than "he" or "she."

Completing the Domestic Violence Screening Form and Referrals

There are seven possible ways that a client can respond to the completion of the screening form:

1. Client checks "Yes," signs the form and wants to see the Domestic Violence Liaison (DVL).

- Must refer the client to the DVL as soon as possible using local procedures.
- Do not record any specific information regarding domestic violence in the case record.
- Follow local policy regarding forwarding all completed Domestic Violence Screening Forms to the DVL.
- Notify essential staff to discontinue all other assessments, especially if client is diverted to child support or employment prior to the temporary assistance eligibility interview.

2. Client checks "Yes," signs the form and does not want to see the Domestic Violence Liaison.

- Offer to refer to the DVL. If the client declines, continue with eligibility interview.
- Follow local policy to forward all completed Domestic Violence Screening Forms to the DVL.
- Write a note on the Domestic Violence Screening Form stating the client declined interview with the DVL.
- Remind client that the DVL is available at any time.

3. Client checks "Yes," but does not sign the form.

- Refer the client to the DVL as soon as possible using local procedures.
- Explain that this information will not be shared with the client's partner or former partner.
- Do not record any specific information regarding domestic violence in the case record.
- Follow local policy to forward all completed Domestic Violence Screening Forms to the DVL.
- Notify essential staff to discontinue all assessments, especially if client is diverted to child support or employment prior to the eligibility interview.

4. Client checks "No" on the screening form.

- Continue with eligibility interview. Forward screening form to DVL.
- Remind client that the DVL is available at any time.

5. Client declines to complete the form.

- Continue with eligibility interview.

6. Client checks no or is not willing to fill out the form but wants to see the DVL.

- Must refer to DVL as soon as possible using local procedures.
- Do not require client to fill out the screening form.

7. Client checks no or is not willing to fill out form but discloses domestic violence during interview.

- If client wants to see DVL, refer the client as soon as possible using local procedures.
- If client does not wish to see DVL, remind the client that the DVL is available at any time and that this is a voluntary and confidential program.

Please remember to forward all completed screening forms (checked either "Yes" or "No") to the Domestic Violence Liaison. No specific references to domestic violence screening or assessment should be made in the case record.

ORIA-195 (E)
CLEARANCE REQUEST FORM (ENGLISH)
Rev. 10/6/20

NYC Human Resources Administration Department of Social Services | Office of Refugee and Immigrant Affairs

OFFICE OF REFUGEE AND IMMIGRANT AFFAIRS (ORIA) CLEARANCE REQUEST FORM

ORIA@dss.nyc.gov, ORIA (212) 331-4550

1. This form should be used for noncitizen/alien clearances.
2. All documents (all pages, front & back) should be scanned and indexed.
3. Documents not listed, should be included under *OTHER* and a*dditional notes if* relevant.

Date:

Staff Information	Name of Staff (Last, First):	Center #:	Contact Tel #:

Client Information	Name of client including alias: First: _____ Last: _____ Alias if any: _____ Male ◯ Female ◯	WMS case#: _____ USCIS #: _____	Date of Birth: _____ Social Security number: _____

Document information	**Immigration document/Form title & number**	**Category Code**	**Required Additional information**
	Permanent Resident Card (Green Card) form I-551: Yes ◯ No ◯	e.g.: FX2, IR6, R8-6, CU-7, C09, CR6 _____	Expiration date (if any) _____
	Employment Authorization Card form I-766 or I-688B: Yes ◯ No ◯	e.g.: A09, (a)(9), C08, (c)(8), _____	Category code[e.g. A05, (a)(5)] _____ **OR** Provision of law (e.g. [“8 C.F.R. § 274a.12(a)(5)”] _____
	USCIS Notice of Action or Notice of receipt form I-797: Yes ◯ No ◯	Receipt number: Starts with: MSC, ESC, LIN + 10 digits ___ ___ ___ _____	
	SAVE Clearance (515WX) Requested: Yes ◯ No ◯ Scanned and Indexed: Yes ◯ No ◯ --- SSA 40 Quarters match Yes ◯ No ◯	Class of admission (COA) as well as any description of the client's immigration status indicated in SAVE: COA (e.g. IR6, IR0, CR6) _____ Date of Entry: _____ Date of status: _____	

