George E. Pataki
Governor

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

Robert Doar
Commissioner

Administrative Directive

Section 1

Transmittal:	06-ADM-10
To:	Local District Commissioners
Issuing Division/Office:	Division of Employment and Transitional Supports
Date:	August 23, 2006
Subject:	Temporary Assistance (TA) Mail-in Recertification Process
Suggested Distribution:	Temporary Assistance Directors Staff Development Coordinators Child Support Directors TOP/CAP Coordinators Employment Directors Food Stamp Directors
Contact Person(s):	Temporary Assistance Bureau at 1-800-343-8859, extension 4-9344; Medical Assistance Local District Support Liaison: Upstate 1-518-474-8887, NYC 1-212-417-4500
Attachments:	Attachment A - Required Mail-in Recert Language Attachment B (PDF version) - LDSS-4887 - Model Mail-In Recert/Eligibility Questionnaire Attachment C (PDF version) - LDSS-4887-SP – Spanish Model Mail-In Recert/Eligibility Questionnaire
Attachments Available On – Line:	☒

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
04 ADM-2 ; 95 ADM-1; 05 INF-24		351.21	SSL 134-a		GIS 05 TA/DC024; GIS 04TA/ DC015; Dear WMS/CNS Coordinator Letter Dated July 5, 2005

Section 2

I. Summary

- This ADM is intended to accomplish three purposes:

  - It informs districts of required language that must be included in all previously approved Temporary Assistance (TA) mail-in recertification waivers that provide for the use of a State-approved local mail-in recertification form and process in lieu of a face-to-face recertification process.

  - It advises districts of the development of a district optional model mail-in recertification form and the systems (CNS) enhancements that have been added to support the model mail-in process.

  - In addition to the main two purposes noted above, the ADM also reviews the procedures districts must follow when requesting a mail-in recertification waiver for TA.

- The district optional model mail-in recertification form (as well as the Spanish version) is attached to the directive.

II. Purpose

There are several reasons for this administrative directive: to notify districts that currently have waivers of required changes to mail-in recertification forms that have previously been approved by OTDA; to inform districts of an optional system-generated model mail-in recertification form that may be used to support the district processing of some previously approved mail-in recertification forms; and to review procedures for requesting mail-in recertification waivers.

III. Background

A number of social services districts have an OTDA approved waiver allowing them to substitute a mail-in recertification form for one of the two mandatory semi-annual Temporary Assistance face-to-face recertification eligibility interviews found in 18 NYCRR section 351.21. OTDA approval of these waivers began in the early 1980's and has continued as districts have found the waivers to be an effective administrative tool in targeting select segments of the TA caseload that do not need to be seen for recertification semi-annually.

The intent of these waivers, which vary minimally from district to district, was generally to free up district staff to allow them to focus on more error prone areas of the TA caseload and case management. Since the waivers were originally granted, a number of changes have occurred that have resulted in informational

language being added to the recertification form (LDSS-3174). This information must now be included in previously approved local mail-in recertification forms.

OTDA has not, in the past, sought to automate support for the mail-in recertification process because of the differences in local mail-in forms from district to district. However, to assist districts, a new optional model mail-in recertification form (**Attachment B**) has been developed which districts may use in lieu of their previously approved local mail-in form. In addition, districts also now have the option of using the Welfare Management System (WMS) to generate the model mail-in recertification form **(Attachment B)** as an attached form to the CNS mail-in recertification notice.

IV. Program Implications

A. Temporary Assistance

There are two areas of TA implication:

1. Required Language

There are five mandated areas of language that must now be addressed on each district's local mail-in recertification form including those which have previously been approved by OTDA. These include the following language:

- **Food Stamps Change Reporting Rules** – federally required FS language for six month reporting.
- **SSI Interim Assistance Repayment Agreement** - required to insure SSI repayment is kept up to date.
- **Lifeline Opt-out** – outlines opt out provision for Lifeline.
- **Able Bodied Adult Without Dependents ("ABAWD") -** required reporting language when an ABAWD's monthly participation in employment or other work activities falls below 80 hours.
- **National Voter Registration Act (NVRA)** – required to ensure recipient awareness of NVRA.

Districts were previously informed of the need to include the Food Stamps Change Reporting Rules language on approved mail-in recertification forms in 04 ADM-2. Consequently, only the remaining four additional mandated language sections must be added to the local mail-in recertification form at this time. The language required for each of these sections is contained in **Attachment A*.*** Districts choosing not to use the model State mail-in recertification form **(Attachment B)** must now include the new additional language found in **Attachment A** (including the FS change reporting rules language they were previously instructed to include in 04 ADM-2 if not yet incorporated) in their previously approved local mail-in recertification form.

2. Optional System Generated Mail-in Recert (CNS)

These procedures apply only to districts outside of New York City (NYC). NYC has already automated their TA mail-in recertification process.

Districts also now have the option of using the Welfare Management System (WMS) to generate the model mail-in recertification form **(Attachment B)** as the attached form to the CNS mail-in recertification notice to be sent to designated TA recipient cases approximately six weeks prior to the six month point of a 12 month certification period. These are the same cases that districts would now currently manually send a local mail-in recertification form.

