Eliot Spitzer
Governor

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

David A. Hansell
Acting Commissioner

Informational Letter

Section 1

Transmittal:	07-INF-04
To:	Local District Commissioners
Issuing Division/Office:	Division of Employment and Transitional Supports
Date:	March 5, 2007
Subject:	Revisions to 22 Mandatory Client Notices
Suggested Distribution:	Temporary Assistance Staff Food Stamp Benefits Staff Medicaid Directors CAP Coordinators Employment Coordinators WMS Coordinators Staff Development Coordinators
Contact Person(s):	Forms Questions: Bob Gullie 1-800-343-8859, Extension 6-1095 Program Questions: TemporaryAssistance - (518) 474-9344 Food Stamps - (518) 473-1469 HEAP - (518) 473-0332 Medicaid Local District Liason - Upstate (518) 474-8887 or NYC (212) 417-4500
Attachments:	Attachment 1: Filing References Revised Forms: LDSS-3152; LDSS-3152 NYC; LDSS-3620; LDSS-3620 NYC; LDSS-3621; LDSS-3621 NYC; LDSS-4013A; LDSS-4013A NYC; LDSS-4013B; LDSS-4013B NYC; LDSS-4014A; LDSS-4014A NYC; LDSS-4014B; LDSS-4014B NYC; LDSS-4015A; LDSS-4015A NYC; LDSS-4015B; LDSS-4015B NYC; LDSS-4016A; LDSS-4016A NYC; LDSS-4016B, and LDSS-4016B NYC
Attachment Available On – Line:	☒

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
See Attachment 1	See Attachment 1	See Attachment 1	See Attachment 1	See Attachment 1	See Attachment 1

Section 2

I. Purpose

The purpose of this release is to introduce 22 revised mandatory client notices. The revisions to the notices include:

- The words "Not Picked UP" on Food Stamp Notices were changed to "Not Used."
- The notices "APPROVED" section now includes an area for listing the names of individuals in the household who were approved for benefits.
- The notices "DENIED" section now includes an area for listing the individuals in the household who were denied benefits and the reason(s) they were denied.
- Notices with an "INCREASE" area now allow workers to list the names of the individuals in the household who have been added to the case, and list the specific individuals who cannot be added to the case and the reason(s) why they cannot be added.

The following are the 22 notices that are affected.

1. **LDSS-3152:** "Action Taken on Your Food Stamp Benefits Case" (Rev. 11/06) (Upstate)
2. **LDSS-3152 NYC:** "Action Taken on Your Food Stamp Benefits Case" (Rev. 11/06) (NYC)
3. **LDSS-3620:** "Notice of Intent To Change Food Stamp Benefits" (Rev. 10/06) (Timely and Adequate) (Upstate)
4. **LDSS-3620 NYC:** "Notice of Intent To Change Food Stamp Benefits" (Rev. 10/06) (Timely and Adequate) (NYC)
5. **LDSS-3621:** "Notice of Intent To Change Food Stamp Benefits" (Rev. 10/06) (Adequate Only) (Upstate)
6. **LDSS-3621 NYC:** "Notice of Intent To Change Food Stamp Benefits" (Rev. 10/06) (Adequate Only) (NYC)
7. **LDSS-4013A:** "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev. 11/06) (Upstate)
8. **LDSS-4013A NYC:** "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev. 11/06) (NYC)
9. **LDSS-4013B:** "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev. 11/06) (Upstate)
10. **LDSS-4013B NYC: "**Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev. 11/06) (NYC)
11. **LDSS-4014A:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-A" (Rev. 11/06) (Upstate)
12. **LDSS-4014A NYC:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-A" (Rev. 11/06) (NYC)
13. **LDSS-4014B:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-B" (Rev. 11/06) (Upstate)
14. **LDSS-4014B NYC:** "Action Taken on Your Recertification: PA, FS, MA Coverage and Services PART-B" (Rev. 11/06) (NYC)

15. **LDSS-4015A:** "Notice of Intent to Change Benefits: PA, FSB, MA Coverage and Services PART-A" (Timely and Adequate) (Rev. 11/06) (Upstate)
16. **LDSS-4015A NYC:** "Notice of Intent to Change Benefits: PA, FSB, MA Coverage and Services PART-A" (Timely and Adequate) (Rev. 11/06) (NYC)
17. **LDSS-4015B:** "Notice of Intent to Change Benefits: PA, FSB, MA Coverage and Services PART-B" (Timely and Adequate) (Rev. 11/06) (Upstate)
18. **LDSS-4015B NYC:** "Notice of Intent to Change Benefits: PA, FSB, MA Coverage and Services PART-B" (Timely and Adequate) (Rev. 11/06) (NYC)
19. **LDSS-4016A:** "Notice of Intent to Change Benefits: PA, FSB, MA Coverage and Services PART-A" (Adequate Only) (Rev. 11/06) (Upstate)
20. **LDSS-4016A NYC:** "Notice of Intent to Change Benefits: PA, FSB, MA Coverage and Services PART-A" (Adequate Only) (Rev. 11/06) (NYC)
21. **LDSS-4016B:** "Notice of Intent to Change Benefits: PA, FSB, MA Coverage and Services PART-B" (Adequate Only) (Rev. 11/06)
22. **LDSS-4016B NYC:** "Notice of Intent to Change: PA, FSB, MA Coverage and Services PART-B" (Adequate Only) (Rev. 11/06) (NYC)

II. Program Implications:

The following is a general listing of the revisions to the 22 Client Notices:

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

FRONT:

1. The Revision Date was **changed** to 11/06.

2. The words "NOT PICKED UP" were **changed** to "NOT USED" at the top of the notice in the statement about what happens to Food Stamp Benefits after 270 Days.

