

George E. Pataki Governor

NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE 40 NORTH PEARL STREET ALBANY, NY 12243-0001

Robert Doar Commissioner

Informational Letter

Section 1

Section 1							
Transmittal:	05-INF-15						
To:	Local District Commissioners						
Issuing Division/Office:	Division of Employment and Transitional Supports						
Date:	August 9, 2005						
Subject:	Revisions to Mandatory Client Notices						
Suggested	Temporary Assistance Staff						
Distribution:	Food Stamp Benefits Staff						
	Medicaid Directors						
	CAP Coordinators						
	Employment Coordinators						
	WMS Coordinators						
	Staff Development Coordinators						
Contact	Forms Questions: Bob Gullie 1-800-343-8859 Extension 6-1095						
Person(s):	Program Questions:						
	Food Stamp Bureau - (518) 473-1469						
	Temporary Assistance Bureau - (518) 474-9344						
	HEAP - (518) 473-0332						
	Metro Region - (212) 961-8207						
	Medicaid Local District Liason - Upstate (518) 474-8216 or NYC (212) 417-4500						
	WMS Questions: (518) 474-8749						
Attachments:	LDSS-3152; LDSS-3152 NYC; LDSS-4013A; LDSS-4013B; LDSS-4013A NYC;						
	LDSS-4013B NYC; LDSS-4014A; LDSS-4014B; LDSS-4014A NYC and LDSS-						
	4014B NYC						
Attachment Avai Line:	lable On –						

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
See Attachment I	See Attachment I	See Attachment I	See Attachment I	See Attachment I	See Attachment I

Section 2

I. Purpose

The purpose of this release is to introduce 10 revised client notices.

The primary reason for the revisions was as a result of a request from the State Education Department to include Food Stamp Benefits information about the "National School Lunch/Breakfast Programs" on the State printed "Action Taken Notices".

The following are the notices that now include that information.

LDSS-3152: "Action Taken on Your Food Stamp Benefits Case" (Rev.5/05)

LDSS-3152 NYC: "Action Taken on Your Food Stamp Benefits Case" (Rev.5/05) (NYC)

LDSS-4013A: "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev. 5/05)

LDSS-4013B: "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev.5/05)

LDSS-4013A NYC: "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev.5/05) (NYC)

LDSS-4013B NYC: "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev.5/05) (NYC)

LDSS-4014A: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-A" (Rev.5/05)

LDSS-4014B: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-B" (Rev.5/05)

LDSS-4014A NYC: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-A" (Rev.5/05) (NYC)

LDSS-4014B NYC: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-B" (Rev.5/05) (NYC)

II. Program Implications:

The following is a general listing of the revisions to the Client Notices:

LDSS-3152: "Action Taken on Your Food Stamp Benefits Case"

FRONT

- 1. The Revision Date was **changed** to 5/05.
- 2. The title of the form was **changed** to "Action Taken on Your Food Stamp Benefits Case".
- 3. The following checked box and information was **added** after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits.
- 4. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

5. The prechecked box regarding "Responsibility to Report Changes" was **moved** to the reverse side of the notice.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following "Free Lunch Program" information was **added** below the "case name" and "address" section at the top of the page.

The information reads as follows:

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

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

List Child(ren)'s nar	me(s):		

- 3. The prechecked box regarding "Responsibility to Report Changes" that was **removed** from the front of this notice was **added** directly after the "Free Lunch Program" information.
- 4. The "LIFELINE" service information was **removed** from the top of the notice.

LDSS-3152 NYC: "Action Taken on Your Food Stamp Benefits Case" (NYC)

COVER – The Revision date was **changed** to 5/05.

FRONT

- 1. The Revision Date was **changed** to 5/05.
- 2. The title of the form was **changed** to "Action Taken on Your Food Stamp Benefits Case" (NYC).
- 3. The following checked box and information was **added** after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.
- 4. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

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The information reads as follows:

<u>National School Lunch and/or Breakfast Programs</u> - The child(ren) listed below are approved to receive free lunch and/or breakfast if he or she attends a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a copy of this notice to the school that your child attends.

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- 3. The prechecked box regarding "Responsibility to Report Changes" that was **removed** from the front of this notice was **added** directly after the "Free Lunch Program" information.
- 4. The "LIFELINE" service information was **removed** from the top of the notice.
- 5. The 2nd paragraph in the "Access to Your File and Copies of Documents" was **changed** to mirror the same paragraph that appears on the Upstate version of this notice.

That second paragraph now reads:

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.

<u>LDSS-4013A</u>: Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART A

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

1. The Revision Date was **changed** to 5/05.

2. The "LIFELINE" service information was **removed** from the top of the notice.

<u>LDSS-4013B</u>: Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART B

FRONT:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.
- 3. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.
- 4. The prechecked box regarding "Responsibility to Report Changes" was **moved** to the reverse side of the notice.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following Free Lunch information was **added** directly below the case name and address section at the top of the page.

The information reads as follows:

<u>National School Lunch and/or Breakfast Programs</u> - The child(ren) listed below are approved to receive free lunch and/or breakfast if he or she attends a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a copy of this notice to the school that your child attends.

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

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

3. The prechecked box regarding "Responsibility to Report Changes" that was removed from the front of this notice was **positioned** directly after the Free Lunch Program information.

<u>LDSS-4013A NYC:</u> Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART A (NYC)

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The "LIFELINE" service information was **removed** from the top of the notice.

LDSS-4013B NYC: Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART B (NYC)

FRONT:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.
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That second paragraph now reads:

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.

<u>LDSS-4014A</u>: Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The "LIFELINE" service information was **removed** from the top of the notice.

<u>LDSS-4014B</u>: Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B

FRONT:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

The information reads as follows:

6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.

- 3. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.
- 4. The prechecked box regarding "Responsibility to Report Changes" was **moved** to the reverse side of the notice.

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- 1. The Revision Date was **changed** to 5/05.
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List Child(ren)'s name(s):		

3. The prechecked box regarding "Responsibility to Report Changes" that was removed from the front of this notice was **positioned** directly after the Free Lunch Program information.

LDSS-4014A NYC: Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A (NYC)

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The "LIFELINE" service information was **removed** from the top of the notice.

<u>LDSS-4014B NYC:</u> Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B (NYC)

FRONT:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

The information reads as follows:

- 6. ☑ If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.
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III. Forms Implications:

We expect that all of the above referenced Client Notices will be printed and delivered to the Albany and NYC/HRA warehouses by the end of October, 2005.

Upon receipt of any of these revised notices, Document Services will immediately distribute supplies to local districts.