Additional comments:

_____

_____

ORIA-195a (E)
CLEARANCE RESPONSE
FORM Rev. 10/06/20

Human Resources Administration
Department of Social Services
Office of Refugee and Immigrant Affairs

OFFICE OF REFUGEE AND IMMIGRANT AFFAIRS (ORIA) CLEARANCE RESPONSE FORM

ORIA@dss.nyc.gov or 212-331-4550

Date: _____

Client: Last, First	ACI Code:	WMS#: Social Security#: Date of entry: Date of status:

Benefits client is eligible for:

☐ SNAP ☐ Cash ☐ On-going Medicaid ☐ Emergency Medicaid

Notes:

_____

Next steps

- ☐ Scan and index clearance response form into HRA Viewer
- ☐ SAVE Request to SAVE Liaison (Form W-515X)
- ☐ Conduct SSA 40 Quarters match check
- ☐ Recall Client to provide immigration documents - scan and index all sides and pages of documents
- ☐ Supervisor submit Form W-200B to FIA Call Center to change ACI code
- ☐ Supervisor submit Inter-agency DOS and DEC transmittal Form (MAP-648M) TO SDOH
- ☐ Request SAVE Result from SAVE Liaison
- ☐ Refer Client to ActionNYC hotline 800-354-0365
- ☐ Other _____

Center Staff: Last, First	**Center #:**	**Contact Tel #:**
ORIA Staff:		

How To Call For An Interpreter

1. DIAL 1-855-938-0533

2. SAY THE LANGUAGE YOU NEED

If you don't know the language, speak to a Customer Service Representative by dialing "0."

3. ENTER YOUR ACCESS CODE: _____

- Call for an interpreter before you make an outgoing call.
- Write down the name and ID number of the interpreter.
- Interpretation services are available 24/7/365 in over 200 languages.
- If you need help, contact your Language Liaison or the Office of Refugee and Immigrant Affairs (ORIA) at 212-331-4550.

Department of Social Services
Human Resources Administration
Department of Homeless Services

PALM-21 (E)
06/18

Working With An Interpreter

- **Tell the interpreter what type of conversation you will have**
- **Do not have side conversations**
- **Speak directly to the client**
  (Ask "what's your name?" instead of "what's her name?")
- **Speak at normal speeds**
- **Do not use acronyms or technical terms**
- **Read any written material slowly**
- **Ask if the caller has any questions**

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

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

Participant Request Control Card

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

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

Group Total _____ **Job Center Total** _____

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

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

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

Remember:

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

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

SECTION I: EMERGENCY ASSISTANCE

The type of emergency assistance I am requesting is:

The reason I need emergency assistance is:

(Turn page)

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

SECTION II: ADDITIONAL ALLOWANCES

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

- ☐ Back rent
- ☐ Repair of essential household items
- ☐ Back mortgage and/or taxes
- ☐ Pregnancy allowance
- ☐ Restaurant allowance because I cannot prepare meals where I am living
- ☐ Burial allowance – you or your duly authorized representative must apply for this allowance at the:
  Office of Burial Services
  33-28 Northern Boulevard, 3rd Floor
  Long Island City, NY 11101
  Telephone: 718-473-8310
- ☐ Additional allowance for fuel
- ☐ Property repairs
- ☐ Replacement of clothing lost as a result of a disaster such as homelessness or fire
- ☐ Other:

☐ **Expenses related to moving:**

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

New Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

When did you move? _____ New rent: $ _____

Landlord's name: _____

Primary tenant's name: _____

Address: _____
(include apartment number)

_____ _____ _____
City State Zip Code

(Turn page)

SECTION III: WORK ACTIVITY-RELATED SUPPORTIVE SERVICES

I am requesting the following supportive services:

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

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

SECTION IV: ADD PERSON TO CASE

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

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

Name: _____
Date moved in/returned: _____
Date of Birth: _____
Social Security Number (if known): _____

Name: _____
Date moved in/returned: _____
Date of Birth: _____
Social Security Number (if known): _____