WMS will not automatically send these forms to designated cases. Rather, districts will have to identify appropriate cases and enter **either** an Anticipated Future Action Code (AFA): Z26 - "TA Mail-in Recert" -**or** Client Notices System (CNS) code of Z26 to ensure that the appropriate notice and mail-in recert form are generated and sent to the case. The district designated cases will be sent the model mail-in recert as an attached "form" to the CNS mail-in recertification notice.

The process of integrating existing mail-in TA cases into the new automated process will require a start-up transition period as districts will have to decide when to enter the new AFA code Z26. It is expected that most districts will do this either by identifying the cases at the first face-to-face recertification or using the AFA report of cases currently scheduled to receive a mail-in report manually from the district. Once the Z26 code is entered, CNS will send the case a mailer at the appropriate time (6 months hence for a case that is seen face-to-face and 12 months hence for a case scheduled to receive a manual mailer). Mailers will be sent to identified recipients over a staggered schedule beginning approximately six weeks prior to the midpoint (sent at the middle of the 5th month) of the twelve month authorization period. The return date (due date) printed on the front of the form will be the printing date (mail date) plus ten days to allow for sufficient time for the recipient to complete the form and obtain any required documentation.

Since the model recertification form **(Attachment B)** already contains the required language noted above under IV A. 1, use of this optional process will obviate the need for a district to make any modifications to its local mail-in recertification form. Rather, districts may substitute the system-generated CNS mail-in recertification form for the local equivalent manual form the district previously used.

Districts are reminded that the mail-in recertification process must not be used for any of the following groups:

- TA cases in which any member of the filing unit has earnings or for which a legally responsible relative's earnings are budgeted; or

- TA cases in which any member of the household is sanctioned; or

- TA cases in which a time-limit trackable individual has reached a time-limit count of 48 months or more, effective January 1, 2006.

Note: In addition to not allowing a mail-in recertification process for TA cases with a time-limit count of 48 months or more, group recertifications are not allowed for TA cases with a time-limit count of 48 months or more, effective January 1, 2006.

The optional CNS-generated mail-in recertification process will **not** apply at this time to any other approved recertification waivers other than allowing districts to substitute a mail-in recertification form for one of the two semi-annual face-to-face recertifications. Accordingly, districts having waivers allowing them to conduct one face-to-face recertification every 24 months for non-parent caregiver cases (see 05 INF-24) as long as they conduct a mail-in recertification at the 12th month, cannot use the automated WMS process to send the mail-in recert form.

In addition, if an individual's status changes by reason of becoming sanctioned or employed during a current certification period when that person is on a mail-in recertification cycle, the district must make the change to remove the person from the mail-in recertification cycle and place them on a six month face-to-face recertification at the time of the next face-to-face recertification.

V. Required Action

A. Temporary Assistance

All districts that have approved waivers allowing them to substitute a local mail-in recertification form for one of the two mandatory semi-annual Temporary Assistance face-to-face recertification eligibility interviews found in 18 NYCRR section 351.21 must either:

- modify the previously approved local mail-in recertification form to include the required language noted in IV-A.1 above, or
- use the State provided optional model mail-in recert form **(Attachment B)** and manually send it to recipients without using automated CNS support, or
- use the model mail-in recertification form **(Attachment B)** available through the optional CNS generated process described in IV-A 2 above.

Districts possessing any other waiver (such as that allowing them to conduct one face-to-face recertification every 24 months for non-parent caregiver cases as long as they conduct a mail-in recertification at the 12th month point), allowing them to substitute a mail-in recertification form for a face-to-face recertification must either modify the previously approved local mail-in recertification form to include the required language referenced in IV-A.1 above and detailed in

Attachment A, or manually use the model mail-in recertification form **(Attachment B)**.

B. Medicaid

When a district has an approved waiver and is substituting a mail-in recertification form for one of the two mandatory semi-annual Temporary Assistance face-to-face recertification eligibility interviews, the recertification form is not considered a Medicaid renewal, since the form used is not a statewide mandated form and does not include all information that Medicaid needs to perform a redetermination. A TA mail-in recertification cannot be substituted for the Medicaid renewal. Because the authorization at the face-to-face interview is for a 12-month period, an eligibility review is not required at the six-month point unless the household's circumstances have changed. Absent such a change, the coverage period established at the face-to-face interview continues.

When a TA case is closed for failure to return the six-month recertification form, Medicaid is continued for the balance of the 12-month period. However, changes reported as part of a TA mail-in recertification must be considered when continuing the recipient's eligibility for Medicaid, including a separate Medicaid eligibility determination as appropriate if the case is no longer eligible for TA.

VI. Systems Implications

Upstate

CNS Mail-in Recert Notices

These procedures apply only to districts outside of New York City. New York City has already automated their TA mail-in recertification process.

