

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

Transmittal:	0.C D.E. 20							
	06-INF-29							
To:	Local District Commissioners							
Issuing Division/Office:	Division of Employment and Transitional Supports							
Date:	Santambar 7, 2006							
Subject:	September 7, 2006							
	Revisions to 12 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):								
	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) 474-8887 or NYC (212) 417-4500							
	WMS Questions: (518) 474-8749							
Attachments:								
	LDSS-3156 NYC; LDSS-4013A; LDSS-4013B; LDSS-4013A NYC; LDSS-4013B							
	NYC; LDSS-4014A; LDSS-4014B; LDSS-4014A NYC and LDSS-4014B NYC							
Attachment Available 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 12 revised client notices.

The Client Notices were revised to:

- add court-stipulated language concerning the "Acevedo" court case to some of the NYC notices
- add to information to the State printed "Action Taken Client Notices" about the New York State Department of Agriculture and Market's "Animal Population Control Program (APCP)"
- make clear that all types of Food Stamp Benefits Overpayment claims are subject to "Compromise".

The following are the 12 notices that are affected.

- 1. **LDSS-3152:** "Action Taken on Your Food Stamp Benefits Case" (Rev. 7/06) (Upstate)
- 2. LDSS-3152 NYC: "Action Taken on Your Food Stamp Benefits Case" (Rev. 7/06) (NYC)
- 3. **LDSS-3156**: "Notice of Food Stamp Benefits Overpayment (Demand Letter) (Timely and Adequate)" (Rev. 7/06) (Upstate)
- 4. **LDSS-3156 NYC:** "Notice of Food Stamp Benefits Overpayment (Demand Letter) (Timely and Adequate)" (Rev. 7/06) (NYC)
- 5. **LDSS-4013A:** "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev. 7/06) (Upstate)
- 6. **LDSS-4013A NYC:** "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev. 7/06) (NYC)
- 7. **LDSS-4013B:** "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev. 7/06) (Upstate)
- 8. **LDSS-4013B NYC:** "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev. 7/06) (NYC)
- 9. **LDSS-4014A:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-A" (Rev. 7/06) (Upstate)
- 10. **LDSS-4014A NYC:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-A" (Rev. 7/06) (NYC)
- 11. **LDSS-4014B:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-B" (Rev. 7/06) (Upstate)
- 12. **LDSS-4014B NYC:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-B" (Rev. 7/06) (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" (Upstate)

FRONT:

- 1. The Revision Date was **changed** to 7/06.
- 2. The following Animal Population Control Program information was **added** as a new number "7" section under the "APPROVED" section.
- 3. 7. ☑ Animal Population Control Program (APCP) If you are approved for Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice

entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

4. The numbering for the "Other Information" section was **changed** from "7" to "8" under the "APPROVED" section.

REVERSE:

The Revision Date was **changed** to 7/06.

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

COVER:

The Revision date was **changed** to 7/06.

FRONT:

- 1. The Revision Date was **changed** to 7/06.
- 2. The following Animal Population Control Program information was **added** as a new number "7" section under the "APPROVED" section.
 - 7. ☑ Animal Population Control Program (APCP) If you are approved for Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.
- 3. The numbering for the "Other Information" section was **changed** from "7" to "8" under the "APPROVED" section.

REVERSE:

The Revision Date was changed to 7/06.

LDSS-3156: "Notice of Food Stamp Benefits Overpayment (Demand Letter) (Timely and Adequate)" (Upstate)

FRONT:

- 1. The Revision Date was **changed** to 7/06.
- 2. In the "REPAYMENT INFORMATION" section, the paragraph below the bulleted section was **revised** to remove references to "Inadvertent Household Error (IHE) and/or an Agency Error (AE)" as all types of claims are subject to "Compromise".

The paragraph was **changed** to read:

If you have a Food Stamp Benefit overpayment that has not been paid back, and your case is now closed or being closed, you may be able to get a compromise (reduction) of what you owe. If you cannot repay the full balance of what you owe, talk to your local

department of social services.

REVERSE:

The Revision Date was **changed** to 7/06.

LDSS-3156 NYC: "Notice of Food Stamp Benefits Overpayment (Demand Letter) (Timely and Adequate)" (NYC)

COVER:

The Revision Date was **changed** to 7/06.

FRONT:

- 1. The Revision Date was **changed** to 7/06.
- 2. In the "REPAYMENT INFORMATION" section, the paragraph below the bulleted section was **revised** to remove references to "Inadvertent Household Error (IHE) and/or an Agency Error (AE)" as all types of claims are subject to "Compromise".

The paragraph was changed to read:

If you have a Food Stamp Benefit overpayment that has not been paid back, and your case is now closed or being closed, you may be able to get a compromise (reduction) of what you owe. If you cannot repay the full balance of what you owe, talk to your local department of social services.

REVERSE:

The Revision Date was **changed** to 7/06.

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

FRONT:

- 1. The Revision Date was **changed** to 7/06.
- 2. Additional lines in the "Public Assistance" section under "Accepted" were **added** to accommodate more information.

REVERSE:

- 1. The Revision Date was **changed** to 7/06.
- 2. A new 5th pre-checked box with the following information was **added**:
 - ☑ Animal Population Control Program (APCP) If you have been approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible

people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

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

FRONT:

The Revision Date was **changed** to 7/06.

REVERSE:

- 1. The Revision Date was **changed** to 7/06.
- 2. A new 5th pre-checked box with the following information was **added**:

☑ Animal Population Control Program (APCP) – If you have been approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

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

FRONT:

The Revision Date was **changed** to 7/06.

REVERSE:

The Revision Date was **changed** to 7/06.

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

FRONT:

The Revision Date was **changed** to 7/06.

REVERSE:

The Revision Date was **changed** to 7/06.

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

FRONT:

The Revision Date was **changed** to 7/06.

REVERSE:

- 1. The Revision Date was **changed** to 7/06.
- 2. A new 5th pre-checked box with the following information was **added**:

☑ Animal Population Control Program (APCP) – If you have been approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

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 7/06.

REVERSE:

- 1. The Revision Date was **changed** to 7/06.
- 2. The following "sanction for non-cooperation" language was added:

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 contin	ue
until contacts 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 action(s). If did not cooperate but now wants to report a good reast 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 the months. 	ree
To find out more information about how to end the sanction, call ()	.•

3. A new 5th pre-checked box with the following information was **added**:

☑ Animal Population Control Program (APCP) – If you have been approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have

their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

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

FRONT:

The Revision Date was **changed** to 7/06.

REVERSE:

The Revision Date was **changed** to 7/06.

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

FRONT:

The Revision Date was **changed** to 7/06.

REVERSE:

The Revision Date was **changed** to 7/06.

III. Forms Ordering Information

We expect that the revised 7/06 versions of the LDSS-3152, LDSS-3152 NYC, LDSS-3156, LDSS-3156 NYC, LDSS-4013A and LDSS-4013A NYC, LDSS-4013B, LDSS-4013B NYC, LDSS-4014A, LDSS-4014A NYC, LDSS-4014B and LDSS-4014B, NYC will be printed and delivered to the Albany and NYC/HRA warehouses by the end of December, 2006. Upon receipt of the revised forms, your district will be shipped an initial supply.