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

_____ _____
Worker's Name Date

Fecha: _____

Nombre del caso: _____

Número de caso: _____

Unidad de casos: _____

Centro: _____

Teléfono del Trabajador(a): _____

Teléfono de FH&C .: _____

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

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

Recuerde:

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

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

SECCIÓN I: ASISTENCIA DE EMERGENCIA

Solicito el siguiente tipo de asistencia de emergencia:

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

(Gire la hoja)

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

SECCIÓN II: ASIGNACIONES ADICIONALES

Solicito la(s) siguiente(s) asignación(es) por necesidad especial:

- ☐ Alquiler atrasado
- ☐ Reparación de artículos del hogar de primera necesidad
- ☐ Hipoteca y/o impuestos atrasados
- ☐ Asignación para embarazo
- ☐ Asignación para restaurante porque no puedo preparar comidas donde vivo
- ☐ Asignación para entierros – usted o su representante debidamente autorizado debe solicitar esta asignación en esta dirección:
  Office of Burial Services
  33-28 Northern Boulevard, 3rd Floor
  Long Island City, NY 11101
  Teléfono: 718-473-8310
- ☐ Asignación adicional para combustible
- ☐ Reparaciones a la propiedad
- ☐ Reemplazo de ropa perdida debido a desastres, tal como falta de albergue o incendio
- ☐ Otras asignaciones:

- ☐ **Gastos relacionados con la mudanza:**
  - ☐ Gastos de mudanza
  - ☐ Depósito/acuerdo de garantía
  - ☐ Comisión del agente inmobiliario o del intermediario/vale de pago (*voucher*)
  - ☐ Muebles y otros artículos del hogar
  - ☐ Almacenamiento de muebles y artículos personales

Nueva dirección: _____
(incluya el número de apartamento)

_____ _____ _____
Ciudad Estado Código Postal

¿Cuándo se mudó? _____ Nuevo alquiler: $_____

Nombre del arrendador: _____

Nombre del inquilino principal: _____

Dirección: _____
(incluya el número de apartamento)

_____ _____ _____
Ciudad Estado Código Postal

(Gire la hoja)

SECCIÓN III: SERVICIOS DE APOYO RELACIONADOS CON ACTIVIDADES DE TRABAJO

Solicito los siguientes servicios de apoyo para:

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

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

SECCIÓN IV: AÑADIR UNA PERSONA AL CASO

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

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

- ☐ **un recién nacido**
- ☐ **un menor que se ha integrado al hogar**
- ☐ **un niño menor de 18 años** (cuyo estado migratorio ha cambiado desde mi última solicitud/recertificación)
- ☐ **un cónyuge/adulto que vive conmigo** quien no haya presentado solicitud anteriormente (para poder recibir asistencia dicha persona debe completar una solicitud)
- ☐ **un cónyuge** quien anteriormente haya presentado solicitud y haya sido rechazado por su estado migratorio, pero dicho estado ya ha cambiado.
- ☐ **a mí mismo/adulto beneficiario del caso**
- ☐ **Otra persona** _____
- ☐ **Otra persona** _____

Nombre: _____
Fecha de mudanza/regreso: _____
Fecha de nacimiento: _____
Número de Seguro Social (de saberlo): _____

Nombre: _____
Fecha de mudanza/regreso: _____
Fecha de nacimiento: _____
Número de Seguro Social (de saberlo): _____

Picture

_____ Firma del participante

_____ Fecha de la petición

_____ Hora de la petición ☐ AM ☐ PM

_____ Worker's Name [Nombre del trabajador(a)]

_____ Date [Fecha]

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

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

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

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

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

_____

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

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

How we will pay:

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

☐ You must pick up check at your Job Center

☐ Check mailed to your home

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

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

☐ Check sent directly to landlord/vendor

☐ Other action:

_____

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

(Turn page)

☐ On _____, you were referred to the Office of Burial Services at 33-28 Northern Boulevard, 3rd Floor, Long Island City, NY 11101, (718) 473-8310, to apply for a burial allowance.