Districts now have the option of using WMS and the Client Notices System (CNS) to generate a model mail-in recertification form **(Attachment B)** to be sent to designated TA recipient cases on a staggered basis approximately six weeks prior to the six month point of a twelve month certification period. These are the same cases that districts would now currently manually send a local mail-in recertification form. The return date (due date) printed on the front of the form will be the printing date (mail date) plus ten days.

Districts have two methods available to them to send a CNS-generated mail-in recertification notice:

1. Workers may enter PA case reason code **Z26 – TA Mail-in Recert** either on the Batch Notice Entry Screen (WCN022) for a group of cases or on the Reason Code Screen (WCN011) for a single case. (Pending notices created individually need to be released to the notice production stream via screen WCN021 – Notice Authorization/Release Screen.)

2. Workers may enter Anticipated Future Action (AFA) code **Z26 – TA Mail-in Recert** on screen 4 of WMS. Cases with this new AFA code will be automatically included in a monthly process that generates the mail-in recert notice. Additional case selection criteria for this process are as follows:
   - Case type = 11,12,16 or 17
   - Case status = Active or Active/Override
   - Case is NOT clocking down
   - Authorization TO Date Month/Year is equal to the Program Execution Date Month/Year plus seven months. (For example, the January, 2007 execution will look for an Authorization To Date Month/Year of August, 2007.)

Since the model recertification form **(Attachment B)** already contains the required language noted above, use of this optional process will obviate the need for a district to make any modifications to its mail-in recertification form. Rather, districts may substitute the CNS generated mail-in recertification for the manual form OTDA previously had approved.

Districts are reminded that the mail-in recertification process should not be used for any of the following groups:

- TA cases in which any member of the filing unit has earnings or for which a legally responsible relative's earnings are budgeted; or
- TA cases in which any case member is sanctioned; or
- TA cases in which a time limit trackable individual has reached a case count of 48 months.

The optional CNS generated mail-in recertification form **will not** apply at this time to any other approved recertification waivers other than allowing districts to substitute a mail-in recertification form for one of the two semi-annual face-to-face recertifications. Accordingly, districts having waivers allowing them to conduct one face-to-face recertification every 24 months for non-parent caregiver cases (see 05 INF-24) as long as they conduct a mail-in recertification at the 12 month, or any OTDA approved recertification waiver, cannot use the automated WMS process to send the mail-in recertification form.

OTDA will not start producing automated CNS mailers as attachments to CNS notices until 4 months have elapsed after the release of this directive. This is to allow districts an opportunity to procedurally review this directive and enter the AFA code in time to actually produce automated mail-in recertification forms.

New York City

While New York City's mail-in recertification process is already automated the systems changes required to add the required language under IV-A.1 will be implemented at a later date to allow for necessary administrative time to necessitate the changes.

VII. Additional Information

A. Temporary Assistance

1. Waiver Requests

Districts wishing to request a waiver to use a mail-in recertification process as a substitute for one of the mandated semi-annual face-to-face recertifications required by 18 NYCRR section 351.21 must submit the request to:

Russell Sykes, Deputy Commissioner
Office of Temporary and Disability Assistance
Division of Employment and Transitional Supports
40 North Pearl St. - 11th Floor
Albany, NY 12243

The requests must address the following:

- Regulation for which a waiver is sought (normally 351.21).
- How the mail-in process will work.
- To whom the process will apply and why this group is appropriate for mail-in recertification rather than face-to-face recertification.
- A copy of the local mail-in recertification form must be included if the model mail-in form will not be used or if the CNS supported process is not being used.
- The waiver request must specifically address the implications of the waiver for Medical Assistance and Food Stamps.

Districts are reminded that they may not modify a waiver request without OTDA approval and must inform OTDA in the instance of stopping a waiver process and reinstituting the regulatory requirement.

VIII. Effective Date

This directive is effective September 1, 2006 unless otherwise noted.

Issued By____
Name: **Russell Sykes**
Title: **Deputy Commissioner**
Division/Office: **Division of Employment and Transitional Supports**

Attachment A - Required Mail-in Recert Language

1. Food Stamps Change Reporting Rules - the following is the required FS change reporting language. Districts should already have included this language on their mail-in recertification form. If not, it must be included now:

FOOD STAMPS

In order to determine if you can still get food stamps, you must complete this eligibility questionnaire and return it by___________________________________(due date at least 10 days after mailing date)

If you do not complete and return the eligibility questionnaire by the due date, your food stamp benefits will be reduced or stopped. We will send you another notice if this happens. This decision is based on Regulation 18 NYCRR 387.17

List of changes you must report for Food Stamps at this time:

- Changes in any **source of income** for anyone in your household
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month
- Changes in your household's total **unearned income from a public source** such as Social Security Benefits or Unemployment Insurance benefits when it goes up or down by more than $50 a month
- Changes in your household's total **unearned income from a private source** such as Child Support Payments or Private Disability Insurance when it goes up or down by more than $100 a month
- Changes in the amount of court ordered **child support you pay** to a child outside of your Food Stamp household
- Changes in **who lives with you**
- **If you move**, your new address and your new rent or mortgage costs, heat costs and utility costs
- **A new or different car**, or other vehicle
- Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2000 for a household without an elderly or disabled household member or $3000 for a household with an elderly or disabled household member."
- If anyone in your food stamp household is an Able-Bodied Adult Without Dependents ("ABAWD"), you must tell us if their work hours go below 80 hours a month within 10 days after the end of that month

2. SSI Interim Assistance Repayment Agreement- the following is the required SSI Interim Assistance Repayment Agreement language which districts must include on their mail-in recertification form now:

AUTHORIZATION FOR REIMBURSEMENT OF PUBLIC ASSISTANCE BENEFITS FROM SSI RETROACTIVE PAYMENT

I authorize the Commissioner of the Social Security Administration (SSA) to send to the local social services district the amount due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if my SSI benefits are terminated or suspended and are later reinstated.