The Spanish versions of these notices (LDSS-3152-SP, LDSS-3152-SP NYC, LDSS-3156-SP, LDSS-3156-SP, NYC, LDSS-4013A-SP, LDSS-4013A-SP NYC, LDSS-4013B-SP, LDSS-4013B-SP NYC, LDSS-4014A-SP, LDSS-4014A-SP NYC, LDSS-4014B-SP and LDSS-4014B-SP NYC) will follow. Upon receipt of any of the revised notices, all previous versions of the forms **must immediately be destroyed**.

 Any future written requests for printed or camera ready only copies of the English and Spanish versions of the Client Notices, should be submitted on OTDA-876 "Request For Forms or Publications", and should be sent to:

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

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

- Camera Ready Copies of the documents may also be ordered through Outlook. To order a Camera Ready Copy you must obtain an OTDA-876 electronically by going to the OTDA Intranet Website at http://otda.state.nyenet/ then to Division of Program Support & Quality Improvement page, then to PSQI E-Forms page (this page contains the electronic OTDA-876).
- For those who do not have Outlook but who have Internet access for sending and receiving email, the Internet email address is: gg7359@dfa.state.ny.us. For a complete list of available forms, please refer to OTDA Intranet site: http://otda.state.nyenet/ldss_eforms/default.htm.

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-10 86 ADM-7 85 ADM-45 85 ADM-17 82 ADM-55 82 ADM-5 81 ADM-55 80 ADM-90 05 INF-15 04 INF-26 03 INF-15 01 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-28		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

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE

NOTICE DATE:				NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE			
CASE NUMBER CIN NUMBER			ER				
	CASE NAME (And C/O Na	me if Present) AND	ADDRESS				
	5/102 / W W. W. E. W.			GENERAL TELEPHONE NO. FOR			
I				QUESTIONS OR HELP			
				OR Agency Conference Fair Hearing information			
				and assistance			
1				Record Access			
ш.				Legal Assistance information			
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAM	E TELEPHONE NO.			
The action	n(s) taken on your appl	ication/recertific	ation request for Foo	d Stamp Benefits dated is			
	below, next to the che						
	FOOD STAN	IP BENEFITS N	NOT PICKED UP WIT	HIN 270 DAYS CANNOT BE REPLACED.			
				to			
1. 🗆	You will get \$ must figure your first r	nonth's henefit t	for the month	ofbecause we			
10				y access your benefit on			
				·			
10				because you gave us proof after it was due.			
2. 🗌				efit for the months of and			
			.This is because	e you applied/provided proof after the 15 th of the month. Your			
	the month. Your secon	⁻\$ nd month's bene	was efit of \$	s figured from the date you applied/provided proof to the end of is for the entire month.			
3. 🗌				monthly in Food Stamp Benefits.			
	You may access these	e benefits on the	e day of e	ach month.			
4. 🗌	Beginning		you will get \$	monthly in Food Stamp Benefits.			
	You may access these						
5. ⊔	is the proof you still no	ed to provide: _		ulated your benefit without all the necessary proof. Listed here			
				re unless you provide this proof. This proof will be used to od Stamp Benefits change due to this proof, you will not be			
6. 🗹	If you applied for Publyou will not get a notice			Food Stamp Benefits might go down or might stop. If this happen			
7. 🗹	Department of Agricu Through the animal p	ulture and Mark population contr	ets has a program to program, eligible p	are approved for Food Stamp Benefits, the New York State that can help pay to have your dog or cat spayed/neutered. Decople can have their cat or dog spayed/neutered for \$20.00. Deceive an application voucher for this program, call 1-866-402-			
8. 🗆	Other Information:						
☐ <u>DENIE</u>	<u>D</u> for Food Stamp Ber	nefits because:					
				Food Stamp Benefits. If you give us this proof we listed above reapply. After that date, you will have to reapply.			
	PAYMENT INFORMAT			respective trace dates, you will have to reapply.			
OVER		• •		ecause you or your household got more in Food Stamp			
	Benefits than you sho	uld have. See th	ne Demand Letter (an	d also, if your case is closing, the Repayment Agreement) for ased on 18 NYCRR 387.19.			
	You currently have a F	Food Stamp Ber	nefits overpayment. If	your case is closing, see the Demand Letter and Repayment and how you will repay this overpayment.			
	•	3 above reflect	s a% reduction	(recoupment) of \$ in your benefits in order to			
		4 above reflect	s a% reduction (r	ecoupment) of \$ in your benefits in order to			
The abov	e decision(s) is based	d on 18 NYCRF					

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

LDSS-3152 (Rev. 7/06) Reverse	FS App/Reapp/OP Recoup/Ad Only/No A/C

NAME:	ADDRESS:	CASE NUMBER:

<u>National School Lunch/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):

- Responsibility To Report Changes See the enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.
- If you were denied Food Stamp Benefits, please tell this agency if you are later approved for Supplemental Security Income (SSI) or Family Assistance (FA), since this may mean you can get Food Stamp Benefits.
- 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** of this notice.

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

If you think our decision was 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.
- 1. <u>CONFERENCE</u> (informal meeting with us) If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice **or** write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.
- 2. **STATE FAIR HEARING** You have **90** days from the date of this notice to ask for a fair hearing.

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by:

<u>Mail:</u> Send a copy of the entire notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

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

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

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

<u>Online</u>: 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 "I awyers".

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 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 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 مسؤول 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.

FS App/Reapp/OP Recoup/Ad Only

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE (NYC)