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

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

☐ Addition to Household § 352.30

☐ Additional Allowance for Fuel § 352.5

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

☐ Back Rent § 352.7 (g)

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

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

☐ Furniture and Other Household Items § 352.7(a)

☐ Moving Expenses § 352.6(a)

☐ Repair of Essential Household Items § 352.7(b)

☐ Pregnancy Allowance § 352.7(k)

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

☐ Rent Security Deposit/ Agreement § 352.6(a)

☐ Work Activity Related Supportive Services § 385.4

☐ Restaurant Allowance § 352.7(c)

☐ Semimonthly Fuel for Heating Allowance § 352.5(b)

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

☐ Other (specify):

_____

_____ _____
JOS/Worker's Name Date

_____ _____
Supervisor's Name Date

(Turn page)

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

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

(Turn page)

Conference and Fair Hearing Information

CONFERENCE

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

STATE FAIR HEARING

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

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

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

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

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

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

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

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

(5) ONLINE: Complete an online request form at:
http://www.otda.state.ny.us/oah/forms.asp

(Turn page)

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

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

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

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

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

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

(Turn page)

FAIR HEARING REQUEST

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

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

Address: _____

_____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Fecha: _____
Número de caso: _____
Nombre del caso: _____
Centro: _____
Unidad de casos: _____
Teléfono del trabajador: _____
Teléfono para programar conferencias FH&C: _____

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

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

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

El día _____ (Fecha), usted pidió:

☐ Asistencia de emergencia
☐ Asignación adicional para:

☐ Su petición para _____ **ha sido aceptada. Usted recibirá:**
- ☐ Un pago de $ _____ .
  Plazo de tiempo cubierto, si corresponde: _____ .

Cómo se hará el pago:

- ☐ Por vale/comisión, a nombre del agente inmobiliario o del intermediario
- ☐ Por cheque, a ser recogido en su centro de trabajo
- ☐ Por cheque, enviado a su vivienda
- ☐ Por medio del sistema de la tarjeta EBT, añadido a su Asistencia en Efectivo normal
- ☐ Por medio del depósito de seguridad/contrato/ vale de pago/ entregado al arrendador
- ☐ Por cheque, enviado directamente al arrendador/ representante
- ☐ Otra medida: _____
- ☐ Usted recibirá un segundo aviso informándole cómo se verán afectados sus beneficios continuos.

(Gire la hoja)

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

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

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

☐ Adición al hogar § 352.30	☐ Asignación adicional para combustible § 352.5	☐ Hipoteca y/o impuestos atrasados § 352.7 (g)	☐ Alquiler atrasado § 352.7 (g)
☐ Comisión del agente inmobiliario o del intermediario/vale de pago § 352.6(a)	☐ Pérdida por catastrófe (reemplazo de ropa y muebles destruidos por fuego, inundación u otro tipo de desastre) § 352.7(d)	☐ Muebles y otros artículos del hogar § 352.7(a)	☐ Gastos de mudanza § 352.6(a)
☐ Reparación de artículos esenciales para el hogar § 352.7(b)	☐ Asignación para el embarazo § 352.7(k)	☐ Reparaciones a la propiedad § 352.4 (d), § 352.6(e)	☐ Depósito de seguridad/ contrato de alquiler § 352.6(a)
☐ Actividad de trabajo relacionada a los Servicios de Apoyo § 385.4	☐ Asignación para restaurantes § 352.7(c)	☐ Asignación quincenal de combustible para calefacción § 352.5(b)	☐ Almacenamiento de muebles y artículos personales § 352.6(f)

☐ Otro (especifique):

_____

_____ _____
Nombre del trabajador(a)/JOS Fecha

_____ _____
Nombre del supervisor(a) Fecha

(Gire la hoja)

¿Tiene usted alguna condición médica, de salud mental o alguna discapacidad? ¿Se le dificulta entender o hacer lo que pide este aviso, debido a su condición? ¿Se le dificulta obtener otros servicios de la HRA debido a su condición? **Nosotros podemos ayudarle**. Llámenos al 212-331-4640. También puede pedir ayuda cuando visite las oficinas de la HRA. La ley le da derecho a pedir este tipo de ayuda.