I understand that the local social services district may take from my retroactive SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that it paid to me during the period that begins (1) with the first day I became eligible for payment of SSI or (2) the first day to which SSI benefits were reinstated after a period of suspension or termination and ends with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments resume).

After taking this money from my SSI check(s), the local social services district will pay me the balance; if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance; I will be given an opportunity for a hearing.

I understand that:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.
- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement. It will not have any effect on cases that have been completely decided or if the SSA

has already made an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I have mutually agreed to terminate the authorization.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon new SSI applications made after that date.

3. Lifeline Opt-out - the following is the required Lifeline Opt out language which districts must include on their mail-in recertification form now:

LIFELINE - For applicants/recipients of Temporary Assistance and/or Food Stamp Benefits: The Office of Temporary and Disability Assistance may or may not release your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate.

If you do *not* want this information released, check this box☐.

You may contact your telephone service provider directly for enrollment in the discounted rate Lifeline Service.

Medicaid-**only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

4. Able Bodied Adult Without Dependents ("ABAWD") - If anyone in your food stamp household is an Able Bodied Adult Without Dependents ("ABAWD"), you must report when the individual's, who is an ABAWD, monthly participation in employment or other work activities falls below 80 hours."

5. National Voter Registration Act - the following is the required NVRA language which districts must include on their mail-in recertification form now:

NOTE: The last page of this form is an application to register to vote. If you would like help filling out the voter registration application form, ask your TA examiner. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency. Return this form to the agency whether it has been completed or not.

TO COMPLETE THIS FORM:

Box 1: Must be completed. If you answer NO, do not complete this form.

Box 2: Must be completed, however if you check NO, do not complete this form UNLESS you are a New York resident who will be 18 by the end of this year.

Box 4: Give your home address.

Box 5: Give your mailing address if it is different from your home address (post office box no., star route or rural route no., etc.)

Box 8: The completion of this box is optional.

Box 9: Must be completed. If you have a current New York driver's license, you must provide that number. If you do not have a current New York driver's license, you must provide the last four digits of your social security number.

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

Box 11: In order to vote in a party primary, you must be enrolled in one of New York's 5 constituted parties. Check one box only.

Box 12: This application must be signed and dated in ink.

Attachment A – continued

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

本表格有中文文本

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

☐ YES (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)

☐ NO because I choose not to register OR

☐ I am already registered at my current address OR

☐ I asked for and received a mail registration form.

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

______________________ (Signature) ___/___/___ (Date)

______________________ (Please Print Name)

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State
- change your name and/or address, if there is a change since you last voted
- enroll in a political party or change your enrollment

To Register You Must:

- be a U.S. citizen
- be 18 years old by December 31 of the year in which you file this form (note: you must be 18 years old by the date of the general, primary, or other election in which you want to vote.)
- be a resident of the County, or of the City of New York at least 30 days before an election.
- not be in jail or on parole for a felony conviction
- not claim the right to vote elsewhere

IMPORTANT!

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

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

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with *New York State Board of Elections, 40 Steuben Street, Albany, New York 12207-2109.*
Tele: 1-800-469-6872, TTY 1-800-533-8683; or visit our web site - www.elections.state.ny.us

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

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (10/03)

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

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

2 I will be 18 years old on or before election day: Yes ☐ No ☐ If you answered NO, do not complete this form, unless you will be 18 by the end of the year.

For Board use only!

3 Last Name | First Name | Middle Initial | Suffix

4 Address Where You Live (do not give P.O. address) | Apt. No. | City/Town/Village | Zip Code | County

5 Address Where You Get Your Mail (if different from above) | P.O. box, star rte., etc. | Post Office | Zip Code

6 Date of Birth

7 Sex (circle) M F

8 Home Tel. Number (optional)

9 ID Number - Check the applicable box and provide your number

☐ New York Driver's License Number ☐ Last four digits of your Social Security number

➔

☐ I do not have a New York driver's license number or a Social Security number.

10 The last year you voted | Your Address was (give house number, street, and city)

In county/state | Under the name (if different from your name now)

11 **Choose a Party** — Check one box only

☐ REPUBLICAN PARTY
☐ DEMOCRATIC PARTY
☐ INDEPENDENCE PARTY
☐ CONSERVATIVE PARTY
☐ WORKING FAMILIES PARTY

Please note: In order to vote in a **primary election**, you must be enrolled in one of these parties.