NOTICE DATE:						NAME AND A	DDRESS OF AGEN	NCY/CENTER OR DIST	RICT OFFICE
CASE NUMB	ER		CIN NU	IMBER					
	CASE	NAME (And C/O Na	mo if Procent)	VND VDD	DESS				
	OAGL	NAME (AND 6/0 Na	ille ii Fresent) A	AND ADDI			LEPHONE NO. FO		
ı					ı		ncy Conference		
						Fair	Hearing information	 1	
							assistance		
						Reco	ord Access		
		 	†	-			l Assistance inform	nation	
OFFICE NO.		UNIT NO.	WORKER NO	. UNI	T OR WORKER NA	AME		TELEPHONE NO.	
		ken on your appl , next to the che			n request for Fo	ood Stamp Ber	efits dated		is
		FOOD STAN	IP BENEFI	rs not	PICKED UP W	/ITHIN 270 DA	YS CANNOT E	BE REPLACED.	
	OVED	for Food Stamp	Benefits from	m			to		
1. 🗆									
	must	figure your first r	month's bene	efit from	:				
1a	а. 🗌 Т	he date you app	lied to the e	nd of the	e month. You m	nay access you	ır benefit on		•
115		he latest date yo	-	-		-	-	f after it was due. 	
2. 🗆	Youw	vill act \$,	which is	a combined be	nefit for the mo	onthe of		and
	first m	nonth's benefit of onth. Your second	f \$ nd month's t	penefit o	This is becau w f \$	se you applied as figured fron	d/provided proon the date you a is for the entire	of after the 15" of t applied/provided p e month.	he month. Your proof to the end of
	You n	nay access your	combined b	enefit or	n		•		_ •
3. 🗆								monthly in Food S	tamp Benefits.
4. 🗆	You may access these benefits on the day of each month. Beginning monthly in Food Stamp Benefits.								
		nay access these						, ,	
5. 🗆		ou could get Food proof you still ne						all the necessary p	roof. Listed here —
		mine the Food S						proof. This proof widue to this proof, y	
6. 🗹	,	applied for Publ					Benefits migh	nt go down or migh	t stop. If this happer
7. 🗹	Depar anima	rtment of Agricult	ure and Marl trol program,	kets has eligible	a program that people can hav	can help pay to re their cat or o	have your dog log spayed/neut	tamp Benefits, the or cat spayed/neu tered for \$20.00. 1-866-402-0666.	tered. Through the
8. 🗆	Other	Information:							
☐ <u>DENIE</u>	D for	Food Stamp Ber	nefits becaus	se:					
								ou give us this proc	
						o reapply. Afte	r that date, you	ı will have to reapp	bly.
		ENT INFORMAT				t hooguas ::	or vous barrail	oold got mars != F	and Stomm
	Benef		uld have. Se	e the D	emand Letter (a	and also, if you	ır case is closin	nold got more in Fo ng, the Repayment I.	
		currently have a lement for more in						ne Demand Letter verpayment.	and Repayment
		enefit in Section your overpayme						in your be	nefits in order to
	The b		4 above ref	lects a _	% reduction	(recoupment)	of \$	in your bene	efits in order to
	Other	·							
The abov	e deci	sion(s) is base	d on 18 NY(CRR					

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

NAME:	ADDRESS:	CASE NUMBER:						
National School Lunch/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 name(s):								

- Responsibility To Report Changes See the enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.
- If you were denied Food Stamp Benefits, please tell this agency if you are later approved for Supplemental Security Income (SSI) or Family Assistance (FA), since this may mean you can get Food Stamp Benefits.
- 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** of this notice.

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

If you think our decision was 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.
- 1. <u>CONFERENCE</u> (informal meeting with us) If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice **or** write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.
- 2. **STATE FAIR HEARING** You have **90** days from the date of this notice to ask for a fair hearing.

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by:

<u>Mail:</u> Send a copy of the entire notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

include a written explanation.)
, ————————————————————————————————————

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

<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

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

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

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.

NOTICE OF FOOD STAMP BENEFITS OVERPAYMENT (DEMAND LETTER) (Timely and Adequate)

NOTICE OF FOOD CIAMI	DENE	110 OVER AT	MILIAI (DEMAND ELITI	=ity (Timoly and Adoquate)
NOTICE DATE:			NAME AND ADDRESS OF AGENC	CY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBE	R	_	
CASE NAME (And C/O Name if I	Present) AND	ADDRESS	GENERAL TELEPHONE NO. FOR	
			OLIESTIONS OF HELD	·
			OR Agency Conference	
			Fair Hearing information and assistance	
		1	Record Access	
			Legal Assistance informa	tion
OFFICE NO. UNIT NO. WOF	RKER NO.	UNIT OR WORKER N	IAME	TELEPHONE NO.
OVERPAYMENT INFORMATION			Data of Diagonami	
1. New Overpayment Amount \$				household got more in Food Stamp
Benefits than you should have	(overpaym	ent). This is becau	se:	The decision of the first of th
1a. We incorrectly gave you below:	ı or your h	nousehold more be	enefits than you should have	gotten (<u>Agency Error</u>); see <u>Reason</u>
rules. If we decide that period of time. The aminstead of one to calcula was an intentional violati Reason: This decision is based on 18 NYCR (12) months from the date of discovers. Amount You Still Owe on Para You or your household were not calculated to the period of time. The amount period of time. The amount period of time. The period of time. The amount period of time. The period of time	it was, you count you de the amoon. R 387.19. ery. Enclose st Overpa	we us may also in a form that show a may be a form that show a form of a Food Stame.	d member will not be able to ncrease. With an intentional was Benefits you owe. We will sent the amount of this type of ove ows how your overpayment was ap Benefits overpayment(s). The	rpayment back to a period of twelve as calculated. ne amount on Line 2 is what you still
	on the fac	t that you have an		that have already been made. You already notified of the overpayment
3. TOTAL You Owe for All New	and Past	Overpayment(s) \$. (Total of Lines 1 + 2)
REPAYMENT INFORMATION – All to 18 NYCRR 387.19, to repay this a		bers in the househ	nold at the time the overpayme	ent occurred are required, according
1. Reduction of Your Food Stamp	Benefits F	or Active/Open Ca	ises:	
			amp Benefits (recoupment) to affect your Food Stamp Benefi	pay back your overpayment. See ts.
	nen this cu	rrent recoupment h	as been completed, we will tal	tion of your Food Stamp Benefits will ke at least ten percent (10%) of your
1c. ☐ Continue Recoupment –	We will co	ntinue your current	recoupment until your current	overpayment is paid off.
In addition to your recoupment, yo	ou may voli	untarily pay back m	ore, including using benefits fr	om your EBT account.
2. \square Collection Methods for Closed	Cases (you	ı may request one	or both collection methods):	
				nent Agreement Request gives you Compromise/Repayment Agreement

- Request for Compromise You may request a compromise (reduction) of your debt. We may approve or deny your request for a Repayment Agreement or Compromise. Your request will be considered and acknowledged in a separate notice.
- Within thirty (30) days, a payment must accompany your response to this demand letter.

If you have a Food Stamp Benefit overpayment that has not been paid back, and your case is now closed or being closed, you may be able to get a compromise (reduction) of what you owe. If you cannot repay the full balance of what you owe, talk to your local department of social services.

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges. This decision is based on 31 CFR 285.

If you do not access your Food Stamp Benefits (FSB) within 270 days, they will be expunged (taken back). If you have a FSB overpayment, your expunged benefits will be put towards your overpayment. If you apply for FSB again, and have not repaid the amount you owe, your FSB will be reduced if you begin to get FSB again. You will be notified, at that time, of the amount of reduced benefits you will get.

BE SURE TO READ THE BACK OF THIS NOTICE TO SEE WHAT RIGHTS YOU HAVE TO APPEAL THIS DECISION.