3. The "APPROVED" section was **changed** to add an area for listing the names of individuals that were approved for Food Stamp Benefits. The revised section now reads:

   ☐ **APPROVED** for Food Stamp Benefits from _____ to _____
   for [name(s)] _____

4. The last 2 sentences in the "Animal Population Control Program (APCP)" section were changed to make clear that you must be approved to receive benefits to participate in this program and that the number to call to get an application was changed. The APCP section now reads:

   ☑ **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. If this notice says you are approved to receive benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.

5. The DENIED section was changed to allow for the listing of individuals that are denied Food Stamp Benefits and the reason(s) for the denial. The changed section now reads:

   ☐ **DENIED** for the following individuals:

   If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

   Name(s): _____Reason(s) _____
   Name(s): _____Reason(s) _____
   Name(s): _____Reason(s) _____
   Name(s): _____Reason(s) _____

REVERSE:

The Revision Date was changed to 11/06.

LDSS-3620 and LDSS-3620 NYC: "Notice of Intent To Change Food Stamp Benefits"
(Timely and Adequate)

FRONT:

1. The Revision Date was changed to 10/06.

2. The words "NOT PICKED UP" were changed to "NOT USED" at the top of the notice in the statement about what happens to Food Stamp Benefits after 270 Days.

REVERSE:

1. The Revision Date was changed to 10/06.

2. The "Lifeline" language was removed from the top of the page.

3. For the **LDSS-3620 NYC ONLY,** the 2nd paragraph of the "Access To Your File and Copies of Documents" was updated.

LDSS-3621 and LDSS-3621 NYC: "Notice of Intent To Change Food Stamp Benefits"
(Adequate Only)

FRONT:

1. The Revision Date was changed to 10/06.

2. The words "NOT PICKED UP" were changed to "NOT USED" at the top of the notice in the statement about what happens to Food Stamp Benefits after 270 Days.

3. The "INCREASE" section was changed to add a check box and a section to list the name(s) of individuals who have been added to a Food Stamp Benefits case. The changed section now reads:

   ☐ **INCREASE** your Food Stamp Benefits from $_____ to $_____ effective

_____.

□ [name(s)] _____has been added to your case.

□ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

4. The **"CONTINUE"** section was changed to add a section to list the name(s) of individuals who will continue to get Food Stamp Benefits. That changed section now reads:

   □ **CONTINUE** your Food Stamp Benefits for [name(s)] _____ at $ _____ effective _____.

5. A check box with a sentence to allow the listing of names of individuals who cannot be added to the Food Stamp Benefits case was added. The changed section now reads:

   □ We cannot add the following individuals to your case:

   Name:_____ Reason(s) _____
   Name:_____ Reason(s) _____

REVERSE:

1. The Revision Date was changed to 10/06.

2. The "Lifeline" Language at the top of the notice was removed.

3. For the **LDSS-3621 NYC ONLY,** the 2nd paragraph of the "Access To Your File and Copies of Documents" was updated.

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

FRONT:

1. The Revision Date was changed to 11/06.

2. The Public Assistance "ACCEPTED" section was changed to include an area to list the name(s) of individuals who are "ACCEPTED" for assistance. The changed section now reads:

   □ **ACCEPTED** for the period from _____ to _____ for [name(s)] _____

   You will get $_____, which will cover the period from _____ to _____. After this you will get $ _____.

3. The Public Assistance "DENIED" section was changed to allow for the listing of individuals and the reason(s) for their denial of assistance. The changed section now reads:

☐ **DENIED** for the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s) _____
Name(s): _____Reason(s) _____
Name(s): _____Reason(s) _____
Name(s): _____Reason(s) _____

REVERSE:

1. The Revision Date was changed to 11/06.
2. The last 2 sentences in the "Animal Population Control Program (APCP)" section were changed to make clear that you must be approved to receive benefits to participate in this program and that the number to call to get an application was changed. The APCP section now reads:

   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. If this notice says you are approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.

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

FRONT:

1. The Revision Date was changed to 11/06.

2. The words "NOT PICKED UP" were changed to "NOT USED" at the top of the notice in the statement about what happens to Food Stamp Benefits after 270 Days.

3. The "APPROVED" section was changed to include a section to list the name(s) of the individuals that have been approved for Food Stamp Benefits. The changes reads as follows:

   ☐ **APPROVED** for Food Stamp Benefits from _____ to _____

   for [name(s)] _____

4. The "DENIED" section was changed to allow for the listing of several individuals and the reason(s) for their denial of Food Stamp Benefits. The changed section now reads:

   ☐ **DENIED** for the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s) _____
Name(s): _____Reason(s) _____
Name(s): _____Reason(s) _____
Name(s): _____Reason(s) _____

REVERSE:

The Revision Date was changed to 11/06.

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

FRONT:

1. The Revision Date was changed to 11/06.
2. The "INCREASE" area under the Public Assistance "RECERTIFIED" section was changed to add 2 additional check boxes. The first check box allows the worker to list the name(s) of the individuals that have been added to the case. The 2nd check box allows the worker to list the individuals that cannot be added to the case and the reason(s) why not. This section now reads as follows:

   ☐ **INCREASE** your monthly Public Assistance benefit for that period effective _____ from $ _____ to $ _____

   ☐ [name(s)] _____has been added to your case.

   ☐ We cannot add the following individuals to your case:

   Name(s): _____ Reason(s)_____
   Name(s): _____ Reason(s)_____
   Name(s): _____ Reason(s)_____
   Name(s): _____ Reason(s)_____

REVERSE:

The Revision Date was changed to 11/06.

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

FRONT:

1. The Revision Date was changed to 11/06.

2. The words "NOT PICKED UP" were changed to "NOT USED" at the top of the notice in the statement about what happens to Food Stamp Benefits after 270 Days.