When any of the revised notices are received, local district staff **must immediately destroy** previous versions and replace them with the newly revised forms.

Additionally, for local district staff, electronic PDF versions of all of the notices referenced in this INF can be accessed on the OTDA Intranet website at http://otda.state.nyenet/otda/ldss_eforms/default.htm .

Any future requests for printed copies of the revised English and Spanish notices or English or Spanish master copies, if that notice is not printed, should be submitted on OTDA-876 (Rev.6/98): "Request For Forms or Publications" form, and should be sent to:

Office of Temporary and Disability Assistance
Document Services
P.O. Box 1990
Albany, New York 12201

Questions concerning ordering forms should be directed to Document Services at 1-800-343-8859, ext. 4-9522.

Issued By	<i>y</i>

Name: Russell Sykes

Title: Deputy Commissioner

Division/Office: Division of Employment and Transitional Supports

ATTACHMENT I

Previous ADMs/INFs	Releases Cancelled	Dept, Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 ADM-21 89 ADM-8 89 ADM-6 88 ADM-4 87 ADM-48 87 ADM-48 86 ADM-7 85 ADM-17 85 ADM-55 82 ADM-55 82 ADM-55 81 ADM-55 80 ADM-90 04 INF-26 03 INF-41 03 INF-17 99 INF-05 92 INF-46 92 INF-42 92 INF-42 92 INF-34 91 INF-57 89 INF-28 88 INF-83		350.5,351.22 351.23 355,358-3.3 360-2.4,2.5, 2.6,6.4,7.5 369.6 387.14 387.20 505.14 (b) (5) (v),(viii),(x) 385.3 385.14	SSL 22 SSL 366-a	MARG pp. 374-382 TASB Section 8 A-J FSSB Sections 4.3.b; 5; 5.2; 5.3.h; 5.3.i; 5.6; 6.2; 6.5; 7.1; 7.1.e; 7.2; 7.2.b; 7.3; 7.4; 7.6; 7.7; 15.3; 15.1.c; 15.1.D; 15.1.e; 15.3; 15.4; 15.5; 15.1.c	GIS 89 MA007 DCL 7/13/83 89 LCM-155 89 LCM-22

OTDA (Rev.8/2005)

11

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE

NOTICE DATE:				NAME AND ADDRESS OF AGE	NCY/CENTER OR DISTRICT OFFICE
CASE NUMBE	R	CIN NUMBE	ER .	1	
	CASE NAME (And C/O Na	ma if Procent) AND	ADDRESS	-	
	CAGE NAME (AND GO NA	ine ii Fresenij Alvo	7	GENERAL TELEPHONE NO. FO	DR .
ı			1	QUESTIONS OR HELP	
				OR Agency Conference Fair Hearing information	
				and assistance	
			1	Record Access	
<u> </u>				Legal Assistance inform	
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NA	ME	TELEPHONE NO.
The action	n(s) taken on your app	lication/recertifi	cation request for Fo	od Stamp Benefits dated _	
is explaine	ed below, next to the c	hecked box(es) 🗹 .		
	FOOD STAN	P BENEFITS	NOT PICKED UP WI	THIN 270 DAYS CANNOT	BE REPLACED.
APPRO	OVED for Food Stamp	Benefits from		to	,
1 🗆	You will get \$		for the month	ı of	because we must figure
1. 🗆	your first month's ben		IOI trie infonti	· · · · · · · · · · · · · · · · · · ·	booked we made again
10	. The date year and	aliad to the and	of the month. You m	ay access your benefit on	
18	. The date you app	Dilea to the end	of the month. Tourn	lay access your benefit on	· · · · · · · · · · · · · · · · · · ·
1b	. The latest date y	ou provided pro	oof we needed. This i	s because you gave us pro	of after it was due.
	You may access	your benefit on	l <u></u> .		<u>-</u> ·
2. 🗌			which is a com	bined benefit for the month	s of
	month's benefit of \$		This is because you. was figu	applied/provided proof afte red from the date you appli	er the 15 th of the month. Your first ed/provided proof to the end of the
	month. Your second	nonth's benefit	of \$	is for the entire	ed/provided proof to the end of the month.
	You may access your	combined ben	efit on		
з. 🗌	Beginning		you will ge	t \$	_ monthly in Food Stamp Benefits.
	You may access thes				
4. 🗌	Beginning		you will get \$	т	onthly in Food Stamp Benefits.
	You may access thes	e benefits on th	ne da	y of each month.	
5. 🔲	So you could get Foo	d Stamp Benef	fits right away, we ca	lculated your benefit withou	it all the necessary proof. Listed here
	is the proof you still n	eed to provide:			
		5 04	D SA- In Abo E d	Luca valenci va va servido el inici	proof. This proof will be used to
	determine the Food S	o get Food Stat Stamp Benefits	mp benefits to the ful you can get. If your F	ture unless you provide this food Stamp Benefits chang	e due to this proof, you will not be
	notified.	•			
6. 🗹	If you applied for Pub	lic Assistance a	and are approved, vo	ur Food Stamp Benefits mig	ght go down or might stop. If this
	happens, you will not				
7. 🗆	Other Information:				
DENIE	D for Food Stamp Be	nefits because	•		

	•	•		·	you give us this proof we listed
_	above by		, you will no	t have to reapply. After that	t date, you will have to reapply.
☐ <u>OVER</u>	PAYMENT INFORMA	<u>TION</u> (check al	l that apply)		
					sehold got more in Food Stamp
				(and also, if your case is clonglessed in the second also is clonglessed and 18 NYCRR 3	osing, the Repayment Agreement)
		•	•		
Ш		•	, ,	t. If your case is closing, se ount you owe and how you	e the Demand Letter and will repay this overpayment.
				-	in your benefits in order to
			ision is based on 1		in your benefits in order to
П					in your benefits in order to
J			ision is based on 1		
П					
The above					