USTED TIENE EL DERECHO DE APELAR ESTA DECISIÓN. ASEGÚRESE DE LEER LA SECCIÓN ADJUNTA A ESTE AVISO SOBRE CONFERENCIAS Y DERECHOS DE APELACIÓN ADMINISTRATIVA PARA SABER CÓMO APELAR ESTA DECISIÓN.

(Gire la hoja)

Información sobre Conferencias y Audiencias Imparciales

CONFERENCIA

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

AUDIENCIA IMPARCIAL ESTATAL

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

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

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

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

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

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

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

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

(Gire la hoja)

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

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

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

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene el derecho de revisar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un fax, le proporcionaremos copias gratuitas de los documentos de su archivo, los mismos que se entregarán al Funcionario de Audiencias durante la Audiencia Imparcial. Además, si usted nos llama, nos escribe o nos manda su petición por fax, le enviaremos copias gratuitas de documentos específicos contenidos en su archivo y que usted considere necesarios para prepararse para la Audiencia Imparcial. Para solicitar documentos o para averiguar cómo revisar su archivo, llámenos al **(718) 722-5012**, por fax al **(718) 722-5018** o escriba a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201**. Si desea copias de documentos contenidos en su archivo, debe solicitarlas con anticipación. Éstas se le proveerán dentro de un plazo adecuado antes de la fecha de la audiencia. Se le enviarán por correo los documentos sólo si así los solicita específicamente.

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

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

(Gire la hoja)

PETICIÓN DE AUDIENCIA IMPARCIAL

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

Nombre en letra de molde: _____ _____ _____ Número de caso: _____
Nombre | Inicial 2do nombre | Apellido

Dirección: _____

_____ Teléfono: _____

Ciudad: _____ Estado: _____ Código postal: _____

Firma: _____ Fecha: _____

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

Permanently Residing Under Color Of Law (PRUCOL) Eligibility Desk Aid
Individuals with PRUCOL status are not eligible for SNAP Benefits or Family Assistance

Description of Status	WMS/ ACI Code	Common Documentation	Safety Net Assistance	Medicaid
Subject to an Order of Supervision. **Note:** If applicant/participant is Cuban or Haitian, a clearance request must be sent to ORIA.	**O**	**Form I-220B** (Order of Supervision); **or** **Form I-766** (Employment Authorization Document) coded **C18**; **or** Any other authoritative document indicating an Order of Supervision.	**Yes**	**Yes**
Granted Cancellation of Removal.	**O**	Order from the Executive Office of Immigration Review (EOIR) granting cancellation of removal; **or** Any other authoritative document from the USCIS indicating cancellation of removal granted.	**Yes**	**Yes**
Granted Deferred Action for Childhood Arrivals (DACA).	**O**	**I-797** (Notice of Action) Indicating approved Deferred Action for Childhood Arrivals application; **or** **Form I-766** (Employment Authorization Document) coded **C33**; **or** Any other documentation from EOIR or USCIS indicating that a DACA application has been approved.	**Yes**	**Yes**
Granted Deferred Action status.	**O**	**Form I-766** (Employment Authorization Document) coded **C14**; **or** Any letter from USCIS granting deferred status to a "U" visa applicant; **or** Any other authoritative document from the USCIS indicating deferred action.	**Yes**	**Yes**
Granted a "U" visa.	**O**	**Form I-797** (Notice of Action) indicating that a petition for U nonimmigrant status was approved; **or** **Form I-94** (Arrival/Departure Record) stamped "**U1**", or "**U2**", or "**U3**", or "**U4**", or "**U5**"; **or** **Form I-766** (Employment Authorization Document) coded **A19** or **A20** (for qualified dependent family members); **or** Any other USCIS authoritative document that verifies "**U**" Nonimmigrant status.	**Yes**	**Yes**
Granted an "S" visa.	**O**	**Form I-94** (Arrival/Departure Record) stamped "**S5**", or "**S6**", or "**S7**"; **or** **Form I-766** (Employment Authorization Document) coded **C21**; **or** Any other USCIS authoritative document that verifies "**S**" Visa status.	**Yes**	**Yes**