3. The "APPROVED" section was changed to include a section to list the name(s) of the individuals that have been approved for Food Stamp Benefits. The changes read as follows:

   □ **APPROVED** for Food Stamp Benefits from _____ to _____
   for [name(s)] _____

4. The "DENIED" section was changed to allow for the listing of several individuals and the reason(s) for their denial of Food Stamp Benefits. The changed section now reads:

   □ **DENIED** for the following individuals:

   If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

   Name(s): _____Reason(s)_____
   Name(s): _____Reason(s)_____
   Name(s): _____Reason(s)_____
   Name(s): _____Reason(s)_____

REVERSE:

The Revision Date was changed to 11/06.

LDSS-4015A and LDSS-4015A NYC: "Notice of Intent To Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A" (Timely and Adequate)

FRONT:

1. The Revision Date was changed to 11/06.

2. The "INCREASE" area under the Public Assistance "RECERTIFIED" section was changed to add 2 additional check boxes. The first check box allows the worker to list the name(s) of the individuals that have been added to the case. The 2nd check box allows the worker to list the individuals that cannot be added to the case and the reason(s) why not. This section now reads as follows:

   □ **INCREASE** your monthly Public Assistance benefit for that period effective _____
   from $ _____ to $ _____

   □ [name(s)] _____has been added to your case.

   □ We cannot add the following individuals to your case:

   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____

REVERSE:

The Revision Date was changed to 11/06.

LDSS-4015B and LDSS-4015B NYC: "Notice of Intent To Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B" (Timely and Adequate)

FRONT:

1. The Revision Date was changed to 11/06.

2. The words "NOT PICKED UP" were changed to "NOT USED" at the top of the notice in the statement about what happens to Food Stamp Benefits after 270 Days.

3. The Food Stamp Benefits "INCREASE" section was changed to allow for the listing of name(s) of individuals added to the case. The change section now reads:

   □ **INCREASE** your Food Stamp Benefits from $ _____ to $ _____ effective _____ .

   □ [name(s)] _____has been added to your case.
   □ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

4. The Food Stamp Benefits "CONTINUE" section was changed to record individuals name(s) that will be continuing their Food Stamp Benefits. The change section now reads:

   □ **CONTINUE** your Food Stamp Benefits for [name(s)] _____ at $ _____ effective _____.

5. A new number "7" was added to accommodate a listing of individuals and reasons why they can't be added to a case. This addition reads as follows:

   □ We cannot add the following individuals to your case:

   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____

REVERSE:

The Revision Date was changed to 11/06.

LDSS-4016A and LDSS-4016A NYC: "Notice of Intent To Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A" (Adequate Only)

FRONT:

1. The Revision Date was changed to 11/06.

2. The Public Assistance "INCREASE" section was changed to read:

   □ **INCREASE** your Public Assistance Benefit effective_____ from $ _____ to $ _____ .

   □ [name(s)] _____has been added to your case.

   □ We cannot add the following individuals to your case:

   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____

REVERSE:

The Revision Date was changed to 11/06.

LDSS-4016B and LDSS-4016B NYC: "Notice of Intent To Change Benefits: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B" (Adequate Only)

FRONT:

1. The Revision Date was changed to 11/06.

2. The words "NOT PICKED UP" were changed to "NOT USED" at the top of the notice in the statement about what happens to Food Stamp Benefits after 270 Days.

3. The Food Stamp Benefits "INCREASE" section was changed to allow for the listing of name(s) of individuals added to the case. The change section now reads:

   □ INCREASE your Food Stamp Benefits from $ _____ to $ _____ effective _____ .

   □ [name(s)] _____has been added to your case.

   □ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

4. A new number "7" was added to accommodate a listing of individuals and reasons why they can't be added to a case. This addition reads as follows:

   □ We cannot add the following individuals to your case:

   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____
   Name(s): _____ Reason(s) _____

REVERSE:

The Revision Date was changed to 11/06.

III. Forms Ordering Information

- We expect that the revised versions of the revised forms (LDSS-3152, LDSS-3152 NYC, LDSS-3620, LDSS-3620 NYC, LDSS-3621, LDSS-3621 NYC, LDSS-4013A, LDSS-4013A NYC, LDSS-4013B, LDSS-4013B NYC, LDSS-4014A, LDSS-4014A NYC, LDSS-4014B, LDSS-4014B NYC, LDSS-4015A, LDSS-4015A NYC, LDSS-4015B, LDSS-4015B NYC, LDSS-4016A, LDSS-4016A NYC, LDSS-4016B and LDSS-4016B NYC) will be printed and delivered to the Albany and NYC/HRA warehouses by the end of May, 2007. Upon delivery of the revised client notices, your district will be shipped an initial supply. Upon receipt of any of the revised client notices, local districts **must immediately destroy** all previous versions.

- The Spanish versions of these notices (LDSS-3152-SP, LDSS-3152-SP NYC, LDSS-3620-SP, LDSS-3620-SP NYC, LDSS-3621-SP, LDSS-3621-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, LDSS-4014B-SP NYC, LDSS-4015A-SP, LDSS-4015A-SP NYC, LDSS-4015B-SP, LDSS-4015B-SP NYC, LDSS-4016A-SP, LDSS-4016A-SP NYC, LDSS-4016B-SP and LDSS-4016B-SP NYC) will follow. Upon receipt of any of the revised Spanish 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 .

Issued By _____

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

ATTACHMENT 1

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept, Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 ADM-21 05 INF-15 04 INF-26 01 INF-17 92 INF-46 92 INF-42 92 INF-34 91 INF-57		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 Chapter 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

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.

Enclosure

LDSS-3152 NYC (Rev. 11/06)

FS App/Reapp/OP Recoup/Ad Only

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The action(s) taken on your application/recertification request for Food Stamp Benefits dated _____ is explained below, next to the checked box(es) ☑ .