☐ OTHER (write in)______________

☐ I DO NOT WISH TO ENROLL IN A PARTY

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

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

↓Signature or mark↓

X ______________________ Date

Please do not write in this space

(Rev. 3/2008)

Dist Cd:	Ofc:	Worker:	Unit:	Case Name:	Case #:

MAIL-IN RECERT/ELIGIBILITY QUESTIONNAIRE

To determine your continued eligibility for Temporary Assistance (TA) and Food Stamps (FS) you must complete this form, sign, date it and return it to us at the address on the first page of the notice by:	**RETURN DATE**

- For TA this form is considered a mail-in recertification form. For FS it is an Eligibility Questionnaire.
- You must enclose copies of letters or documents that verify the changes you report.
- Failure to return the form or returning it without the required verification may result in the closing of your case or reduction of benefits.

1. Do you still need:	Temporary Assistance? Yes ☐ No ☐	Food Stamps? Yes ☐ No ☐	Medical Assistance? Yes ☐ No ☐

2. Did anyone **move into** or **out of** your household since the last time you reported the number of persons in your household (including births)?

If yes, provide the information requested below.

If they want to apply for assistance an application must be filed.

If you are reporting a newborn enclose a copy of a birth certificate for verification.

Yes ☐ No ☐

SOCIAL SECURITY #	NAME	RELATIONSHIP TO YOU	MOVED IN	MOVED OUT	DATE

3. Other than Temporary Assistance, did you or anyone in your household, have a change in income? Has anyone begun receiving any new or increased income or lost income from any of the following sources since the last time you reported your income? If you check "YES", indicate the amount you receive and whether this amount is new, more or less. If this amount has changed enclose photocopies to verify your last four weeks of pay, or other proof of how much you receive.

SOURCE OF INCOME	YES	NO	AMOUNT	NEW	MORE	LESS
A. Contributions			$			
B. Employment Please indicate the number of hours working per week _______.			$			
C. Unemployment Insurance Benefits (UIB)			$			
D. Supplemental Security Income (SSI)			$			
E. Child Support (Including Court Ordered Payments)			$			
F. Veterans Or Other Military Benefits			$			
G. Other income			$			

4. Have there been any changes in the following since you last reported to us:

YES	NO	
		A. Rent cost: Increase ☐ Decrease ☐ New Amount $ _________ (Enclose rent receipt copy if your rent changed)
		B. Someone is now pregnant or disabled. Name: ___________________ (Enclose copy of Medical Proof)
		C. Resources (examples: motor vehicle, bank account, etc.)
		D. Other changes (including hours employed or in work activities), please explain:

SIGNATURE SECTION

I swear (or) affirm that the information I have provided on this form is true and correct.

Sign here: X	Date:
Husband/Wife or Authorized Representative Signature: X	Date:

WARNING: Federal and State law provides for penalties of fine, imprisonment or both if you do not tell the truth or if you conceal or fail to disclose facts regarding your continuing eligibility for assistance. Regulations require that you immediately notify this agency of any changes in needs, income, resources, living arrangements or address.

MAIL-IN RECERT/ELIGIBILITY QUESTIONNAIRE

FOOD STAMPS

In order to determine if you can still get food stamps, you must complete this eligibility questionnaire and return it by the date on the front of this questionnaire. If you do not complete and return the eligibility questionnaire by the due date, your food stamp benefits will be reduced or stopped. We will send you another notice if this happens. This decision is based on Regulation 18 NYCRR 387.17.

List of changes you must report for Food Stamps at this time:

- Changes in any **source of income** for anyone in your household.
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month.
- Changes in your household's total **unearned income** from **a public source** such as Social Security Benefits or Unemployment Insurance benefits when it goes up or down by more than $50 a month.
- Changes in your household's total **unearned income from a private source** such as Child Support Payments or Private Disability Insurance when it goes up or down by more than $100 a month.
- Changes in the amount of court ordered **child support you pay** to a child outside of your Food Stamp household.
- Changes in **who lives with you.**
- **If you move**, your new address and your new rent or mortgage costs, heat costs and utility costs.
- **A new or different car**, or other vehicle.
- Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2000 for a household without an elderly or permanently disabled household member or $3000 for a household with an elderly or permanently disabled household member.
- If anyone in your food stamp household is an Able-Bodied Adult Without Dependents ("ABAWD"), you must tell us if their work hours go below 80 hours a month within 10 days after the end of that month.

MEDICAL ASSISTANCE - You must immediately report any changes in your address, income, resources or household size to this agency. You will be notified if your Medical Assistance coverage changes.

Authorization For Reimbursement of Public Assistance Benefits From SSI Retroactive Payment

I authorize the Commissioner of the Social Security Administration (SSA) to send to the local social services district the amount due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if my SSI benefits are terminated or suspended and are later reinstated.
I understand that the local social services district may take from my retroactive SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that it paid to me during the period that begins (1) with the first day I became eligible for payment of SSI or (2) the first day to which SSI benefits were reinstated after a period of suspension or termination and ends with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments resume).