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

D\$S-3152 (Rev. 5/05) Reve	FS App/Reapp/Op Recoup/Ad Only No A/C	
AME:	ADDRESS:	CASE NUMBER:
e or she attends a schoo ke or send a copy of this his notice also entitles y	I that participates in the National School Lunch and notice to the school that your child attends.	below are approved to receive free lunch and/or breakfast if /or Breakfast Programs. To receive this benefit, you must erram such as a school, club or camp that participates in the ovide it to the sponsor.
List Child(ren)'s name	(s):	
Responsibility To Represent changes.	port Changes - See the enclosed LDSS-3151: "F	ood Stamp Change Report Form" for information on when t
	ood Stamp Benefits, please tell this agency if you A), since this may mean you can get Food Stamp E	are later approved for Supplemental Security Income (SSI) denefits.
help with your heating		np Benefits or Medical Assistance, you still may be able to go e Program (HEAP). You can get more information on HEAP
	CONFERENCE AND FAIR HEARING SECTION	- DO YOU THINK WE ARE WRONG?
•		We will correct our mistakes. You can do both 1 and 2:
Ask for a meeting (conference) with one of our supervisors; 2.	Ask for a State fair hearing with a State hearing officer.
call us to set up a me	eeting. To do this, call the conference phone number. Sometimes this is the fastest way to solve any	n was wrong, or if you do not understand our decision, pleas per on the front of this notice or write to us at the address of problem you may have. We encourage you to do this eve
STATE FAIR HE	EARING - You have 90 days from the date of the	is notice to ask for a fair hearing.
OW TO ASK FOR	A FAIR HEARING: You can ask for a fa	air hearing in writing, by phone, by fax or online
Iriting: Send a copy of od Disability Assistance,	both sides of this notice <i>completed</i> to the Office of P.O. Box 1930, Albany, New York 12201. Please k	Administrative Hearings, New York State Office of Temporar eep a copy for yourself.
I want a fair hearing include a written ex		may explain why you disagree below, but you do not have

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

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

Online: Complete an online request form at: http://www.otda.state.ny.us/oah/forms.asp.

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the front of this notice or write to us at the address on the front of this notice.

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

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

IMPORTANT NOTICE

Important Notice: If you need help reading this notice, contact your worker.

Aviso importante: Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a) de casos.

إخطار هام: إذا احتجت إلى مساعدة في قراءة هذا الإخطار، خاطب مسوول ملفك.

重要通知:如需幫助閱讀此通知,請與您的個案負責人接洽。

Avis important: Si vous avez besoin d'assistance pour lire cet avis, veuillez contacter votre travailleur.

Avi enpòtan. Si w bezwen èd pou li avi sa a, antre an kontak ak travayè w la.

중요한 통지서: 이 통지서를 읽는데 도움이 필요하시면, 담당 직원에게 연락하십시오.

Важная информация. Если при чтении этого извещения у Вас возникнут трудности, обратитесь к сотруднику, ведущему Ваше дело.

Thông báo quan trọng. Nếu cần được giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

וויכטיגע מעלדונג איז: אויב איר דארפט הילף צו לייענען די מעלדונג, פארבינדט זיך מיט אייער ארבעטער.

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE (NYC) NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance Information UNIT OR WORKER NAME TELEPHONE NO OFFICE NO. UNIT NO. WORKER NO. The action(s) taken on your application/recertification request for Food Stamp Benefits dated is explained below, next to the checked box(es) \(\overline{\mathbb{\pi}} \) . FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED. APPROVED for Food Stamp Benefits from ____ 1. You will get \$ _ for the month of must figure your first month's benefit from: 1a. The date you applied to the end of the month. You may access your benefit on ____ 1b. The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on ___ 2. You will get \$ which is a combined benefit for the months of _ .This is because you applied/provided proof after the 15th of the month. Your first month's benefit of \$ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of \$ _____ is for the entire month. You may access your combined benefit on ____ you will get \$ _____ monthly in Food Stamp Benefits. 3. Beginning ____ You may access these benefits on the _____ day of each month. 4. Beginning ______ you will get \$_____ ____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month. 5. So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: _ You will not be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will not be notified. 6. 🗹 If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits. 7. Other Information: DENIED for Food Stamp Benefits because: 7. You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed , you will not have to reapply. After that date, you will have to reapply. OVERPAYMENT INFORMATION (check all that apply) We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. This decision is based on 18 NYCRR 387.19. You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment. The benefit in Section 3 above reflects a ____% reduction (recoupment) of \$_____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19. The benefit in Section 4 above reflects a ____% reduction (recoupment) of \$_____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19. U Other: The above decision(s) is based on 18 NYCRR __

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she a send This			<u> </u>	
	a copy of this notice to the scho	in the National School Lunch and/or Brook that your child attends.	v are approved to receive free lunch and/or breakfast if eakfast Programs. To receive this benefit, you must tak	е ог
		e a copy for your records so you can pro	ram such as a school, club or camp that participates ovide it to the sponsor.	III LIK
List	t Child(ren)'s name(s):			
_				
	Responsibility To Report Chang report changes.	es - See the enclosed LDSS-3151: "Fo	ood Stamp Change Report Form* for information on w	hen to
		Benefits, please tell this agency if you a is may mean you can get Food Stamp B	are later approved for Supplemental Security Income (Senefits.	3SI) o
r		pplying for the Home Energy Assistance	np Benefits or Medical Assistance, you still may be able Program (HEAP). You can get more information on HE	
	CONFER	ENCE AND FAIR HEARING SECTION	- DO YOU THINK WE ARE WRONG?	
f you	u think our decision was wrong, y	ou can ask for a review of our decision.	We will correct our mistakes. You can do both 1 and 2:	
i. As	sk for a meeting (conference) with	n one of our supervisors; 2. Ask for a S	tate fair hearing with a State hearing officer.	
t	call us to set up a meeting. To o	to this, call the conference phone numb nes this is the fastest way to solve any	n was wrong, or if you do not understand our decision, er on the front of this notice or write to us at the addr problem you may have. We encourage you to do this	ess or
2. §	STATE FAIR HEARING	- You have 90 days from the date of th	is notice to ask for a fair hearing.	
HOW	V TO ASK FOR A FAIR HEARIN	G: You can ask for a fair hearing by:		
		ice <i>completed</i> to the Office of Admin Albany, New York 12201. Please keep	strative Hearings, New York State Office of Tempora a copy for yourself.	ry and
	I want a fair hearing. I do no include a written explanation.)	- ·	nay explain why you disagree below, but you do not h	ave to

<u>Walk-In:</u> Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, New York or 330 West 34th Street, NYC.

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

Online: Complete an online request form at: http://www.otda.state.ny.us/oah/forms.asp.