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

☐ **APPROVED** for Food Stamp Benefits from _____ to _____
for [name(s)] _____

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:
   - 1a. ☐ The date you applied to the end of the month. You may access your benefit on _____.
   - 1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____ .
2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____ .This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $ _____ is for the entire month.

   You may access your combined benefit on _____ .
3. ☐ Beginning _____ you will get $ _____ monthly in 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. ☐ 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. ☑ **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. If this notice says you are approved to receive benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.
8. ☐ Other Information: _____
   _____

☐ **DENIED** for the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____

☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed above by _____ , you will not have to reapply. After that date, you will have to reapply.

☐ **OVERPAYMENT INFORMATION** (check all that apply)

- ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
- ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
- ☐ The benefit in Section 3 above reflects a ____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19**.
- ☐ The benefit in Section 4 above reflects a ___% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19**.
- ☐ Other: _____
  _____

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

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

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

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

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:

Mail: 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.)

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

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

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

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

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

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

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

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

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

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

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

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

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

LDSS-3152 (Rev. 1106)

FS App/Reapp/OP Recoup/Ad Only

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The action(s) taken on your application/recertification request for Food Stamp Benefits dated _____ is explained below, next to the checked box(es) ☑ .

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

☐ **APPROVED** for Food Stamp Benefits from _____ to _____
for [name(s)] _____

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:
   - 1a. ☐ The date you applied to the end of the month. You may access your benefit on _____.
   - 1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____ .
2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____ .This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $ _____ is for the entire month.

   You may access your combined benefit on _____ .
3. ☐ Beginning _____ you will get $ _____ monthly in 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. ☐ 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. ☑ **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. If this notice says you are approved to receive benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.
8. ☐ Other Information: _____
   _____

☐ **DENIED** for the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____

☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed above by _____ , you will not have to reapply. After that date, you will have to reapply.

☐ **OVERPAYMENT INFORMATION** (check all that apply)

- ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
- ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
- ☐ The benefit in Section 3 above reflects a ____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19**.
- ☐ The benefit in Section 4 above reflects a ___% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19**.
- ☐ Other: _____
  _____

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

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

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

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

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:

Mail: 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

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

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

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help 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.

Enclosure

LDSS-3620 NYC (Rev. 10/06)

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We are CHANGING your Food Stamp Benefits, as explained below, next to the checked boxes ☑:

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

1. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____ effective _____ .

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

2. ☐ **DISCONTINUE** your Food Stamp Benefits as of_____.

3. ☐ **OVERPAYMENT INFORMATION**

   ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19**.

   ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

   ☐ The benefit above reflects a ____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19**.

4. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

The reason for this action is: _____

_____

_____

_____

_____

_____

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

☑ Responsibility To Report Changes – See enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

2. **STATE FAIR HEARING** – You have **90** days from the date of this notice to ask for a fair hearing.

KEEPING YOUR BENEFITS THE SAME: We will not change your Food Stamp Benefits, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any benefits you got, but should not have gotten, while you were waiting for the decision.

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

☐ I do not want to keep my Food Stamp Benefits the same until the fair hearing decision is issued.

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

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

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

_____

_____

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

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

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

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

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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 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.**

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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 INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We are CHANGING your Food Stamp Benefits, as explained below, next to the checked boxes ☑:

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

1. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____ effective _____ .

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

2. ☐ **DISCONTINUE** your Food Stamp Benefits as of_____.

3. ☐ **OVERPAYMENT INFORMATION**

   ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19**.

   ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

   ☐ The benefit above reflects a ____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19**.

4. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

The reason for this action is: _____

_____

_____

_____

_____

_____

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

☑ 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.

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

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

2. **STATE FAIR HEARING** – You have **90** days from the date of this notice to ask for a fair hearing.

KEEPING YOUR BENEFITS THE SAME: We will not change your Food Stamp Benefits, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any benefits you got, but should not have gotten, while you were waiting for the decision.

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

☐ I do not want to keep my Food Stamp Benefits the same until the fair hearing decision is issued.

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

Mail: Send a copy of this 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

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

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

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

IMPORTANT NOTICE

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

Aviso importante: Si necesita ayuda para leer este aviso, comuníquese con la persona a cargo de su caso.

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.

Thoâng baùo quan troïng. Neáu caàn ñöôïc giuùp ñôõ ñeå ñoïc baûn thoâng baùo naøy, xin lieân laïc vôùi nhaân vieân xaõ hoäi cuûa quyù vò.

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

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (Adequate Only)(NYC)

NOTICE DATE:	CIN NUMBER	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE 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 NAME	TELEPHONE NO.

We are CHANGING your Food Stamp Benefits, as explained below, next to the checked boxes ☑ .

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED

1. ☐ **INCREASE** your Food Stamp Benefits from $_____ to $_____ effective _____.

   ☐ [name(s)] _____has been added to your case.

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____ .

2. ☐ **CONTINUE** your Food Stamp Benefits for [name(s)] _____

   at $_____ effective _____.

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

3. ☐ **REDUCE** your Food Stamp Benefits from $_____ to $_____

   effective _____ .

   ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____

5. ☐ **OVERPAYMENT INFORMATION**

   ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter and also, if your case is closing, the Repayment Agreement for more information on this overpayment. **This decision is base on 18 NYCRR 387.19.**

   ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

   ☐ The benefit above reflects a ____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

6. ☐ We cannot add the following individuals to your case:

   Name:_____ Reason(s)_____
   Name:_____Reason(s)_____
   _____

7. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

8. ☐ **OTHER** _____

   _____

The reason for this action is:_____

_____

_____

The above decision(s) is based on 18 NYCRR_____

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

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

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

2. **STATE FAIR HEARING –** You have 90 days from the date of this notice to ask for a fair hearing:

   KEEPING YOUR BENEFITS THE SAME: We will restore your Food Stamp Benefits to the same level they were before this notice, if you ask for a fair hearing within ten (10) days of the postmark of the mailing of this notice. If you lose the fair hearing, you will have to pay back any Food Stamp Benefits you got, but should not have gotten, while you were waiting for the decision.