After taking this money from my SSI check(s), the local social services district will pay me the balance; if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance; I will be given an opportunity for a hearing.
I understand that:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.
- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement. It will not have any effect on cases that have been completely decided or if the SSA has already made an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I have mutually agreed to terminate the authorization.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon new SSI applications made after that date.

LIFELINE - For applicants/recipients of Temporary Assistance and/or Food Stamp Benefits: The Office of Temporary and Disability Assistance may or may not release your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate.

If you do *not* want this information released, check this box ☐.

You may contact your telephone service provider directly for enrollment in the discounted rate Lifeline Service. Medicaid-**only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

Able Bodied Adult Without Dependents (**ABAWDs**) - If anyone in your food stamp household is an Able Bodied Adult Without Dependents ("ABAWD"), you must report when the individual's, who is an ABAWD, monthly participation in employment or other work activities falls below 80 hours."

NOTE: The last part of this form is an application to register to vote. If you would like help filling out the voter registration application form, ask your TA examiner. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency. Return this form to the agency whether it has been completed or not.

TO COMPLETE THIS FORM:

Box 1**:** Must be completed. If you answer NO, do not complete this form.

Box 2: Must be completed, however if you check NO, do not complete this form UNLESS you are a New York resident who will be 18 by the end of this year.

Box 4: Give your home address.

Box 5: Give your mailing address if it is different from your home address (post office box no., star route or rural route no., etc.)

Box 8: The completion of this box is optional.

Box 9: Must be completed. If you have a current New York driver's license, you must provide that number. If you do not have a current New York driver's license, you must provide the last four digits of your social security number.

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

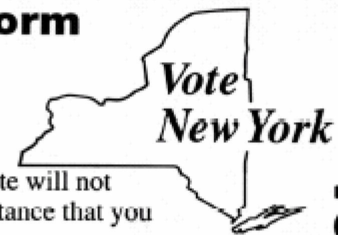
Box 11: In order to vote in a party primary, you must be enrolled in one of New York's 5 constituted parties. Check one box only.

Box 12: This application must be signed and dated in ink.

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

本表格有中文文本



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

☐ YES (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)

☐ NO because I choose not to register OR

☐ I am already registered at my current address OR

☐ I asked for and received a mail registration form.

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

____________________ (Signature) ___/___/___ (Date)

____________________ (Please Print Name)

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State
- change your name and/or address, if there is a change since you last voted
- enroll in a political party or change your enrollment

To Register You Must:

- be a U.S. citizen
- be 18 years old by December 31 of the year in which you file this form (note: you must be 18 years old by the date of the general, primary, or other election in which you want to vote.)
- be a resident of the County, or of the City of New York at least 30 days before an election.
- not be in jail or on parole for a felony conviction
- not claim the right to vote elsewhere

IMPORTANT!

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

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

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with *New York State Board of Elections, 40 Steuben Street, Albany, New York 12207-2109.*
Tele: 1-800-469-6872, TTY 1-800-533-8683; or visit our web site - www.elections.state.ny.us

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

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (10/03)

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

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

2 I will be 18 years old on or before election day: Yes ☐ No ☐
If you answered NO, do not complete this form, unless you will be 18 by the end of the year.

For Board use only!

3 Last Name | First Name | Middle Initial | Suffix

4 Address Where You Live (do not give P.O. address) | Apt. No. | City/Town/Village | Zip Code | County

5 Address Where You Get Your Mail (if different from above) | P.O. box, star rte., etc. | Post Office | Zip Code

6 Date of Birth

7 Sex (circle) M F

8 Home Tel. Number (optional)

9 ID Number - Check the applicable box and provide your number
☐ New York Driver's License Number ☐ Last four digits of your Social Security number
➔
☐ I do not have a New York driver's license number or a Social Security number.

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

11 Choose a Party — Check one box only
☐ REPUBLICAN PARTY
☐ DEMOCRATIC PARTY
☐ INDEPENDENCE PARTY
☐ CONSERVATIVE PARTY
☐ WORKING FAMILIES PARTY
☐ OTHER (write in)__________
☐ I DO NOT WISH TO ENROLL IN A PARTY

Please note: In order to vote in a **primary election**, you must be enrolled in one of these parties.

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

↓ Signature or mark ↓

X ____________________ Date

Please do not write in this space

LDSS-4887 SP (6/06) New York State Office of Temporary And Disability Assistance

Dist Cd:	Ofc:	Worker:	Unit:	Case Name:	Case #:

SOLICITUD DE RENOVACIÓN POR CORREO / CUESTIONARIO DE HABILITACIÓN

Para determinar si usted puede continuar recibiendo Asistencia Temporal (TA) y Cupones para Alimentos (FS), debe rellenar este formulario, firmarlo, fecharlo y regresarlo a la dirección que aparece en la primera página, para el día:

REGRESARLO PARA EL

- En relación con el Programa de Asistencia Temporal, este formulario se considera una solicitud de renovación por correo. En relación con el programa de cupones, se considera un cuestionario de habilitación.
- Debe adjuntar copias de cartas o documentos que verifiquen los cambios que ha reportado.
- Si usted no devuelve el formulario, o lo devuelve sin los comprobantes exigidos, es posible que cerremos su caso o reduzcamos la cantidad de beneficios que recibe.