Enclosure

LDSS-3156 (Rev. 7/06) Reverse		FS AE/IHE-A	ctive/Closing/Closed Case-New/Previous OP/Timely
NAME:	ADDRESS:		CASE NUMBER:
Responsibility To Report Changes – report changes.	See enclosed LDSS-3151: '	Food Stamp Change R	eport Form" for information on when to
CONFERENCE AND FAI	R HEARING SECTIO	N – DO YOU THIN	IK WE ARE WRONG?
If you think our decision is wrong, you can as	sk for a review of our decision	. We will correct our mist	akes. You can do both 1 and 2:
1. Ask for a meeting (conference) with one of	f our supervisors;	2. Ask for a State fair h	earing with a State hearing officer.
call us to set up a meeting. To do this,	, call the conference phone n is is the fastest way to solve	umber on the front of th	u do not understand our decision, please is notice or write to us at the address on ave. We encourage you to do this even
If you <u>only</u> ask for a meeting with us, w if you ask for a State fair hearing. (See			eal. Your benefits will stay the same only
2. STATE FAIR HEARING - You	u have 90 days from the date	of this notice to ask for a	a fair hearing.
	days of the date of this notice	e. If you do not call for a	ay them back and you do not agree, you fair hearing within 90 days of the date of as wrong.
effective date stated in this notice. Ho	wever, if you lose the fair he g for the decision. If you do n	aring, you will have to pa ot want your benefits to s	if you ask for a fair hearing before the ay back any benefits you got, but should tay the same until the decision is issued, the box below:
☐ I do not want to keep my Food Sta	amp Benefits the same until th	ne fair hearing decision is	sissued.
HOW TO ASK FOR A FAIR HEARING: You	can ask for a fair hearing by	mail, by phone, by fax o	or online .
<u>Mail:</u> Send a copy of this notice <i>comp</i> and Disability Assistance, P.O. Box 1930			New York State Office of Temporary for yourself.
_			

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

a written explanation.)

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.

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

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 get ready for the hearing, you have a right to look at your case file. If you call or write 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 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 مسؤول 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.

OTICE DATE:				NAME AND ADDRESS OF AGENC	CY/CENTER OR DISTRICT OFFICE
ASE NUMBER		CIN NUMBE	R		
C	ASE NAME (And C/O	Name if Present) AND	ADDRESS		
	ACE NAME (AND OFC	ivalile ii i resentį Aivo	ADDICESS	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	
			ı	OR Agency Conference	
				Fair Hearing information	
			1	and assistance Record Access	
_					
FFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAM	-	TELEPHONE NO.
OVERPAYN	MENT INFORMAT	ION	1		
				Date of Discovery	
We di Benefi	scovered that fro	m ı should have (ove	to to		ur household got more in Food Stamp
1a. 🗌	We incorrectly ga	ve you or your hou	usehold more benefit	s than you should have gotte	en (<u>Agency Error</u>); see <u>Reason below:</u>
		•			ted in us giving you more benefits thar
			Ve may calculate the		payment back to a period of twelve (12
months from	the date of disco	very. Enclosed is	a form that shows ho	w your overpayment was ca	lculated.
	_	on Past Overpay			
owe. \ not all	You have a right to	o a fair hearing thang on the fact that	at this amount is cor	rect and shows all payments	The amount on Line 2 is what you still that have already been made. You are dry notified of the overpayment and were
B. TOTA	L you owe for al	I New and Past O	verpayment(s) \$		(Total of Lines 1 + 2)
	NT INFORMATION 387.19, to repay t		bers in the househo	ld at the time the overpayme	ent occurred are required, according to
1. ☐ <u>Reduc</u>	ction of Your Food	I Stamp Benefits F	or Active/Open Case	es:	
				enefits (recoupment) to pay Food Stamp Benefits.	back your overpayment. See separate
	made at this time	. When this currer		een completed, we will take a	tion of your Food Stamp Benefits will be at least ten percent (10%) of your Food
1c. \square	Continue Recoup	ment – We will co	ntinue your current re	ecoupment until your current	overpayment is paid off.
In additio	n to your recoupn	nent, you may volu	ıntarily pay back mor	e, including using benefits fr	om your EBT account.
2. Collect	tion Methods for C	Closed Cases (you	may request one or	both collection methods):	
					nt Agreement Request gives you way nise/Repayment Agreement Request.

- Request for Compromise You may request a compromise (reduction) of your debt. We may approve or deny your request for a Repayment Agreement or Compromise. Your request will be considered and acknowledged in a separate notice.
- Within thirty (30) days, a payment must accompany your response to this demand letter.

If you have a Food Stamp Benefit overpayment that has not been paid back, and your case is now closed or being closed, you may be able to get a compromise (reduction) of what you owe. If you cannot repay the full balance of what you owe, talk to your local department of social services.

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If you do not access your Food Stamp Benefits (FSB) within 270 days, they will be expunged (taken back). If you have a FSB overpayment, your expunged benefits will be put towards your overpayment. If you apply for FSB again, and have not repaid the amount you owe, your FSB will be reduced if you begin to get FSB again. You will be notified, at that time, of the amount of reduced benefits you will get.

BE SURE TO READ THE BACK OF THIS NOTICE TO SEE WHAT RIGHTS YOU HAVE TO APPEAL THIS DECISION.

Enclosure

DISTRIBUTION: White-Client/Fair Hearing Copy Yellow-Client Copy Pink-Agency Copy

NAM	SS-3156 NYC (Rev.7/06) Reverse	ADDRESS:	FS AE/IHE	-Active/Closing/Closed Case-New/Previous OP CASE NUMBER:	7 i imeiy
INAIV	viL.	ADDINESS.		OAGE NOWIDEN.	
V	Responsibility To Report Changes – changes.	See enclosed LDSS-3151:	"Food Stamp Change Re	eport Form" for information on when	n to repor
	CONFERENCE AND F	AIR HEARING SECT	TION – DO YOU TH	IINK WE ARE WRONG?	
f yo	ou think our decision is wrong, you can a	sk for a review of our decision	n. We will correct our mist	akes. You can do both 1 and 2:	
1. A	ask for a meeting (conference) with one c	of our supervisors;	2. Ask for a State fair h	earing with a State hearing officer.	
1.	CONFERENCE (informal meeting us to set up a meeting. To do this, cal this notice. Sometimes this is the faste for a fair hearing.	I the conference phone numb	per on the front of this not	tice or write to us at the address on th	ne front o
	If you only ask for a meeting with us, ask for a State fair hearing. (See Keep			eal. Your benefits will stay the same	only if you
2.	STATE FAIR HEARING - Yo	ou have 90 days from the date	e of this notice to ask for a	a fair hearing.	
	If this notice is telling you that you go MUST call for a fair hearing within 90 notice, you cannot claim in the future to	days of the date of this notice	ce. If you do not call for	a fair hearing within 90 days of the d	
	KEEPING YOUR BENEFITS THE SA date stated in this notice. However, if y while you were waiting for the decision when you call for a fair hearing or, if yo	you lose the fair hearing, you n. If you do not want your ben	will have to pay back any efits to stay the same unt	benefits you got, but should not have	e gotten,
	I do not want to keep my Food S	tamp Benefits the same until	the fair hearing decision is	s issued.	
НΟ\	W TO ASK FOR A FAIR HEARING: You	u can ask for a fair hearing by	r.		
	<u>il</u> : Send a copy of the entire notice c d Disability Assistance, P.O. Box 193				orary
	I want a fair hearing. I do not agre	e with the agency's action	. (You may explain why	you disagree below, but you do	not

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

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

have to include a written explanation.)