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

   ☐ I do not want to keep my Food Stamp Benefits the same until the fair hearing decision is issued.

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

Mail: Send a copy of the entire notice 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 back of this notice to: **(518) 473-6735.**

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

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, by walk-in or online, please write to ask for a fair hearing before the deadline.

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

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

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

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

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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call, write or fax to us, we will send you free copies of the documents from your 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-3621 (Rev.10/06) **FS Red/Clos/Inc/Cont-A/C-Adequate**

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (Adequate Only)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We are CHANGING your Food Stamp Benefits, as explained below, next to the checked boxes ☑ .

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

1. ☐ **INCREASE** your Food Stamp Benefits from $_____ to $_____ effective _____.
   - ☐ [name(s)] _____has been added to your case.
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.
2. ☐ **CONTINUE** your Food Stamp Benefits for [name(s)] _____ at $ _____ effective _____.
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.
3. ☐ **REDUCE** your Food Stamp Benefits from $_____ to $_____ effective _____ .
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.
4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____ .
5. ☐ **OVERPAYMENT INFORMATION**
   - ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter and also, if your case is closing, the Repayment Agreement for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
   - ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
   - ☐ The benefit above reflects a ____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**
6. ☐ We cannot add the following individuals to your case:

   Name:_____Reason(s) _____
   Name:_____Reason(s) _____
   _____
7. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.
8. ☐ **OTHER** _____
   _____

The reason for this action is:_____
_____
_____
_____
_____

The above decision(s) is based on 18 NYCRR_____

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

☑ 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.

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

2. **STATE FAIR HEARING –** You have 90 days from the date of this notice to ask for a fair hearing:

   KEEPING YOUR BENEFITS THE SAME: We will restore your Food Stamp Benefits to the same level they were before this notice, if you ask for a fair hearing within ten (10) days of the postmark of the mailing of this notice. If you lose the fair hearing, you will have to pay back any Food Stamp Benefits you got, but should not have gotten, while you were waiting for the decision.

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

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

Mail: Send a copy of this notice 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

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.

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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.

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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 NYC (Rev. 11/06)

ACTION TAKEN ON YOUR APPLICATION: PART A

PA, MA, FS App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The action(s) taken on your application 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

☐ **ACCEPTED** for the period from _____ to _____

for [name(s)] _____ _____ .

You will get $_____, for the period from _____ to _____. After this you will get $ _____.

☐ The above grant is based on a reduced budget because:

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

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

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

☐ screening ☐ 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 recoupment is: _____.
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 the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

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

MEDICAL ASSISTANCE

☐ **ACCEPTED** for Medical Assistance effective _____ for [name(s)] _____ _____

☐ **ACCEPTED** for Medical Assistance with a SPENDDOWN, effective _____ for [name(s)] _____

Your total monthly income is $ _____. Your total monthly deductions are $ _____.
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.

☐ **PENDED**

☐ We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than _____ at_____ so we can tell you the information we need.

☐ Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.

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

☐ **OTHER** _____

This above decision(s) is based on _____.

Enclosure

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

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

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

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

☑ 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. If this notice says you are approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program, call 1-888-669-0870.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-3621 (Rev.10/06) **FS Red/Clos/Inc/Cont-A/C-Adequate**

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (Adequate Only)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We are CHANGING your Food Stamp Benefits, as explained below, next to the checked boxes ☑ .

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

1. ☐ **INCREASE** your Food Stamp Benefits from $_____ to $_____ effective _____.
   - ☐ [name(s)] _____has been added to your case.
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.
2. ☐ **CONTINUE** your Food Stamp Benefits for [name(s)] _____ at $ _____ effective _____.
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.
3. ☐ **REDUCE** your Food Stamp Benefits from $_____ to $_____ effective _____ .
   - ☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.
4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____ .
5. ☐ **OVERPAYMENT INFORMATION**
   - ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter and also, if your case is closing, the Repayment Agreement for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
   - ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
   - ☐ The benefit above reflects a ____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**
6. ☐ We cannot add the following individuals to your case:

   Name:_____Reason(s) _____
   Name:_____Reason(s) _____
   _____
7. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.
8. ☐ **OTHER** _____
   _____

The reason for this action is:_____
_____
_____
_____
_____

The above decision(s) is based on 18 NYCRR_____

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

2. **STATE FAIR HEARING –** You have 90 days from the date of this notice to ask for a fair hearing:

   KEEPING YOUR BENEFITS THE SAME: We will restore your Food Stamp Benefits to the same level they were before this notice, if you ask for a fair hearing within ten (10) days of the postmark of the mailing of this notice. If you lose the fair hearing, you will have to pay back any Food Stamp Benefits you got, but should not have gotten, while you were waiting for the decision.

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

   ☐ I do not want to keep my Food Stamp Benefits the same until the fair hearing decision is issued.

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

Mail: Send a copy of this notice 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

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.

LDSS-4013A NYC (Rev. 11/06)

ACTION TAKEN ON YOUR APPLICATION: PART A

PA, MA, FS App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The action(s) taken on your application 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

☐ **ACCEPTED** for the period from _____ to _____

for [name(s)] _____ _____ .

You will get $_____, for the period from _____ to _____. After this you will get $ _____.