1. Todavía necesita:	Asistencia Temporal: Sí ☐ No☐	Cupones para Alimentos: Sí ☐ No ☐	Asistencia Médica: Sí ☐ No ☐

2. ¿Se han agregado o retirado miembros del grupo familiar desde la última vez que usted reportó el número de integrantes del grupo familiar (incluyendo los recién nacidos)? Sí ☐ No☐

Si contestó que sí, suministre los siguientes datos. Si desean solicitar de un programa de asistencia social, deben llenar una solicitud. Si va a reportar la adición al grupo familiar de un recién nacido, favor de adjuntar como comprobante, una copia de la partida de nacimiento.

№ DE SEGURO SOCIAL	NOMBRE	PARENTESCO CON USTED	SE INCORPORÓ	SE RETIRÓ	FECHA:

3. Aparte de lo que recibe en Asistencia Temporal, ya sea usted o un miembro del grupo familiar ¿ha visto una modificación de ingresos? Algún miembro del grupo familiar ¿ha comenzado a recibir ingresos de una nueva fuente, o ha recibido un aumento de ingresos o ha perdido ingresos de una de las siguientes fuentes?: si contestó que «SÍ», indique la cantidad que recibe y si esta nueva cantidad representa una pérdida, un aumento, o una nueva fuente de ingresos. Si esa cantidad ha cambiado, favor de adjuntar copias para verificar el pago de las últimas cuatro semanas, u otro comprobante de cuánto usted recibe.

FUENTE DE INGRESO	SÍ	NO	CANTIDAD	NUEVA	AUMENTO	REDUCCIÓN
A. Contribuciones			$			
B. Empleo: número de horas que trabaja por semana___________.			$			
C. Beneficios de Seguro de Desempleo (UIB)			$			
D. Seguridad de Ingreso Suplementario (SSI)			$			
E. Sustento de menores (incluyendo pagos ordenados por el juez)			$			
F. Beneficios de veteranos u otros beneficios a militares			$			
G. Otro tipo de ingresos			$			

4. ¿Se han dado cambios en las siguientes situaciones desde la última vez que usted reportó los datos?:

SÍ	NO	
		A. Pagos de alquiler: Aumento ☐ Reducción ☐ Nueva cantidad $_________ (adjunte copia de recibo de alquiler si la cantidad ha cambiado)
		B. Hay una persona embarazada o incapacitada. Nombre: ________________________ (adjunte copia de comprobante médico)
		C. Recursos (por ejemplo: auto, cuenta bancaria, etc.)
		D. Otros cambios (incluyendo horas de trabajo o horas de actividad laboral), favor de explicar:

FIRMAS

Juro (o) afirmo que los datos que he proporcionado en este formulario son verdaderos y exactos.

Firme aquí: X	Fecha:
Firma del esposo(a) o representante autorizado: X	Fecha:

ADVERTENCIA: las leyes federales y estatales disponen sanciones en la forma de multas, encarcelamiento o ambas, si usted no dice la verdad o si usted retiene o no revela datos pertinentes a si usted continúa reuniendo los requisitos para recibir asistencia. La reglamentación exige que usted notifique inmediatamente esta agencia sobre todo cambio en sus necesidades, ingresos, recursos, situación de vivienda o domicilio.

SOLICITUD DE RENOVACIÓN POR CORREO / CUESTIONARIO DE HABILITACIÓN

CUPONES PARA ALIMENTOS

Para que podamos determinar si usted puede continuar recibiendo cupones para alimentos, debe llenar este cuestionario de habilitación y regresarlo para la fecha que aparece en la primera página. Si no rellena y regresa el cuestionario para la fecha indicada, sus beneficios de cupones se reducirán o se suspenderán. De ser así, le enviaremos otro aviso. Esta decisión se basa en 18 NYCRR 387.17.

Lista de cambios, relativos al programa de cupones, que debe reportar en este momento:

- Cambios en **fuente de ingresos** de algún miembro del hogar.
- Cambios en el total de **ingresos trabajados** del hogar cuando este total aumenta o disminuye por más de $100 al mes.
- Cambios en el total de **ingresos no trabajados** del hogar **provenientes de fondos públicos**, tales como beneficios de Seguro Social o beneficios del Seguro de Desempleo (UIB), cuando este total aumenta o disminuye por más de $50 al mes.
- Cambios en el total de **ingresos no trabajados** del hogar, **provenientes de fondos privados**, tales como pagos de Sustento de Menores o pagos del seguro privado por incapacidad, cuando este total aumenta o disminuye por más de $100 al mes.
- Cambios en los **pagos por orden judicial de Sustento de Menores** a favor de un niño que no sea miembro del grupo familiar que recibe cupones.
- Cambio en **quiénes viven con usted.**
- **Si se muda,** su nuevo domicilio, o los nuevos montos de alquiler o hipoteca; gastos de calefacción y servicios públicos.
- Un automóvil nuevo o diferente, u otro vehículo.
- Aumento en lo que el hogar tiene en dinero en efectivo, acciones, bonos, dinero en el banco o en una institución de ahorros cuando el total del dinero en efectivo y ahorros de todos los miembros del hogar sobrepasa los $2,000 y, en el hogar no hay una persona de edad mayor o con una incapacidad permanente; o $3,000 cuando en el hogar hay una persona de edad mayor o con una incapacidad permanente.
- **Si algún integrante de su hogar beneficiario de cupones para alimentos es un Adulto Habilitado para Trabajar sin Dependientes** (“ABAWD”), usted **DEBE** informarnos si esa persona trabajó menos de 80 horas al mes dentro de los diez días de finalizado dicho mes.