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

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

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

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

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

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

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

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

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

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

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE NOTICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information WORKER NO TELEPHONE NO OFFICE NO. LINIT NO LINIT OR WORKER NAME is explained below and on Part B, next to the checked box(es) 🗹 : The action(s) taken on your application dated SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION. PUBLIC ASSISTANCE ☐ ACCEPTED for the period from which will cover the period _ this you will get \$ ☐ A RECOUPMENT at the rate of percent (%) is being taken against your Public Assistance. If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d). ☐ **DENIED** for [name(s)] because OTHER The above decision(s) is based on 18 NYCRR MEDICAL ASSISTANCE □ ACCEPTED for Medical Assistance effective _____ for [name(s)] for [name(s)] ☐ ACCEPTED for Medical Assistance with a SPENDDOWN, effective ____ ____. Your total monthly deductions are \$ ____ Your total monthly income is \$ _ The difference between these figures is your monthly net income for Medical Assistance. This is \$ ____ The allowable income standard for a family household your size is \$ between your net income and this standard (\$____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program. ☐ DENIED Medical Assistance effective _______ for [name(s)] ____ because In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department. We do not have enough information to decide your eligibility under the Medical Assistance program. Please at_____ so we can tell you contact us no later than the information we need. Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days. Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance. ☐ OTHER This above decision(s) is based on

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

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

	PUBLIC ASS	SISTANCE, FOOD ST	AMP BENEF	ITS AND MEDICAL ASSISTAN	
NOTICE DATE:				NAME AND ADDRESS OF AGENCY	CENTER OR DISTRICT OFFICE
CASE NUMBER	₹	CIN NUMBER	· · · · · · · · · · · · · · · · · · ·	†	
	CASE NAME (And C/O Nam	ne if Present) AND ADORESS	}	GENERAL TELEPHONE NO FOR	
			\neg	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	
				OR Agency Conference	
				Fair Hearing Information and assistance	
1			1	Record Access	
OFFICE NO.	UNIT NO.	WORKER NUMBER UNI		Legal Assistance informa	TELEPHONE NUMBER
OFFICE NO.	ONT NO.	WORKER WOMBER OW	OR WORKER		TEELT PONE INCOMPEN
The action(is explained below	w and on <u>Part A</u> , next to the checked INFORMATION.
	FOOD ST	AMP BENEFITS NOT	PICKED UP	WITHIN 270 DAYS CANNOT B	E REPLACED.
☐ APPRO				to	
1 🗆	You will get \$		for the mo	nth of	because we must figure
	r first month's benefit				•
1a.	The date you ap	plied to the end of the	month. You r	may access your benefit on	·
1b.				is because you gave us proof a	after it was due.
2. 🗆	You will get \$		which is a c	combined benefit for the months	s of
	hne	Th	ie ie hocous	you applied/provided proof at	fter the 15 th of the month. Your first
	the month. Your se	cond month's benefit	of \$		applied/provided proof to the end of is for the entire month. You may
	-	ed benefit on			
3. ⊔					monthly in Food Stamp Benefits.
	•	se benefits on the			
4. 🗆		se benefits on the			nonthly in Food Stamp Benefits.
_ (")					Water
5. ⊔				alculated your benefit without a	If the necessary proof. Listed here is
	Variable and he able	to got Food Stomp	Danafita ia ti	no fistura unlana vasu provida th	nis proof. This proof will be used to
_	determine the Food notified.	Stamp Benefits you o	an get. If yo	ur Food Stamp Benefits chang	e due to this proof, you will not be
6. 🗹		olic Assistance and are ice about your Food St			go down or might stop. If this happens
7. 🗆 (Other Information:			·	
☐ <u>DENIE</u>	D for Food Stamp Be	nefits for [name(s)] be	ecause:		
⊹ i Yo	ou did not give us the	proof we need to see	if you can ge	et Food Stamp Benefits. If you g y. After that date, you will have t	give us this proof we listed above by to reapply.
_ □ ОТНЕ		, you will viscous			- · · · · · · · · · · · · · · · · · · ·
	<u></u>				
OVER	PAYMENT INFORMA	TION (check all that a	oply)		
tha	an you should have.	Food Stamp Benefits of See the Demand Le payment. This decision	tter (and als	so, if your case is closing, the	d got more in Food Stamp Benefits e Repayment Agreement) for more
				. If your case is closing, see to how you will repay this overpa	the Demand Letter and Repayment ayment.
		3 above reflects a t. This decision is base			in your benefits in order to
re	epay your overpayme	nt. This decision is bas			in your benefits in order to
The above	decision(s) is based	on 18 NYCRR:			

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

LDSS-4013B (Rev. 5/05) (Part B) Revers NAME:	ADDRESS:	PA, MA, FS App – No A/C – Adequate CASE NUMBER:
she attends a school that participa send a copy of this notice to the sch	fast Programs - The child(ren) listed below are appates in the National School Lunch and/or Breakfast I hool that your child attends. ren) to free meals if they attend a program such as a	Programs. To receive this benefit, you must take of
	by for your records so you can provide it to the sponso	
List Child(ren)'s name(s):		
Responsibility To Report Char changes.	nges ~ See enclosed LDSS-3151: "Food Stamp Chan	nge Report Form" for information on when to report
CONFERENCE	AND FAIR HEARING SECTION - DO YO	U THINK WE ARE WRONG?
f you think our decision was wr and 2:	rong, you can ask for a review of our decision. V	We will correct our mistakes. You can do both
Ask for a meeting (conference	e) with one of our supervisors; 2. Ask for a	a State fair hearing with a State hearing officer
please call us to set up a me the address on the front or	te) with one of our supervisors; 2. Ask for a setting with us) If you think our decision was we setting. To do this, call the conference phone number this notice. Sometimes this is the fastest was when you have asked for a fair hearing.	rong, or if you do not understand our decision mber on the front of this notice or write to us a
CONFERENCE (Informal me please call us to set up a me the address on the front o encourage you to do this eve	eeting with us) If you think our decision was we eeting. To do this, call the conference phone nur of this notice. Sometimes this is the fastest w	mber on the front of this notice or write to us a vay to solve any problem you may have. W
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CONFERENCE (Informal me please call us to set up a me the address on the front or encourage you to do this eve STATE FAIR HEARING – You	eeting with us) If you think our decision was wi beting. To do this, call the conference phone nur of this notice. Sometimes this is the fastest we an when you have asked for a fair hearing.	rong, or if you do not understand our decision mber on the front of this notice or write to us a vay to solve any problem you may have. Whate of this notice to ask for a fair hearing:
CONFERENCE (Informal me please call us to set up a me the address on the front or encourage you to do this eve STATE FAIR HEARING – You	eeting with us) If you think our decision was wi beting. To do this, call the conference phone nur of this notice. Sometimes this is the fastest w on when you have asked for a fair hearing. ou have the following number of days from the d	rong, or if you do not understand our decision mber on the front of this notice or write to us a vay to solve any problem you may have. Whate of this notice to ask for a fair hearing:
1. CONFERENCE (Informal me please call us to set up a me the address on the front of encourage you to do this everage. 2. STATE FAIR HEARING — You Public Assistance, Medical Food Stamp Benefits	eeting with us) If you think our decision was wi beting. To do this, call the conference phone nur of this notice. Sometimes this is the fastest w on when you have asked for a fair hearing. ou have the following number of days from the d	rong, or if you do not understand our decision mber on the front of this notice or write to us a vay to solve any problem you may have. W late of this notice to ask for a fair hearing: TIME LIMIT 60 days 90 days
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1. CONFERENCE (Informal me please call us to set up a me the address on the front of encourage you to do this everage. 2. STATE FAIR HEARING — You Public Assistance, Medical Food Stamp Benefits HOW TO ASK FOR A FAIR HEMAIL: Send a copy of Part A a Disability Assistance, P.O. Box	eeting with us) If you think our decision was weeting. To do this, call the conference phone nurse this notice. Sometimes this is the fastest wen when you have asked for a fair hearing, ou have the following number of days from the decision of the second services EARING: You can ask for a fair hearing by mail, and Part B to the Office of Administrative Hearing 1930, Albany, New York 12201. Please keep a contragree with the agency's action. (You may expected the second seco	rong, or if you do not understand our decision mber on the front of this notice or write to us a ray to solve any problem you may have. Whate of this notice to ask for a fair hearing: TIME LIMIT 60 days 90 days by phone, by fax or online. ings, New York State Office of Temporary an copy of each notice for yourself.
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Fax: Fax a copy of the front and reverse of this notice to: (518) 473-6735 or