☐ The above grant is based on a reduced budget because:

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

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

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

☐ screening ☐ 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 recoupment is: _____.
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 the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

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

MEDICAL ASSISTANCE

☐ **ACCEPTED** for Medical Assistance effective _____ for [name(s)] _____ _____

☐ **ACCEPTED** for Medical Assistance with a SPENDDOWN, effective _____ for [name(s)] _____

Your total monthly income is $ _____. Your total monthly deductions are $ _____.
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.

☐ **PENDED**

☐ We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than _____ at_____ so we can tell you the information we need.

☐ Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.

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

☐ **OTHER** _____

This above decision(s) is based on _____.

Enclosure

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

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

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

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

☑ 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. If this notice says you are approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program, call 1-888-669-0870.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013A (Rev. 11/06)

ACTION TAKEN ON YOUR APPLICATION: PART A

PA, MA, FS App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The action(s) taken on your application 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

☐ **ACCEPTED** for the period from _____ to _____
for [name(s)] _____
You will get $_____, which will cover the period from _____ to _____.
After this you will get $ _____.

_____

_____

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

☐ **DENIED** for the following individuals:
If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s)_____Reason(s)_____

☐ **OTHER** _____

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

MEDICAL ASSISTANCE

☐ **ACCEPTED** for Medical Assistance effective _____ for [name(s)] _____

_____

☐ **ACCEPTED** for Medical Assistance with a SPENDDOWN, effective _____ for [name(s)]
_____

Your total monthly income is $ _____. Your total monthly deductions are $ _____.
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.

☐ **PENDED**

- ☐ We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than _____ at_____ so we can tell you the information we need.
- ☐ Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.
- ☐ Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance.

☐ **OTHER** _____

This above decision(s) is based on _____.

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

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

☑ 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. If this notice says you are approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013B NYC (Rev. 11/06) **ACTION TAKEN ON YOUR APPLICATION: PART B** PA, MA, FS, App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

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 USED WITHIN 270 DAYS CANNOT BE REPLACED.

☐ **APPROVED** for Food Stamp Benefits from _____ to _____

for [name(s)] _____.

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:

   1a. ☐ The date you applied to the end of the month. You may access your benefit on _____ .

   1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____ .

2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____ . This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $_____ is for the entire month. You may access your combined benefit on _____.

3. ☐ Beginning _____ you will get $_____ monthly in 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. ☐ 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 the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____

☐ You did not give us the proof we need to see if you can get 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.

☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

☐ The benefit in Section 3 above reflects a _____ % reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

☐ The benefit in Section 4 above reflects a _____ % reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

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

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

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

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 enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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

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

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

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

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**.

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

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

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be 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-4013B (Rev. 11/06)

ACTION TAKEN ON YOUR APPLICATION: PART B

PA, MA, FS, App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

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 USED WITHIN 270 DAYS CANNOT BE REPLACED.

☐ **APPROVED** for Food Stamp Benefits from _____ to _____

for [name(s)] _____

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:
   - 1a. ☐ The date you applied to the end of the month. You may access your benefit on _____.
   - 1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____.
2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____. This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $_____ is for the entire month. You may access your combined benefit on _____.
3. ☐ Beginning _____ you will get $_____ monthly in 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. ☐ 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 the following individuals:

If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

☐ You did not give us the proof we need to see if you can get 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.
- ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
- ☐ The benefit in Section 3 above reflects a ____ % reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.
- ☐ The benefit in Section 4 above reflects a ____ % reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

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

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

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

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 enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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

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

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

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

_____

_____

_____

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

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

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.

LDSS-4014A NYC (Rev. 11/06) **ACTION TAKEN ON YOUR RECERTIFICATION: PART A** PA, MA, FS, Serv-Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
	OR Agency Conference _____
	Fair Hearing information and assistance _____
	Record Access _____
	Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

The action(s) taken on your recertification dated _____ is explained below and on Part 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 _____ to _____

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

☐ The above grant is based on a reduced budget because:

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

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

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

☐ screening ☐ assessment ☐ rehabilitation

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

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

☐ [name(s)] _____has been added to your case.

☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

☐ **CONTINUE** your Public Assistance benefit unchanged at $ _____ .

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

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

☐ **DISCONTINUE** your Public Assistance benefit effective _____ .

The **REASON** for this action is _____

_____ .

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

MEDICAL ASSISTANCE

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

☐ **CONTINUE** the Medical Assistance coverage for [name(s)]

_____

pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

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

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

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

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

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

The above decision(s) is based on _____ .

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

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

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

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 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 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 (_____)_____.

☑ 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. If this notice says you are approved to continue to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4014A (Rev. 11/06) **ACTION TAKEN ON YOUR RECERTIFICATION: PART A** PA, MA, FS, Serv-Recert

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

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____	
OR Agency Conference _____	
Fair Hearing information and assistance _____	
Record Access _____	
Legal Assistance information _____	

OFFICE NO.	UNIT NO.	WORKER NUMBER	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 _____ to _____

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

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

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

☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

☐ **CONTINUE** your Public Assistance benefit unchanged at $ _____ .

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

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

☐ **DISCONTINUE** your Public Assistance benefit effective _____

The **REASON** for this action is _____

_____.

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

MEDICAL ASSISTANCE

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

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____

_____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____

_____ pending our review of eligibility. We will send you our decision within thirty days.

☐ **REDUCE** the Medical Assistance coverage effective_____ for [name(s)] _____

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

☐ **DISCONTINUE** Medical Assistance for (name(s)) _____ effective _____ because _____

_____

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

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

The above decision(s) is based on _____ .

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

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

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

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. If this notice says you are approved to continue to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4014B NYC (Rev. 11/06) **ACTION TAKEN ON YOUR RECERTIFICATION: PART B** PA, MA, FS, Serv Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

NOTICE DATE:	CASE NUMBER	CIN NUMBER	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NAME (And C/O Name if Present) AND ADDRESS			

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

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

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED

☐ **APPROVED** for continued Food Stamp Benefits from _____ to _____

for [name(s)] _____.