<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.

<u>Online</u>: 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, by walk-in or online, please write to ask for a fair hearing before the deadline.

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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.

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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.

LDSS-4013A (Rev. 7/06) ACTION TAKEN ON YOUR APPLICATION: PART A PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE

NOTICE	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
DATE: CASE NUMBER CIN NUMBER	
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 NO. UNIT OR WORKER N	JAME TELEPHONE NO.
The action(s) taken on your application dated	
SEE <u>PART B</u> FOR FOOD STAMP BENE PUBLIC ASSISTANCE	FITS AND FAIR HEARING INFORMATION.
	to You will got
\$ which will cover the period	to You will get After
this you will get \$	
-	-
☐ A RECOUPMENT at the rate of percent (%) is being taken against your Public Assistance
	family an undue hardship, you should contact your worker to explain
	es not have enough income to eat, to pay for shelter or utilities, to get
	ay for medical needs not covered by Medical Assistance. Your worker
	w that the recoupment at this rate will cause an undue hardship. If we b, the recoupment rate will be changed to a rate between 5 and 10%.
The recoupment rate must be at least 5%. This decision is	-
☐ DENIED for [name(s)]	because
OTHER	
The above decision(s) is based on 18 NYCRR	
The above decision(s) is based on 18 NYCRR	
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- 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.
- Animal Population Control Program (APCP) If you have been approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013A NYC (Rev. 7/06) **ACTION TAKEN ON YOUR APPLICATION:** PA, MA, FS App PART A PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC) NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE NOTICE DATE: CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO FOR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information WORKER NO OFFICE NO UNIT NO UNIT OR WORKER NAME TELEPHONE NO is explained below and on Part B, next to the checked box(es) lacksquare: 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 to _____, which will cover 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 ___ . Read the detailed instructions on the back of this notice. To lift this sanction, call (_ failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]: ☐ assessment ☐ rehabilitation 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). □ DENIED for [name(s)]____ _____ because__ The above decision(s) is based on 18 NYCRR _ **MEDICAL ASSISTANCE** _____for [name(s)] _____ ☐ ACCEPTED for Medical Assistance effective ___ ☐ 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 \$ _ _____. The difference between your net income and this standard (\$______) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program. □ **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 contact us no later than _____ so we can tell you the information we ☐ Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.

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

□ Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance.

This above decision(s) is based on

☐ OTHER

Te	Lift a Sanction for Non-cooperation with a Child Support Requirement
A sanction for n	ion-cooperation with a child support requirement is open-ended and will continue until
When	contacts the Child Support Enforcement Unit and cooperates. contacts the Child Support Enforcement Unit, he or she will be told what
	e taken to end the sanction. The sanction will end when he or she takes the required
	did not cooperate but now wants to report a good reason for not
	child support he or she should call () .
	· ·
Some examples of	of a good reason for not cooperating with child support are:
 fear of emotion 	onal or physical harm to you or the children in your family; or,
	born due to rape or incest; or,
	eed for adoption; or, you are now being assisted by an agency to determine whether to put
	or adoption and discussions have not gone on for more than three months.
•	
	information about how to end the sanction, call () .

Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.

Even if you are no longer eligible for Public Assistance or Medical Assistance, 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.
- Animal Population Control Program (APCP) If you have been approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013B (Rev. 7/06)

ACTION TAKEN ON YOUR APPLICATION: PART B

ART B PA, MA, FS, App

PUBLIC ASSISTANCE	FOOD STAMP	BENEFITS A	ND MEDICAL	ASSISTANCE COVERAGE			

NOTICE DATE:			PUBLIC ASS	OISTANCE,	гоор	STAWIF DE	INEFI			CENTER OR DISTRICT	OFFICE
CASE NU	MBEF	₹		CIN NU	JMBER						
	(CASE I	NAME (And C/O Nam	e if Present) Al	ND ADD	RESS					
							7	GENERAL TELI QUESTIONS O	EPHONE NO. FOR R HELP		
								Fair H	cy Conference Hearing information assistance		
ı							ı	Reco	rd Access		
OFFICE N	10		UNIT NO.	WORKER NIII	MDED	UNIT OR WO	DVED V	<u>-</u>	Assistance informa	TELEPHONE NUM	
OFFICE	10.		UNIT NO.	WORKER NO	WIDER	UNIT OR WO	KKEKI	NAME		TELEPHONE NUM	DEK
The ac										w and on <u>Part A,</u> ne INFORMATION.	ext to the checked
			FOOD STA	MP BENEI	FITS N	OT PICKED	O UP V	WITHIN 270 DA	YS CANNOT B	E REPLACED.	
☐ <u>A</u>	PR	OVE	of for Food Stamp	Benefits fro	om			to _			
1.			will get \$ month's benefit			for th	e mor	nth of		becaus	se we must figure
	1a.		The date you ap	plied to the	end of	the month.	You m	nay access you	r benefit on		
	1b.		The latest date y							after it was due.	
2.		You	will aet \$			which	is a co	ombined benefi	t for the months	s of	
		and mon the	th's benefit of \$	cond month	 's ben	This is be	cause w	you applied/pr as figured fron	rovided proof af	ter the 15 th of the applied/provided pr is for the entire	month. Your first oof to the end of
3.			•							monthly in Food St	amp Benefits.
			may access the							•	•
4.		Begi	nning			you w	ill get	\$	n	nonthly in Food Sta	mp Benefits.
		You	may access thes	se benefits o	on the		da	y of each mont	h.		
5.										II the necessary pro	
			rmine the Food							nis proof. This proof	
6.	$\overline{\checkmark}$		u applied for Put will not get a noti						Benefits might	go down or might s	top. If this happens,
7.		Other	Information:								
□ <u>DI</u>	NIE	 D for	Food Stamp Be	nefits for [n	ame(s))] because:					
	Yo	ou dic	I not give us the							give us this proof wo reapply.	ve listed above by
□ <u>o</u>	THE	R :									
_ <u>'0</u>	/ER	PAYI	MENT INFORMA	TION (chec	k all th	at apply)					
	th	an yo		See the D	eman	d Letter (ar	nd als	o, if your case	is closing, the	d got more in Foo e Repayment Agre	
			rrently have a F nent for more info							the Demand Letter syment.	and Repayment
			nefit in Section our overpaymen) of \$	in your be	enefits in order to
	re	pay	your overpaymer	nt. This deci	sion is	based on 1	8 NYC	CRR 387.19.	-	in your be	enefits in order to
The ab	ove	deci	sion(s) is based	on 18 NYC	CRR: _						