Online: Complete an online request form at: http://www.otda.state.ny.us/oah/forms.asp.

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the front of this notice or write to us at the address on the front of this notice.

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

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

<u>PART</u>

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC) NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP Agency Conference Fair Hearing information and assistance OFFICE NO. WORKER NO. UNIT OR WORKER NAME TELEPHONE NO. is explained below and on Part B, next to the checked box(es) 🗹 : The action(s) taken on your application dated SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION. **PUBLIC ASSISTANCE** to _____. You will get \$_____, which will cover ACCEPTED for the period from _____ to ______. After this you will get \$ _____ The above grant is based on a reduced budget because: failed without good cause to cooperate with the Office of Child Support Enforcement (OCSE) on by [18NYCRR 352.3(d)]: To lift this sanction, call (_____) Read the detailed instructions on the back of this notice. failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]: ☐ assessment rehabilitation screening or, has not provided consent or revoked consent to disclose treatment information to the agency. ☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance. The reason for this If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d), __ because_ □ DENIED for [name(s)] The above decision(s) is based on 18 NYCRR MEDICAL ASSISTANCE ACCEPTED for Medical Assistance effective ______ for [name(s)] _____ _____ for [name(s)] ☐ ACCEPTED for Medical Assistance with a SPENDDOWN, effective ____ Your total monthly deductions are \$ Your total monthly income is \$ ___ The difference between these figures is your monthly net income for Medical Assistance. This is \$ ____ NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program. ☐ DENIED Medical Assistance effective ______ for [name(s)]____ In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department. ☐ We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than _ the information we need. Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days. ☐ Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance. OTHER_ This above decision(s) is based on

	To Lift a Sanction for Non-cooperation with a Child Support Requirement
	A sanction for non-cooperation with a child support requirement is open-ended and will continue untilcontacts the Child Support Enforcement Unit and cooperates. When contacts the Child Support Enforcement Unit, he or she will be told what action(s) must be taken to end the sanction. The sanction will end when he or she takes the required actions(s). If did not cooperate but now wants to report a good reason for not cooperating with child support he or she should call ()
	Some examples of a good reason for not cooperating with child support are:
	 fear of emotional or physical harm to you or the children in your family; or, the child was born due to rape or incest; or, the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three months. To find out more information about how to end the sanction, call ()
V	Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.
	Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.
	For further information, please contact your services worker or call the general phone number on the front of this notice.
Ø	If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
☑	Regulations require that you immediately notify this Department of any changes in needs, income, resources living arrangements or address.
Ø	Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013B NYC (Rev. 5/05) PA, MA, FS, App **ACTION TAKEN ON YOUR APPLICATION: PART B** PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC) NOTICE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information OFFICE NO WORKER NUMBER | UNIT OR WORKER NAME TELEPHONE NUMBER The action(s) taken on your application dated is explained below and on Part A, next to the checked box(es) . SEE PART A FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE INFORMATION. FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED. APPROVED for Food Stamp Benefits from ___ because we must figure __ for the month of _ your first month's benefit from: 1a.

The date you applied to the end of the month. You may access your benefit on The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on ___ 2. You will get \$ which is a combined benefit for the months of This is because you applied/provided proof after the 15th of the month. Your first and was figured from the date you applied/provided proof to the end of month's benefit of \$ the month. Your second month's benefit of \$ is for the entire month. You may access your combined benefit on ____ monthly in Food Stamp Benefits. 3. Beginning _ __ you will get \$____ You may access these benefits on the _____ day of each month. 4. Beginning ____ you will get \$__ monthly in Food Stamp Benefits. You may access these benefits on the ____ __ day of each month. 5. 🗆 So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: _ You will not be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will not be 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits. Other Information: □ <u>DENIED</u> for Food Stamp Benefits for [name(s)] because:_ ☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed above by ____, you will not have to reapply. After that date, you will have to reapply. OVERPAYMENT INFORMATION (check all that apply) ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. This decision is base on 18 NYCRR 387.19. You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

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

☐ The benefit in Section 3 above reflects a _____ % reduction (recoupment) of \$ _____ in your benefits in order to

% reduction (recoupment) of \$ _

repay your overpayment. This decision is based on 18 NYCRR 387.19.

repay your overpayment. This decision is based on 18 NYCRR 387.19.