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:

   1a. ☐ The date you applied to the end of the month. You may access your benefit on _____ .

   1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____.

2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____. This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $_____ is for the entire month. You may access your combined benefit on _____ .

3. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.

   3a. ☐ You will continue to get the benefit above until _____. This is because you are eligible for Transitional Food Stamp Benefits. You are not required to report any changes until the end of this transition period. If you have changes during your transition period that may increase your benefits, you must contact your worker to file an early recertification application in order to receive any increase. Early recertifications that result in a benefit increase will end your transition period, otherwise, your transitional period and benefit will continue as described above.

4. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide:

   _____

   _____

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

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

7. ☐ Other information: _____ .

☐ **DENIED** for the following individuals:

If **ALL** is in listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

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

☐ **OTHER**:_____

_____

☐ **OVERPAYMENT INFORMATION**

☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**

☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

☐ The benefit in Section 3 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

☐ The benefit in Section 4 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

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

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

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

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 enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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

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

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

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

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

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

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

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

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

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

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

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

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

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

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

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be 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-4014B (Rev. 11/06)

ACTION TAKEN ON YOUR RECERTIFICATION: PART B

PA, MA, FS, Serv Recert

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

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

The action(s) taken on your recertification dated _____ is explained below and on Part A, next to the checked box(es) ☑:

SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE, AND SERVICES INFORMATION.

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED

☐ **APPROVED** for continued Food Stamp Benefits from _____ to _____
for [name(s)] _____.

1. ☐ You will get $ _____ for the month of _____ because we must figure your first month's benefit from:
   - 1a. ☐ The date you applied to the end of the month. You may access your benefit on _____
   - 1b. ☐ The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _____ .
2. ☐ You will get $ _____ which is a combined benefit for the months of _____ and _____ .This is because you applied/provided proof after the 15th of the month. Your first month's benefit of $ _____ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of $_____ is for the entire month. You may access your combined benefit on _____ .
3. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.
   - 3a. ☐ You will continue to get the benefit above until _____ . This is because you are eligible for Transitional Food Stamp Benefits. You are not required to report any changes until the end of this transition period. If you have changes during your transition period that may increase your benefits, you must contact your worker to file an early recertification application in order to receive any increase. Early recertifications that result in a benefit increase will end your transition period, otherwise, your transitional period and benefit will continue as described above.
4. ☐ Beginning _____ you will get $_____ monthly in Food Stamp Benefits. You may access these benefits on the _____ day of each month.
5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide:_____
   _____
   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.
6. ☑ If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits.
7. ☐ Other information: _____
   _____ .

☐ **DENIED** for the following individuals:

If **ALL** is in listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____ Reason(s) _____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____
Name(s): _____Reason(s)_____

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

☐ **OTHER**:_____
_____

☐ **OVERPAYMENT INFORMATION**

- ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**
- ☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
- ☐ The benefit in Section 3 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**
- ☐ The benefit in Section 4 above reflects a _____% reduction (recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

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

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

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

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 enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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

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

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

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

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

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

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

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

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

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

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

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

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

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

_____

_____

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

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

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 number on the **front** of this notice or write to us at the address on the **front** of this notice.

LDSS-4015 A NYC (Rev. 11/06)

NOTICE OF INTENT TO CHANGE BENEFITS: PART A

PA, MA, FS, Serv – Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE) (NYC)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

We are CHANGING your benefits as explained below and on PART B, next to the checked box(es) ☑ :

SEE PART B FOR FOOD STAMP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **REDUCE** your Public Assistance Benefit effective _____ from $ _____ to $ _____ because:

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

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

☐ Other: _____.

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

☐ [name(s)] _____has been added to your case.

☐ We cannot add the following individuals to your case:

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

☐ **CONTINUE** your Public Assistance Benefit unchanged at $ _____ .

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

☐ **DISCONTINUE** your Public Assistance grant 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)]_____unchanged.

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

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

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

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

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

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

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

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

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

Enclosure

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

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 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 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 (_____)_____.

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

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

For further information, please contact your services worker or call the general phone number on the front of this notice.

☑ If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.

☑ Regulations require that you immediately notify this department of any changes in needs, income, resources, living arrangements or address.

☑ Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4015 A (Rev. 11/06)

NOTICE OF INTENT TO CHANGE BENEFITS: PART A

PA, MA, FS, Serv – Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____	
OR Agency Conference _____	
Fair Hearing information and assistance _____	
Record Access _____	
Legal Assistance information _____	

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

We are CHANGING your benefits as explained below and on PART B, next to the checked box(es) ☑ :

SEE PART B FOR FOOD STAMP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **REDUCE** your Public Assistance Benefit effective _____ from $ _____ to $ _____.

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

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

☐ We cannot add the following individuals to your case:

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

☐ **CONTINUE** your Public Assistance Benefit unchanged at $ _____ .

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

☐ **DISCONTINUE** your Public Assistance grant 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)] _____ unchanged.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____ eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

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

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

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

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

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

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

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

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

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

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.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4015 B (Rev. 11/06) PA, MA, FS, Serv Change

NOTICE OF INTENT TO CHANGE BENEFITS: PART B

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
	OR Agency Conference _____
	Fair Hearing information and assistance _____
	Record Access _____
	Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

We are CHANGING your benefits, as explained below and on Part A, next to the checked box(es) ☑ :

SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE AND SERVICES INFORMATION.

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

FOOD STAMPS

1. ☐ **INCREASE** your Food Stamp Benefits from $ _____ to $ _____

effective _____ .