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

LDSS-4013B (Rev. 7/06) (Part B) Reverse	PART B	PA, MA, FS App – No A/C – Adequate
NAME:	ADDRESS:	CASE NUMBER:
	the National School Lunch and/or Breakfa	approved to receive free lunch and/or breakfast if he or lest Programs. To receive this benefit, you must take or
	o free meals if they attend a program such as your records so you can provide it to the spo	s a school, club or camp that participates in the Summer nsor.
List Child(ren)'s name(s):		
Responsibility To Report Changes - changes.	- See enclosed LDSS-3151: "Food Stamp Ch	hange Report Form" for information on when to report
CONFERENCE AN	D FAIR HEARING SECTION - DO Y	YOU THINK WE ARE WRONG?
If you think our decision was wrong, and 2:	you can ask for a review of our decision	n. We will correct our mistakes. You can do both 1
1. Ask for a meeting (conference) wit	th one of our supervisors; 2. Ask for	or a State fair hearing with a State hearing officer.
please call us to set up a meeting the address on the front of this	. To do this, call the conference phone	number on the front of this notice or write to us at
please call us to set up a meeting the address on the front of this encourage you to do this even wh	i. To do this, call the conference phone is notice. Sometimes this is the fastest en you have asked for a fair hearing.	number on the front of this notice or write to us at
please call us to set up a meeting the address on the front of this encourage you to do this even wh	i. To do this, call the conference phone is notice. Sometimes this is the fastest en you have asked for a fair hearing.	wrong, or if you do not understand our decision, number on the front of this notice or write to us at t way to solve any problem you may have. We e date of this notice to ask for a fair hearing:
please call us to set up a meeting the address on the front of this encourage you to do this even wh	D. To do this, call the conference phone is notice. Sometimes this is the fastest en you have asked for a fair hearing. EVEL TO THE TO	number on the front of this notice or write to us at tway to solve any problem you may have. We e date of this notice to ask for a fair hearing:
please call us to set up a meeting the address on the front of this encourage you to do this even wh 2. STATE FAIR HEARING – You ha	D. To do this, call the conference phone is notice. Sometimes this is the fastest en you have asked for a fair hearing. EVEL TO THE TO	number on the front of this notice or write to us at tway to solve any problem you may have. We e date of this notice to ask for a fair hearing:
please call us to set up a meeting the address on the front of this encourage you to do this even wh 2. STATE FAIR HEARING – You have Public Assistance, Medical Assistance Food Stamp Benefits	i. To do this, call the conference phone is notice. Sometimes this is the fastest en you have asked for a fair hearing. In the stance of the stance of the stance, Social Services	number on the front of this notice or write to us at t way to solve any problem you may have. We e date of this notice to ask for a fair hearing: TIME LIMIT 60 days 90 days
please call us to set up a meeting the address on the front of this encourage you to do this even wh 2. STATE FAIR HEARING – You have Public Assistance, Medical Assistance Food Stamp Benefits HOW TO ASK FOR A FAIR HEARING HAMING FOR A COPY OF Part A and P	Description of the conference phone is notice. Sometimes this is the fastest en you have asked for a fair hearing. BENEFIT AREA stance, Social Services NG: You can ask for a fair hearing by materials.	number on the front of this notice or write to us at t way to solve any problem you may have. We e date of this notice to ask for a fair hearing: TIME LIMIT 60 days 90 days ail, by phone, by fax or online. earings, New York State Office of Temporary and

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 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.

PA, MA, FS, App

LDSS-4013B NYC (Rev. 7/06) **ACTION TAKEN ON YOUR APPLICATION:** PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC) NOTICE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE DATE: 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 LINIT 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 □ 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. \square 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 \$ _ is for the entire month. You may the month. Your second month's benefit of \$ access your combined benefit on ___ _ you will get \$____ 3. Beginning _ monthly in Food Stamp Benefits. 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. \square 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 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. ☐ OTHER: 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. \square 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

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

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

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

LDSS-4013B NYC (Rev. 7/06) (Part B) Reverse	PART B - NYC	PA, MA, FS App - No A/C - Adequate
NAME:	ADDRESS:	CASE NUMBER:
	rams - The child(ren) listed below are approved to re National School Lunch and/or Breakfast Programs. our child attends.	
This notice also entitles your child(ren) to free Food Service Program. Make a copy for your	e meals if they attend a program such as a school, clurecords so you can provide it to the sponsor.	ub or camp that participates in the Summer
List Child(ren)'s name(s):		
Responsibility To Report Changes -	- See enclosed LDSS-3151: "Food Stamp Chan	ge Report Form" for information on

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

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

- 1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer.
- 1. <u>CONFERENCE</u> (Informal meeting with us) If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.
- 2. **STATE FAIR HEARING** You have the following number of days from the date of this notice to ask for a fair hearing:

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

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

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

☐ I want a fair hearing. written explanation.)	0 ,	You may explain why you disagree 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 of this notice to: **(518) 473-6735**.

when to report changes.

<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 or 330 West 34th Street, NYC.

<u>Online</u>: 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 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.

LDSS-4014A (Rev. 7/06) ACTION TAKEN ON YOUR RECERTIFICATION: PART A PA, MA, FS, Serv-Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES

NOTI DA	CE TE:	210 71001017111	<u>, : 005 017</u>		NAME AND ADDRESS OF AGENCY/CE	ENTER OR DISTRICT OFFICE
CASE	NUMBER		CIN NUMBER		-	
	CASE N	NAME (And C/O Nam	e if Present) AND ADD	RESS	GENERAL TELEPHONE NO. FOR	
					QUESTIONS OR HELP	
					OR Agency Conference Fair Hearing information	
					and assistance Record Access	
L	_				Legal Assistance information	
OFFIC	CE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER	NAME	TELEPHONE NUMBER
The	action(s) tak	en on your recer	rtification dated		is explained	d below and on <u>Part B</u> , next to
the	checked box	•				
PUF	BLIC ASSIST	<u> </u>	TB FOR FOOD S	STAMP BENEFIT	S AND FAIR HEARING INFORM	IATION.
			from		to	
Г	DEDUCE	your monthly Pul	hlic Assistanco hon	ofit for that paried	offoctivo	
L			to \$	·	effective	
	¬ worea	SE	N. I. P A	6. 6	. Latter of the	
L		-	ublic Assistance be to \$	•	od effective	
_						
L	CONTIN	UE your Public A	Assistance benefit	unchanged at \$_		·
	If you bel reason. A clothing, t what kind recoupme	ieve the recoupm in undue hardship to buy general ite If of proof you wi ent will cause an i	nent at this rate will o means that a persons of need, or to pail need to show the	I cause your family son does not have ay for medical nea nat the recoupment e recoupment rate	taken against your Public Assistance y an undue hardship, you should do enough income to eat, to pay for seeds not covered by Medical Assistant at this rate will cause an undue will be changed to a rate betweer 31(d).	contact your worker to explain your shelter or utilities, to get necessary ance. Your worker will let you know e hardship. If we decide that the
					· · ·	
The	REASON for	this action is				
The	above decis	ion(s) is based o	on 18 NYCRR			
	DICAL ASSI					
			tance coverage for	[name(s)]		unchanged.
	CONTINUE	the Medical Assis	tance coverage for	[name(s)]		
	the receipt of	f information nece	essary to decide co	ntinued eligibility. F	Please contact us no later than	pending
					so we can te	
			_	- ' '-	review of eligibility. We will send yo	
	REDUCE the	e Medical Assista	nce coverage effec	tive	for [name(s)]	
	deductions a	re \$	The differe	nce between these	hly income is \$ e is your monthly net income for Mo	edical Assistance.
	between you	r net income and	this standard (\$		nily household your size is \$ _) is your monthly excess income (n and Optional Pay-In Program.	
	enective			necause		
		=			cal Assistance (See attached Medic	
	support payn	nents.			due to receipt o	•
The			on			
still Soci	can get Social Services.	al Services at you At your recertifica	ur next scheduled ation, we will do a	recertification. This redetermination to	sistance and Medical Assistance B s does not necessarily mean that to see if you can continue to get e number at the top of this notice.	you will no longer be able to get 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 (Rev. 7/06) (Part A) Reverse	PART A	PA, MA, FS, Serv – Recert
NAME:	ADDRESS:	CASE NUMBER:

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.
- Animal Population Control Program (APCP) If you have been approved to continue to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

PART A **ACTION TAKEN ON YOUR RECERTIFICATION:** LDSS-4014A NYC (Rev.7/06) PA, MA, FS, Serv-Recert PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC) NOTICE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE DATE: 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 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 B, next to the checked box(es) **≤**: SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION. **PUBLIC ASSISTANCE** ☐ **RECERTIFIED** for the period from _ ☐ 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 [18NYCRR 352.3(d)]: Read the detailed instructions on the back of this notice. To lift this sanction, call (____ ____ failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]: □ screening □ assessment □ rehabilitation or, has not provided consent or revoked consent to disclose treatment information to the agency. □ **REDUCE** your monthly Public Assistance benefit for that period effective __ _____ to \$ _ ☐ INCREASE your monthly Public Assistance benefit for that period effective _ to \$ _ ☐ **CONTINUE** your Public Assistance benefit unchanged at \$ percent (%) is being taken against your Public Assistance. A RECOUPMENT at the rate of 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)] _ 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)] ____ to coverage with a SPENDDOWN. Your total gross monthly income is \$ ______ __ . Your total monthly deductions are _ . The difference between these is your monthly net income for Medical Assistance. This is \$ _ The allowable income standard for a family household your size is \$ ______. The difference between your net income and _) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program. □ **DISCONTINUE** Medical Assistance for [name(s)] because

☐ Medical Assistance coverage will continue until ____ _____due to receipt of/increase in child or spousal support payments. The above decision(s) is based on SERVICES - If you are getting Social Services and lose your Public Assistance and Medical Assistance Benefits, we will need to see if you still can get Social Services at your next scheduled recertification. This does not necessarily mean that you will no longer be able to get Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any questions, please contact your Services worker

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

or call the general phone number at the top of this notice.

NAME:	ADDRESS:	CASE NUMBER:

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 () .

\checkmark	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.
- Animal Population Control Program (APCP) If you have been approved to continue to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4014B (Rev. 7/06)

ACTION TAKEN ON YOUR RECERTIFICATION: PART B

PA, MA, FS, Serv Recert

PUBLIC ASSISTANCE, NOTICE DATE:	FOOD STAMP BENEFITS,	MEDICAL ASSISTANCE COVERA NAME AND ADDRESS OF AGENCY/CEN	
CASE NUMBER	CIN NUMBER	-	
CASE NAME (And C/O Name if Pres	sent) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	
	·	OR Agency Conference Fair Hearing information and assistance	
I	I	Record Access	
OFFICE NO. UNIT NO. WORK	ER NUMBER UNIT OR WORKER		TELEPHONE NUMBER
OFFICE NO. UNIT NO. WORK	LER NOWBER ONLY OR WORKER	NAME	TELEPHONE NOMBER
The action(s) taken on your recertification box(es) ☑: SEE PART A		is explained below a , MEDICAL ASSISTANCE, AND S	
FOOD STAMP	BENEFITS NOT PICKED U	P WITHIN 270 DAYS CANNOT BE	REPLACED
APPROVED for continued Food Si			
month's benefit from:		b	
1b. ☐ The latest date you pro		nay access your benefit onis because you gave us proof after	
2.	which is a com This is because you applied. As figured from the date you a	bined benefit for the months of provided proof after the 15 th of the applied/provided proof to the end of the may access your combined benefits.	month. Your first month's benefit the month. Your second month's
		ill get \$	
	efits on theday of		
Stamp Benefits. You a during your transition papplication in order to	re not required to report any operiod that may increase your receive any increase. Early r	. This is because you a changes until the end of this transit benefits, you must contact your we ecertifications that result in a benefit will continue as described above	ion period. If you have changes orker to file an early recertification it increase will end your transition
		get \$	monthly in Food Stamp Benefits.
•			e necessary proof. Listed here is the
the Food Stamp Benefits you 6. If you applied for Public Ass will not get a notice about yo	ou can get. If your Food Stam istance and are approved, yo our Food Stamp Benefits.	np Benefits change due to this proo	lown or might stop. If this happens, you
DENIED for Food Stamp Benefits I	because:		
	, you will not have to	Food Stamp Benefits. If you give ureapply. After that date, you will har	
OVERPAYMENT INFORMATION	B		
	nand Letter (and also, if your	ecause you or your household got case is closing, the Repayment Ag 387.19.	
Agreement for more information	on on the amount you owe an	your case is closing, see the Dema d how you will repay this overpaym	nent.
repay your overpayment. This	decision is based on 18 N		
☐ The benefit in Section 4 above repay your overpayment. This The above decision(s) is based on 18	decision is based on 18 N	on (recoupment) of \$ YCRR 387.19.	in your benefits in order to