Permanently Residing Under Color Of Law (PRUCOL) Eligibility Desk Aid
Individuals with PRUCOL status are not eligible for SNAP Benefits or Family Assistance

Description of Status	WMS/ ACI Code	Common Documentation	Safety Net Assistance	Medicaid
Granted a "K3", or "K4" or "V" visa.	**O**	Unexpired "**K3**", or "**K4**", or "**V**" visa in passport; **Note**: If an expired "**K**" or "**V**" visa is submitted, then proof that an I-539 (Application to Extend/Change Nonimmigrant Status) was filed with USCIS must be submitted; **or** **Form I-94** (Arrival/Departure Record) stamped "**K3**", or "**K4**", or "**V1**", or "**V2**", or "**V3**"; **or** **Form I-766** (Employment Authorization Document) coded **A9**, or **A09**, or **A14**, or **A15**; **and** Any authoritative USCIS document indicating an I-130 petition is pending or approved.	**Yes**	**Yes**
Continuous entry and residence in the U.S. prior to January 1, 1972.	**O**	**Form I-797** (Notice of Action) indicating Adjustment of Status to Permanent Resident pursuant to INA § 249; **or** **Form I-766** (Employment Authorization Document) coded **C16**; **or** Any letter/notice from the USCIS or EOIR indicating Registry Application is pending; **or** Any documentary proof establishing entry and continuous residence.	**Yes**	**Yes**
Permanent nonimmigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and Marshall Islands).	**O**	**Form I-94** (Arrival/Departure Record) stamped CFA/MIS "**DS**" (Duration of Status), **D/S**; **or** **Form I-766** (Employment Authorization Document) coded **A8**.	**Yes**	**Yes**
Granted Temporary Protected Status (TPS).	**O**	**Form I-797** (Notice of Action) indicating TPS status granted; **or** **Form I-766** (Employment Authorization Document) coded **A12**.	**Yes**	**Yes**
Applicants for Asylum with work authorization. **Note:** If applicant/participant is Cuban or Haitian, a clearance request must be sent to ORIA.	**O**	**Form I-766** (Employment Authorization Document) with Category Code **C8** or **C08**; **or** **Form I-797** (Notice of Action) indicating an **I-765** application received or pending for a Category Code **C8** or **C08**; **or** **Form I-797** (Notice of Action) indicating an **I-589** application for asylum received or pending, filed 180 days prior to the date the applicant is presenting to the center; **or** Any other authoritative the USCIS document indicating an asylum application is pending and that they are authorized to work in the US.	**Yes**	**Yes**

Permanently Residing Under Color Of Law (PRUCOL) Eligibility Desk Aid
Individuals with PRUCOL status are not eligible for SNAP Benefits or Family Assistance

Description of Status	WMS/ ACI Code	Common Documentation	Safety Net Assistance	Medicaid
Living in the U.S. with knowledge and permission or acquiescence of the USCIS and whose departure the Agency does not contemplate enforcing for an indefinite period of time.	**TBD**	If documentation is submitted and the status of the non-citizen does not fit in any of the other categories listed in this guide, the Worker must contact the Office of Refugee and Immigrant Affairs (ORIA), at **(212) 331-4550** or oria@hra.nyc.gov, who will determine if the non-citizen meets PRUCOL status.	**TBD**	**TBD**
Granted Special Immigrant Juvenile Status.	**E***	**Form I-797** (Notice of Action) indicating approval of Special Immigrant Juvenile Status; **or** Any other authoritative USCIS document indicating that Special Immigrant Juvenile Status was granted.	**No**	**Yes**
Applicants for Asylum without work authorization.	**E***	**Form I-797** (Notice of Action) indicating Asylum application received or pending; **or** Any other authoritative USCIS document indicating an Asylum application.	**No**	**Yes**
Applicants for Temporary Protected Status (TPS).	**E***	**Form I-797** (Notice of Action) indicating a pending application for Temporary Protected Status; **or** **Form I-766** (Employment Authorization Document) coded **C19**.	**No**	**Yes**
Applicants for Deferred Action for Childhood Arrivals (DACA).	**E***	**Form I-797** (Notice of Action) indicating a pending application for Deferred Action for Childhood Arrivals (DACA); **or** Any other authoritative USCIS document indicating an application for Deferred Action for Childhood Arrivals (DACA).	**No**	**Yes**
Applicants for Special Immigrant Juvenile Status.	**E***	**Form I-797** (Notice of Action) indicating a pending application for Special Immigrant Juvenile Status; **or** Any other authoritative USCIS document indicating an application for Special Immigrant Juvenile Status.	**No**	**Yes**
Applicants for Adjustment of Status. **Note:** Ask applicants/participants on what basis they are seeking adjustment of status. Check the prior status on both the Alien Desk Aid and this Desk Aid.	**E***	**Form I-766** (Employment Authorization Document) coded **C9**, or **C09**, or **C09P**; **or** **Form I-797** (Notice of Action) indicating an application for Adjustment of Status.	**No**	**Yes**
Applicants for Cancellation of Removal.	**E***	**Form I-766** (Employment Authorization Document) coded **C10**; **or** Any other authoritative USCIS document indicating an application for Cancellation of Removal.	**No**	**Yes**