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

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

2. ☐ **CONTINUE** your Food Stamp Benefits for [name(s)] _____
at $ _____ effective _____

3. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____

effective _____

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____

4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____

5. ☐ **OTHER** _____

_____

6. ☐ **OVERPAYMENT INFORMATION (Check All That Apply)**

☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp Benefits than you should have. See the Demand Letter (and also, if your case is closing the Repayment Agreement) for more information on this overpayment. **This decision is based on 18 NYCRR 387.19.**

☐ You currently have a Food Stamp Benefits overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.

☐ The benefit above reflects a ____% reduction (Recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

7. ☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

8. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

9. ☐ **OTHER INFORMATION:** _____

_____

The reason for this action is: _____

_____.

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

☑ Responsibility To Report Changes – See enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

I do not want to keep my benefits the same until the fair hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ Food Stamp Benefits ☐ Social Services

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

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

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

_____

_____

_____

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

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

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

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, fax, or 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 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.

LDSS-4016 A NYC (Rev. 11/06)

NOTICE OF INTENT TO CHANGE BENEFITS: PART A

PA, MA, FS, Serv Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY) (NYC)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

We are CHANGING your benefits as explained below and on PART B , next to the checked box(es) ☑:

SEE PART B FOR FOOD STAMP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **REDUCE** your Public Assistance Benefit effective _____ from $ _____ to $ _____.

☐ **INCREASE** your Public Assistance Benefit effective _____ from $ _____ to $ _____ .

☐ [name(s)] _____has been added to your case.

☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

☐ **CONTINUE** your Public Assistance Benefit unchanged at $ _____ .

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

☐ **DISCONTINUE** your Public Assistance grant 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)] _____ unchanged.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____

_____pending the receipt of information necessary to decide continued eligibility. Please contact us no later than_____ at _____so we can tell you the information we need.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____

_____ pending our review of eligibility. We will send you our decision within thirty days.

☐ **REDUCE** the Medical Assistance coverage effective _____for [name(s)] _____

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

☐ **DISCONTINUE** Medical Assistance for [name(s)] _____

effective _____ because _____

_____ .

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

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

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

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

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

Enclosure

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

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.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4016 A (Rev. 11/06)

NOTICE OF INTENT TO CHANGE BENEFITS: PART A

PA, MA, FS, Serv Change

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

We are CHANGING your benefits as explained below and on PART B , next to the checked box(es) ☑:

SEE PART B FOR FOOD STAMP AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **REDUCE** your Public Assistance Benefit effective _____ from $ _____ to $ _____ .

☐ **INCREASE** your Public Assistance Benefit effective _____ from $ _____ to $ _____ .

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

☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

☐ **CONTINUE** your Public Assistance Benefit unchanged at $ _____ .

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

☐ **DISCONTINUE** your Public Assistance grant 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)] _____ unchanged.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____

_____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____

_____ pending our review of eligibility. We will send you our decision within thirty days.

☐ **REDUCE** the Medical Assistance coverage effective _____ for [name(s)] _____

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

☐ **DISCONTINUE** Medical Assistance for [name(s)] _____

effective _____ because _____

_____ .

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

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

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

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

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

Enclosure

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

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.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

NOTICE OF INTENT TO CHANGE BENEFITS: PART B

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY) (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

We are CHANGING your benefits, as explained below and on Part A , next to the checked box(es) ☑ :

SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE AND SERVICES INFORMATION.

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

FOOD STAMPS

1. ☐ **INCREASE** your Food Stamp Benefits from $ _____ to $ _____effective _____

☐ [name(s)] _____has been added to your case.

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

2. ☐ **CONTINUE** your Food Stamp Benefits for at $ _____ effective _____.

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

3. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____ effective _____ .

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____.

4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____ .

5. ☐ **OTHER** _____

_____

6. ☐ **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 that you should have. See the Demand Letter and also, if your case is closing, the Repayment Agreement for more information on this overpayment. This decision is based on 18 NYCRR 387.19.

☐ 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 above reflects a _____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

7. ☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

8. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

9. ☐ Other Information: _____

_____

The reason for this action is:_____

_____

_____

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

☑ Responsibility To Report Changes – See enclosed LDSS-3151: "Food Stamp Change Report Form" for information on when to report changes.

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

KEEPING YOUR BENEFITS THE SAME:

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

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

I do not want to keep my benefits the same until the fair hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ Food Stamp Benefits ☐ Social Services

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

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

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

_____

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LDSS-4016 B (Rev. 11/06)

NOTICE OF INTENT TO CHANGE BENEFITS: PART B

PA, MA, FS, Serv Change

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER

We are CHANGING your benefits, as explained below and on Part A , next to the checked box(es) ☑ :

SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE AND SERVICES INFORMATION.

FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS CANNOT BE REPLACED.

FOOD STAMPS

1. ☐ **INCREASE** your Food Stamp Benefits from $ _____ to $ _____effective _____

☐ [name(s)] _____has been added to your case.

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____

2. ☐ **CONTINUE** your Food Stamp Benefits at $ _____ effective _____.

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____

3. ☐ **REDUCE** your Food Stamp Benefits from $ _____ to $ _____effective _____

☐ Your Food Stamp Benefits certification period has been extended. Your benefits will now end in _____

4. ☐ **DISCONTINUE** your Food Stamp Benefits as of _____ .

5. ☐ **OTHER** _____

6. ☐ **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 that you should have. See the Demand Letter and also, if your case is closing, the Repayment Agreement for more information on this overpayment. This decision is based on 18 NYCRR 387.19.

☐ 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 above reflects a _____% reduction (recoupment) of $ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.

7. ☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

Name(s): _____ Reason(s) _____

8. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

9. ☐ Other Information: _____

_____

The reason for this action is:_____

_____

_____

_____

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

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

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_____

_____

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.