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

LDSS-4014B (Rev. 7/06) (Part B) Reverse		PART B	PA. MA. FS.	, Serv Recert - Timely – A/C No FS
NAME:	ADDRESS:	- · · · · · · ·	CASE NUMBER:	
National School Lunch/or Breakfast Prog attends a school that participates in the Natio of this notice to the school that your child atte	onal School Lunch and			
This notice also entitles your child(ren) to from Food Service Program. Make a copy for your			hool, club or camp tha	t participates in the Summe
List Child(ren)'s name(s):				
Responsibility To Report Changes – See changes.	enclosed LDSS-3151	: "Food Stamp Change Re	port Form" for informat	ion on when to report
CONFERENCE AND	FAIR HEARING S	SECTION - DO YOU	THINK WE ARE W	<u>/RONG?</u>
If you think our decision is wrong, you can as	sk for a review of our de	ecision. We will correct our	mistakes. You can do	both 1 and 2:
1. Ask for a meeting (conference) with on	e of our supervisors;	2. Ask for a State	fair hearing with a Sta	te hearing officer.
 <u>CONFERENCE</u> (Informal meeting winto set up a meeting. To do this, call the conotice. Sometimes this is the fastest way fair hearing. 	onference phone numl	ber on the front of this not	tice or write to us at the	e address on the front of this
If you <u>only</u> ask for a meeting with us, we v for a State fair hearing. (See "Keeping Yo			peal. Your benefits will	stay the same only if you ask
2. STATE FAIR HEARING – You have the	ne following number of	days from the date of this	notice to request a fair	hearing:
	BENEFIT ARE	A		TIME LIMIT
Public Assistance, Medical Assistance,	Social Services			60 days
Food Stamp Benefits				90 days
If this notice is telling you that you owe a Pu for a fair hearing within 60 days of the date of claim in the future that the agency's decision	of this notice. If you do	not call for a fair hearing		
KEEPING YOUR BENEFITS THE SAME: We level they were before this notice, if you ask hearing, your Food Stamp Benefits cannot shown in this notice. If you lose the fair hea while you were waiting for the decision. Also,	for a fair hearing befor be continued in the aring, you will have to	ore the effective date state same amount as before pay back any Public Assis	ed in this notice. Howe your recertification, b	ver, even if you ask for a fair ut will be in the new amount
If you do not want your benefits to stay the send back this notice, check the box or boxe		on is issued, you must tell	the State when you ca	all for a fair hearing or, if you
I do not want to "keep my benefits the same"	until the Fair Hearing	decision is issued:		
Public Assista	ance \square N	Medical Assistance	Social Service	es
HOW TO ASK FOR A FAIR HEARING: You	ı can ask for a fair he	earing by mail , by phon	e, by fax or online.	
<i>Mail:</i> Send a copy of <u>Part A and Part B</u> to t P.O. Box 1930, Albany, New York 12201. Ple			State Office of Tempor	ary and Disability Assistance
I want a fair hearing. I do not agree with written explanation.)	h the agency's action.	(You may explain why yo	u disagree below, but	you do not have to include a
<u>Phone</u> : 800-342-3334 (PLEASE HAVE THIS	S NOTICE WITH YOU	WHEN YOU CALL.)		
Fax: Fax a copy of the front and reverse of the	nis notice to: (518) 473	8-6735 or		
Online: Complete an online request form at:	http://www.otda.stat	e.ny.us/oah/forms.asp.		
If you cannot reach the New York State Offi hearing before the deadline	ice of Temporary and	Disability Assistance by pl	hone, by fax or online,	please write to ask for a fair
WHAT TO EXPECT AT A FAIR HEARING:	The State will send you	a notice that tells you when	and where the fair heari	ng 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.

	PUBLIC ASSISTANC	E, FOOD STAMP	BENEFITS, MEI	I	RAGE AND SERVICES (NYC)
NOTICE DATE:				NAME AND ADDRESS OF AGEN	CY/CENTER OR DISTRICT OFFICE
CASE NUMBER		CIN NUMBER		-	
C	ASE NAME (And C/O Name	e if Present) AND ADD	RESS	-	
	(· · · · · · · · · · · · · · · · · · ·		GENERAL TELEPHONE NO. FO QUESTIONS OR HELP	R
				OR Agency Conference Fair Hearing informati and assistance	
1			1	Record Access	
<u> </u>	1 1			· ·	rmation
OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER	NAME	TELEPHONE NUMBER
The action(s	•	·			elow and on Part A, next to the checked D SERVICES INFORMATION.
box(es) E.				P WITHIN 270 DAYS CANN	
		·			
	You will get \$ month's benefit from:		for the month of		because we must figure your first
1a.	☐ The date you app	lied to the end of	the month. You m	nay access your benefit on	·
1b.	☐ The latest date your You may access you	•		s because you gave us proo	f after it was due.
2. 🗆	You will get \$		which is a coml	pined benefit for the months of	of and
		This is beca	use you applied/	provided proof after the 15 th o	of the month. Your first month's benefit end of the month. Your second month's
	benefit of \$	was ligared in is for the	entire month. Yo	u may access your combined	benefit on
					monthly in Food Stamp Benefits.
	You may access thes	-			
3a.	Stamp Benefits. during your trans application in ord	You are not requisition period that refer to receive any	ired to report any nay increase you increase. Early	changes until the end of the benefits, you must contact	use you are eligible for Transitional Food his transition period. If you have changes your worker to file an early recertification a benefit increase will end your transition above.
					monthly in Food Stamp Benefits.
	You may access thes				
	So you could get Foo proof you still need to	•	right away, we ca	iculated your benefit without	all the necessary proof. Listed here is the
					proof. This proof will be used to determine s proof, you will not be notified.
	If you applied for Publ ou will not get a notice			our Food Stamp Benefits mig	nt go down or might stop. If this happens,
•	•	•	•		
☐ <u>DENIE</u>	of for Food Stamp Ber	efits because:			
					give us this proof we listed on the above ill have to reapply for benefits.
□ <u>othe</u>	<u>;</u>				
	AYMENT INFORMA	TION			
	<u> </u>	<u></u>			
Sec		d also, if your case i			in Food Stamp Benefits than you should have mation on this overpayment. This decision is
	u currently have a Food s rmation on the amount y				etter and Repayment Agreement for more
	e benefit in Section 3 aborpayment. This decisio			upment) of \$	_ in your benefits in order to repay your
ove	e benefit in Section 4 aborrows rpayment. This decision decision(s) is based	n is based on 18 N		upment) of \$	_ in your benefits in order to repay your

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

LDSS-4014B NYC (Rev. 7/06) (Part B) Reverse	PART B – NYC	PA, MA, FS, Serv Recert - Timely - A/C No FS
NAME:	ADDRESS:	CASE NUMBER:
	tional School Lunch and/or Breakfast Program	to receive free lunch and/or breakfast if he or shms. To receive this benefit, you must take or send
	ee meals if they attend a program such as a records so you can provide it to the sponsor.	school, club or camp that participates in the Summ
List Child(ren)'s name(s):	,	
, , , ,		
Responsibility To Report Changes – See changes.	e enclosed LDSS-3151: "Food Stamp Change	Report Form" for information on when to report
<u>CONFERENCE</u>	AND FAIR HEARING SECTION – DO YOU T	HINK WE ARE WRONG?
lf you think our decision is wrong, you can as	sk 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 o	f our supervisors; 2. Ask for a State fair he	earing with a State hearing officer.
set up a meeting. To do this, call the confe	erence phone number on the front of this no	you do not understand our decision, please call us tice or write to us at the address on the front of thurage you to do this even when you have asked for
f you <u>only</u> ask for a meeting with us, we will for a State fair hearing. (See "Keeping Your		opeal. Your benefits will stay the same only if you a
. STATE FAIR HEARING — You have the follow	wing number of days from the date of this notic	ce to ask for a fair hearing:
	BENEFIT AREA	TIME LIMIT
Public Assistance, Medical Assistance, Social	Services	60 days
Food Stamp Benefits		90 days
for a fair hearing within 60 days of the date o	of this notice. If you do not call for a fair hearing	
for a fair hearing within 60 days of the date o claim in the future that the agency's decision	of this notice. If you do not call for a fair hearing that you owe the debt was wrong.	of agree that you owe this overpayment, you must can within 60 days of the date of this notice, you cannot stance and Social Soc
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omplete an online request form at: <u>http://www.otda.state.ny.us/oah/forms.asp</u>

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.