☐ The benefit in Section 4 above reflects a ____

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

in your benefits in order to

LDSS-4013B NYC (Rev. 5/05) (Part B) Reverse	PART B		PA, MA, FS App - No A/C - Adequate
NAME:	ADDRESS:	1	CASE NUMBER:
National School Lunch/or Breakfast Proc she attends a school that participates in the send a copy of this notice to the school that	National School Lunch and	pelow are approved to re for Breakfast Programs.	eceive free lunch and/or breakfast if he of the control of the con
his notice also entitles your child(ren) to fre food Service Program. Make a copy for you			b or camp that participates in the Summe
List Child(ren)'s name(s):			
Responsibility To Report Changes when to report changes.	- See enclosed LDSS-315	1: "Food Stamp Chang	ge Report Form" for information on
CONFERENCE AND F	AIR HEARING SECTIO	<u>N – DO YOU THINK</u>	WE ARE WRONG?
f you think our decision is wrong, you can as	k for a review of our decision.	We will correct our mista	ikes. You can do both 1 and 2:
1. Ask for a meeting (conference) with	one of our supervisors;	2. Ask for a State fair	hearing with a State hearing officer.
 CONFERENCE (Informal meeting please call us to set up a meeting. To do the front of this notice. Sometimes this is you have asked for a fair hearing. 	this, call the conference phone	e number on the front of	this notice or write to us at the address of
2. STATE FAIR HEARING - You have	e the following number of days	from the date of this not	tice to ask for a fair hearing:
	BENEFIT AREA		TIME LIMIT
Public Assistance, Medical Assistance,	Social Services		60 days
Food Stamp Benefits			90 days
HOW TO ASK FOR A FAIR HEARING: You	can ask for a fair hearing by	nail, by phone, by fax, b	y walk-in or online.
Mail: Send a copy of Part A and Part B Assistance, P.O. Box 1930, Albany, New Yo	to the Office of Administrativ	ve Hearings, New York of each notice for yourse	State Office of Temporary and Disabilitielf.
I want a fair hearing. I do not agree with written explanation.)	the agency's action. (You may	explain why you disagre	e below, but you do not have to include a
Phone: 800-342-3334 (PLEASE HAVE	THIS NOTICE WITH YOU	WHEN YOU CALL.)	
Fax: Fax a copy of the front and reverse			
 ··			Pinchille, Appletoner of 44 De
<i>rvaik-in:</i> Bring a copy of this entire notic	e to the New York State U	nice or Temporary and	I Disability Assistance at 14 Boerum

Online: Complete an online request form at: http://www.otda.state.ny.us/oah/forms.asp.

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

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

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

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

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

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

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

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

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

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

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE NOTICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information WORKER NUMBER | UNIT OR WORKER NAME TELEPHONE NUMBER OFFICE NO is explained below and on Part B, next to The action(s) taken on your recertification dated ____ the checked box(es) SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION. **PUBLIC ASSISTANCE** RECERTIFIED for the period from _ REDUCE your monthly Public Assistance benefit for that period effective ___ _____ to \$ __ INCREASE your monthly Public Assistance benefit for that period effective _ from \$ _____ to \$ _____ CONTINUE your Public Assistance benefit unchanged at \$ A RECOUPMENT at the rate of ______ percent (%) is being taken against your Public Assistance. If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d). DISCONTINUE your Public Assistance benefit effective The REASON for this action is _ The above decision(s) is based on 18 NYCRR _ MEDICAL ASSISTANCE CONTINUE the Medical Assistance coverage for [name(s)] _ CONTINUE the Medical Assistance coverage for [name(s)] ____ the receipt of information necessary to decide continued eligibility. Please contact us no later than _ so we can tell you the information we need. CONTINUE the Medical Assistance coverage for [name(s)] pending our review of eligibility. We will send you our decision within thirty days. REDUCE the Medical Assistance coverage effective ______ for [name(s)] ____ _____ . Your total monthly coverage to coverage with a SPENDDOWN. Your total gross monthly income is \$______ deductions are . The difference between these is your monthly net income for Medical Assistance. This is \$ _ The allowable income standard for a family household your size is \$ _____ . The difference between your net income) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility and this standard (\$ under the Excess Income Program and Optional Pay-In Program. DISCONTINUE Medical Assistance for (name(s)) effective ______because Medical Assistance coverage will continue under Transitional Medical Assistance (See attached Medical Assistance Fact Sheet). due to receipt of/increase in child or spousal Medical Assistance coverage will continue until ____ support payments. The above decision(s) is based on SERVICES - If you are getting Social Services and lose your Public Assistance and Medical Assistance Benefits, we will need to see if you still can get Social Services at your next scheduled recertification. This does not necessarily mean that you will no longer be able to get Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any

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

questions, please contact your Services worker or call the general phone number at the top of this notice.

NAME:		ADDRESS:	CASE NUMBER:
Ø		u education and counseling about birth co	
		gible for Public Assistance or Medical Assist ng for up to 90 days from the date of your a	
	For further information, pleas of this notice.	e contact your Services worker or call the	general phone number on the front
Ø	If you know of children under learn about Child Health Plus	the age of 19 who do not have health care coverage.	e coverage, call 1-800-698-4543 to
	Regulations require that your resources, living arrangement	u immediately notify this Department of ts or address.	any changes in needs, income,
V	you still may be able to get	be able to get Public Assistance, Food Star help with your heating costs by applying et more information on HEAP by calling the	for the Home Energy Assistance

LDSS-4014A (Rev. 5/05) (Part A) Reverse

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES NOTICE DATE: NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information OFFICE NO UNIT NO WORKER NUMBER LINIT OR WORKER NAME TELEPHONE NUMBER The action(s) taken on your recertification dated is explained below and on Part A, next to the checked box(es) ☑: SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE, AND SERVICES INFORMATION. FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED APPROVED for continued Food Stamp Benefits from ____ You will get \$ ___ for the month of _ because we must figure your first month's benefit from: The date you applied to the end of the month. You may access your benefit on _ 1b. The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _ which is a combined benefit for the months of .This is because you applied/provided proof after the 15th of the month. Your first month's benefit was figured from the date you applied/provided proof to the end of the month. Your second month's is for the entire month. You may access your combined benefit on benefit of \$ __ you will get \$_ monthly in Food Stamp Benefits. Beginning You may access these benefits on the _____ day of each month. . This is because you are eligible for Transitional Food You will continue to get the benefit above until Stamp Benefits. You are not required to report any changes until the end of this transition period. If you have changes during your transition period that may increase your benefits, you must contact your worker to file an early recertification application in order to receive any increase. Early recertifications that result in a benefit increase will end your transition period, otherwise, your transitional period and benefit will continue as described above. __ you will get \$_ ___ monthly in Food Stamp Benefits. You may access these benefits on the ____ ___ day of each month. So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: You will not be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will not be notified. 6. 🗹 If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits. 7. Other information: DENIED for Food Stamp Benefits because:_ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed on the above , you will not have to reapply. After that date, you will have to reapply for benefits. OTHER: J OVERPAYMENT INFORMATION We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. This decision is based on 18 NYCRR 387.19. You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment. The benefit in Section 3 above reflects a ____% reduction (recoupment) of \$__ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19. The benefit in Section 4 above reflects a _____% reduction (recoupment) of \$___ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19. The above decision(s) is based on 18 NYCRR:

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

Islational School Lunchfor Breakfast Programs - The child(ren) listed below are approved to receive free lunch and/or breakfast if he or thords a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a refined as school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a refined as program such as a school, dub or camp that participates in the Sun ood Service Program. Make a copy for your records so you can provide it to the sponsor. List Child(ren)'s name(s). List Child(ren)'s name(s). List Child(ren)'s name(s). CONFERENCE AND FAIR HEARING SECTION — DO YOU THINK WE ARE WRONG? You think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2: 1. Ask for a meeting conference with one of our supervisors. 2. Ask for a State fair hearing with a state hearing officer. CONFERENCE (Informal Imeeting with us) — If you think our decision was wrong or if you do not understand our decision notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked fair hearing. If you ghly ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a state fair hearing. If you ghly ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a state fair hearing. If you ghly ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a state fair hearing with us. STATE FAIR HEARING — You have the following number of days from the date of this notice to request a fair hearing will not the property of the date of this notice. If you do not call for a fair hearing within 50 days of the date of this notice. If you do not call for a fair hea	.DSS-40148 (Rev. 5/05) (Part B) Reverse	PART B		A, MA, FS, Serv Recert - Timely A/C No F
Itends a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a it this notice to the school that you cribid attends, his notice also entitles your child(ren) to free meals if they attend a program such as a school, club or camp that participates in the Suriood Service Program. Make a copy for your records so you can provide it to the sponsor. List Child(ren)'s name(s): 2 Responsibility To Report Changes – See enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report hanges. CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG? you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes, You can do both 1 and 2: 1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a 3tate hearing officer. CONFERENCE (Informal meeting with us) - If you think our decision was wrong or if you do not understand our decision, please or to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of notice. Sometimes this is the faisest way to solve any problem you may have. We encourage you to do this even you have asked fair hearing. 1 Fyou phy ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a State fair hearing. (See "Keeping Your Benefits The Same" below). STATE FAIR HEARING — You have the following number of days from the date of this notice to request a fair hearing of days of the date of this notice is telling you that you owe a Public Assistance work of days from the date of this notice to request a fair hearing. EEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance, Medical Assistance and Social Services 60 days The notice is telling you that you owe a Public Assistance over pour recordification, but will be in the new amony in this notic	NAME:	ADDRESS:	CASE NU	MBER:
List Child(ren)'s name(s): Responsibility To Report Changes – See enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report hanges. CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG? You think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2: 1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer. CONFERENCE (Informal meeting with us) – If you think our decision was wrong or if you do not understand our decision, please co to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at didress on the front of notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked fair hearing. If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a State feir hearing. (See "Keeping Your Benefits The Same" below). STATE FAIR HEARING — You have the following number of days from the date of this notice to request a fair hearing: STATE FAIR HEARING — You have the following number of days from the date of this notice to request a fair hearing: BENEFIT AREA	ttends a school that participates in the N	ational School Lunch and/or Breakf		
Responsibility To Report Changes – See enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report tanges. CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG? you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2: 1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer. CONFERENCE (Informal meeting with us) - If you think our decision was wrong or if you do not understand our decision, please ce to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of oncice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked fair hearing. If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a State fair hearing. (See "Keeping Your Benefits The Same" below.) STATE FAIR HEARING — You have the following number of days from the date of this notice to request a fair hearing: BENEFIT AREA TIME LIMIT BENEFIT AREA THE	ood Service Program. Make a copy for y			camp that participates in the Sumn
CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG? you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2: 1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer. CONFERENCE (Informal meeting with us) - If you think our decision was wrong or if you do not understand our decision, please cat to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked fair hearing. If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a State fair hearing. (See "Keeping Your Benefits The Same" below.) STATE FAIR HEARING. — You have the following number of days from the date of this notice to request a fair hearing. BENEFIT AREA TIME LIMIT Public Assistance, Medical Assistance, Social Services 60 days Food Stamp Benefits 90 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice. If you ask for a fair hearing within 60 days of the date of this notice. If you ask for a fair hearing within 60 days of the date of this notice. If you ask for a fair hearing within 60 days of the date of this notice, if you ask for a fair hearing before the effective date stated in this notice. How one of the property decision hat you or we determ that the agency's decision hat you can be continued in the same amount as before your recertification, but will be in the new amount in this notice. However, even if you ask for a fair hearing, you will have to pay back any Public Assis				
CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG? you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2: 1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer. CONFERENCE (Informal meeting with us) - If you think our decision was wrong or if you do not understand our decision, please cs to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked fair hearing. If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a State fair hearing. (See "Keeping Your Benefits The Same" below.) STATE FAIR HEARING — You have the following number of days from the date of this notice to request a fair hearing: BENEFIT AREA TIME LIMIT Public Assistance, Medical Assistance, Social Services 60 days Food Stamp Benefits 90 days This notice is telling you that you owe a Public Assistance overpayment, and if you do not agree that you owe this overpayment, you must a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, if you ask for a fair hearing within 60 days of the date of this notice, if you ask for a fair hearing within 60 days of the date of this notice, if you ask for a fair hearing within 60 days of the date of this notice, if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing within 60 days of the date of this notice, if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing to the decision, but will be in the new analymy of the decision, but will		ee enclosed LDSS-3151: "Food Str	amp Change Report Form" for	information on when to report
you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2: 1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer. CONFERENCE (Informal meeting with us) - If you think our decision was wrong or if you do not understand our decision, please cat to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked fair hearing. If you gnly, ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you for a State fair hearing. (See "Keeping Your Benefits The Same" below.) STATE FAIR HEARING - You have the following number of days from the date of this notice to request a fair hearing: BENEFIT AREA TIME LIMIT Public Assistance, Medical Assistance, Social Services BENEFIT AREA Find the public Assistance, Medical Assistance, Social Services and in the future that the agency's decision that you owe the debt was wrong. EEPING YOUR BENEFITS THE SAME: We will restore your Public Assistance, Medical Assistance and Social Services Benefits to the seven they were before this notice, if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing before the effective date stated in this notice. However, even if you ask for a fair hearing to the debt was meaning to the decision. Also, we may recover Medical Assistance benefits you got but should not have go hile you were waiting for the decision. Also, we may recover Medical Assistance benefits you got but should not have go like you benefits the same until the Fair Hearing decision is issued. Public Assistance W		D FAIR HEARING SECTION	N – DO YOU THINK WE	ARE WRONG?
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nline: Complete an online request form at: http://www.otda.state.ny.us/oah/forms.asp .			ah/forms.asp.	
you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax or online, please write to ask for	f you cannot reach the New York State (learing before the deadline	Office of Temporary and Disability A	Assistance by phone, by fax o	r online, please write to ask fo

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the front of this notice or write to us at the address on the front of this notice.