ASISTENCIA MÉDICA: debe notificar inmediatamente a esta agencia de todo cambio de domicilio, ingresos, recursos o tamaño de su grupo familiar. Se le notificará si habrá cambios en la cobertura de Asistencia Médica.

Autorización de reembolso de beneficios de asistencia pública de los pagos retroactivos de SSI

Yo autorizo al comisionado de la Administración del Seguro Social (SSA) para que envíe al distrito local de servicios sociales, la cantidad que se me adeuda al momento de mi primer pago de (1) pago retroactivo de Seguridad de Ingreso Suplementario que pueda recibir al presentar una solicitud de SSI, o (2) beneficios retroactivos que pueda recibir si mis beneficios de SSI cesan o se suspenden y más tarde se restituyen. Yo comprendo que el distrito local de servicios sociales podría descontar de mi pago de SSI la cantidad de Asistencia Pública (excepto la asistencia pagada total o parcialmente con fondos federales) que se me pagó durante el periodo que comienza con el primer día que tuve derecho a los beneficios de SSI o el primer día en que los beneficios fueron restituidos después de un periodo de suspensión o cancelación y terminando con el mes en el que los pagos del SSI comenzaron (o el mes siguiente si el distrito local de servicios sociales no puede detener el envío de mi último pago de asistencia pública durante el mes en que los pagos del SSI comenzaron).

Después de deducir este dinero de mi(s) cheque(s) de SSI, el distrito local de servicios sociales me pagará el balance, si existiera alguno, a más tardar dentro de los 10 días laborales a partir de la fecha en que recibe mi pago de SSI. También, estoy al tanto de que si el distrito deduce más dinero del que yo creo me fue pagado por Asistencia Pública, se me dará la oportunidad de refutarlo por medio de una audiencia.
Comprendo que:

- la Administración del Seguro Social puede considerar la fecha en que presento esta autorización firmada ante la oficina local de servicios sociales, como la fecha inicial en la que comienzo a satisfacer los requisitos para recibir beneficios del SSI, si someto una solicitud de beneficios de SSI dentro de los próximos 60 días.
- esta autorización tendrá efecto con relación a toda solicitud de SSI o apelación que actualmente esté pendiente ante la oficina de la Administración de Seguro Social tocante a mi persona y a toda solicitud de SSI que yo presente, o apelación que reclame con respecto al periodo que concluye transcurrido un año de la fecha de mi firma en este acuerdo. Lo anterior no afectará los casos sobre los cuales ya se tomó una resolución definitiva, o si la Administración de Seguro Social ya hizo un pago inicial de SSI, ya sea en base a mi solicitud o después de un periodo de suspensión o cancelación, o cuando el Estado y yo, de mutuo acuerdo, decidamos cancelar la autorización.

Esta autorización caducará un año (1) después de que el distrito local de servicios sociales la reciba y no tendrá ningún efecto en las futuras solicitudes de SSI que se hagan después de esa fecha.

LIFELINE: (solicitantes / beneficiarios de Asistencia Temporal y/o Cupones para Alimentos) es posible que la Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York *(NYS Office of Temporary and Disability Assistance)* revele su nombre y domicilio a la compañía telefónica. El suministrador de servicios telefónicos puede usar esos datos con objeto de brindarle la tarifa de descuento conocida como *Lifeline.*

Si no desea que se revele este tipo de información, marque esta casilla ☐
Puede comunicarse directamente con la compañía de servicios telefónicos y solicitar el servicio de descuento de *Lifeline.* **Sólo** los solicitantes / beneficiarios de Medicaid deben comunicarse directamente con la compañía de servicios telefónicos y solicitar incripción en el servicio económico de *Lifeline.*

Adultos Habilitados para Trabajar sin Dependientes (ABAWD): si un miembro del grupo familiar que recibe cupones es un Adulto Habilitado para Trabajar sin Dependientes debe informarnos cuando las horas laborales mensuales de esta persona sean menos de 80.

NOTA: la última página de esta solicitud es una solicitud de registro de votante. Si necesita ayuda para llenar la solicitud de registro de votante, pídale a la persona a cargo de su caso que le ayude. El inscribirse o no para votar no afecta de ninguna manera la decisión de esta agencia en cuanto a la cantidad de prestaciones que se le otorgue. Regrese este formulario a la agencia, aunque no lo haya rellenado completamente.