***** If ACI code is “E” a Medicaid separate determination must be done.

Permanently Residing Under Color Of Law (PRUCOL) Eligibility Desk Aid
Individuals with PRUCOL status are not eligible for SNAP Benefits or Family Assistance

Quick Tips:

This is a guide. Staff may see documents that are not on this guide. If you have a document that is not on this guide, check the Alien Eligibility Desk Aid and the POS Alien Checklist Module. If you still cannot find the document, call ORIA for a clearance.

All staff:

- Ask applicants/participants to provide all documentation they have and consider all of the documents you receive.
- Scan and index all immigration documents. Scan all sides and all pages of passports including blank pages, front and back of cards, legibly and in color in the HRA OneViewer (**PB 07-82-OPE**).
- Consult the Alien Eligibility Desk Aid (**LDSS-4579**) first. If you do not find the documentation the client presented, then look to the PRUCOL Desk Aid. If you do not find the documentation on both desk aids, contact ORIA at **oria@hra.nyc.gov** or **(212) 331-4550**.
- Request a SAVE search for any noncitizen members of the household who do not present themselves as undocumented. For any documentation that shows a pending application, check with USCIS.GOV for current case updates (**PD-17-11-ELI**)
- Individuals may still be eligible for public benefits if they do not have a Social Security number (**PB-16-20-OPE** and **PD-16-20-ELI**).
- If you are unsure about an individual's eligibility for benefits, contact ORIA. For a clearance, email the **ORIA-195** (ORIA Clearance Request) to **oria@hra.nyc.gov** after you have scanned and indexed all immigration documents and filled out and scanned the SAVE referral form (**W-515X**).
- **If applicant/participant is Cuban/Haitian, a clearance request must be sent to ORIA along with all the documents that have been scanned and indexed.**

Form W-515X
Rev. 10/11/13

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

Systematic Alien Verification for Entitlements (SAVE) Referral

Forward original to: **SAVE Liaison**

Name: _____

Location: _____

Telephone Number: _____

☐ Application ☐ Recertification ☐ Other Contact

One Clearance per Referral

We are requesting a SAVE clearance on the following individual:

Case Name	Alien Number
Case Number	Card Number*
SAVE clearance for: (Individual's Name) (as it appears on alien registration card)	Date of Entry/Date Status Granted
	Date of Birth Month/Day/Year

*Only required if Permanent Resident Card (Form **I-551**) issued from 1997 or later, or if Employment Authorization Document (Form **I-766**) is presented.

Enclose a copy of alien registration card, immigration stamp on passport or other pertinent immigration documentation useful to facilitate this request.

SAVE request is required to verify the following item(s). Please check (☑) type of request.

- ☐ Verification of Alien Registration Number
- ☐ Date of entry/Date status was granted
- ☐ Admitting immigration status (Refugee, Asylee, etc.)
- ☐ Verification of current immigration status
- ☐ Citizenship verification
- ☐ Country of birth
- ☐ Other: _____

_____ _____
Worker's Signature Date

_____ _____
Supervisor's Signature Telephone Number