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

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

LDSS-4014A NYC (Rev. 5/05) ACTION TAKEN ON YOUR RECERTIFICATION: PART A PA, MA, FS, Serv-Recert

NOTI DA		DD STAMP BE	NEFITS, MEDIC	NAME AND ADDRESS OF AGENCY/	
CASE	NUMBER	CIN NUMBER		1	
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The	action(s) taken on your recertifica	I ation dated		is explain	ed below and on Part B, next to
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	DISCONTINUE your Public Assist	ance benefit ef	fective		
The	REASON for this action is		-		
The	above decision(s) is based on 18	NYCRR			
MEI	DICAL ASSISTANCE				
	CONTINUE the Medical Assistance	e coverage for [name(s)]		unchanged.
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The	support payments. above decision(s) is based on				
	tVICES - If you are getting Social S		se vour Public Ass	sistance and Medical Assistance	Renefits, we will peed to see if you
still Soci	can get Social Services at your ne ial Services. At your recertification, stions, please contact your Services	ext scheduled re , we will do a	ecertification. This redetermination to	s does not necessarily mean that o see if you can continue to ge	it you will no longer be able to get t Social Services. If you have any

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

LDSS-	4014A NYC (Rev. 5/05) (Part A) Reverse	PART A - NYC	PA, MA, FS, Serv - Recert
NAME:		ADDRESS:	CASE NUMBER:
Ø		u education and counseling about no previous for your desired family or to prev	ut birth control and can assist you in getting rent unwanted pregnancies.
		gible for Public Assistance or Med ing for up to 90 days from the date	lical Assistance, you may get information and e of your application.
	For further information, pleas of this notice.	se contact your Services worker of	or call the general phone number on the fron
abla	If you know of children unde learn about Child Health Plus	•	health care coverage, call 1-800-698-4543 to
V	Regulations require that yources, living arrangement		ntment of any changes in needs, income
Ø	you still may be able to ge	t help with your heating costs b	Food Stamp Benefits or Medical Assistance y applying for the Home Energy Assistance calling the general telephone number on the

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC) NOTICE DATE: NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO FOR QUESTIONS OR HELP Agency Conference Fair Hearing information and assistance Legal Assistance information OFFICE NO UNIT NO WORKER NUMBER UNIT OR WORKER NAME TELEPHONE NUMBER The action(s) taken on your recertification dated is explained below and on Part A, next to the checked box(es) SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE, AND SERVICES INFORMATION. FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED ■ APPROVED for continued Food Stamp Benefits from _____ 1. You will get \$ for the month of because we must figure your first month's benefit from: 1a. The date you applied to the end of the month. You may access your benefit on _ 1b. 🗖 The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _ 2. You will get \$_ which is a combined benefit for the months of This is because you applied/provided proof after the 15th of the month. Your first month's benefit was figured from the date you applied/provided proof to the end of the month. Your second month's of \$ benefit of \$ is for the entire month. You may access your combined benefit on _ monthly in Food Stamp Benefits. 3. 🗀 Beginning _you will get \$___ You may access these benefits on the _____ day of each month. . This is because you are eligible for Transitional Food Stamp Benefits. You are not required to report any changes until the end of this transition period. If you have changes during your transition period that may increase your benefits, you must contact your worker to file an early recertification application in order to receive any increase. Early recertifications that result in a benefit increase will end your transition period, otherwise, your transitional period and benefit will continue as described above. monthly in Food Stamp Benefits. 4. Beginning __ you will get \$_ You may access these benefits on the ____ _ day of each month. 5. 🗆 So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: You will not be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will not be notified. 6. 🗹 If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits. 7.
Other information: DENIED for Food Stamp Benefits because: ☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed on the above , you will not have to reapply. After that date, you will have to reapply for benefits. ☐ OTHER: OVERPAYMENT INFORMATION ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. This decision is based on 18 NYCRR 387.19. You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment. ☐ The benefit in Section 3 above reflects a _ _% reduction (recoupment) of \$__ repay your overpayment. This decision is based on 18 NYCRR 387.19. ☐ The benefit in Section 4 above reflects a ____ _% reduction (recoupment) of \$__ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19. The above decision(s) is based on 18 NYCRR:

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

NAME:	ADDRESS:	PART B - NYC	CASE NUMBER:	cert - Timely - A/C No FS
ational School Lunch/or Breakfast Pro- tends a school that participates in the Na opy of this notice to the school that your ch	itional School Lunch a			
his notice also entitles your child(ren) to fi			ol, club or camp that partic	ipates in the Summ
ood Service Program. Make a copy for you	r records so you can p	rovide it to the sponsor.		
List Child(ren)'s name(s):				
List Clinically a Harricay.				
Responsibility To Report Changes – Sectional Responsibility To Report Changes – Section Report C	enclosed LDSS-3151	: "Food Stamp Change Rep	ort Form" for information on	when to report
CONFERENCE AN	ID FAIR HEARING	SECTION - DO YOU TH	NK WE ARE WRONG?	
you think our decision is wrong, you can a	sk for a review of our d	ecision. We will correct our i	mistakes. You can do both 1	l and 2:
Ask for a meeting (conference) with one of	of our supervisors;	Ask for a State fair hearing	g with a State hearing office	er.
CONFERENCE (Informal meeting with o set up a meeting. To do this, call the co- notice. Sometimes this is the fastest way to air hearing.	nference phone numb	er on the front of this notice	or write to us at the addres	ss on the front of th
you <u>only</u> ask for a meeting with us, we wil r a State fair hearing. (See "Keeping Your			l. Your benefits will stay the	same only if you a
STATE FAIR HEARING - You have th	e following number of o	days from the date of this no	tice to ask for a fair hearing	:
	BENEFIT AREA			TIME LIMIT
Public Assistance, Medical Assistance, Socia	Services			60 days
Food Stamp Benefits				90 days
this notice is telling you that you owe a Pu r a fair hearing within 60 days of the date of aim in the future that the agency's decision	of this notice. If you do	not call for a fair hearing wi	ree that you owe this overp thin 60 days of the date of t	ayment, you must c his notice, you cann
EEPING YOUR BENEFITS THE SAME: V				
	be continued in the uring, you will have to p	ore the effective date stated same amount as before y pay back any Public Assista	our recertification, but will t	e in the new amou
earing, your Food Stamp Benefits cannot nown in this notice. If you lose the fair hea	, we may recover Medi	cal Assistance Benefits.		
earing, your Food Stamp Benefits cannot nown in this notice. If you lose the fair hea hile you were waiting for the decision. Also you do not want your benefits to stay the	same until the decisio	cal Assistance Benefits.	e State when you call for a	fair hearing or, if yo
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If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, fax, walk-in or online, please write to ask for a fair hearing before the deadline.

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

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

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

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

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

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

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

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

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