

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

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	Temporary Assistance Staff					
Distribution:	Food Stamp Benefits Staff					
	Medicaid Directors					
	CAP Coordinators					
	Employment Coordinators					
	WMS Coordinators					
	Staff Development Coordinators					
Contact	Forms Questions: Bob Gullie 1-800-343-8859, Extension 6-1095					
Person(s):	Program Questions:					
	TemporaryAssistance - (518) 474-9344					
	Food Stamps - (518) 473-1469					
	HEAP - (518) 473-0332					
A44 1	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					
A 44 1 4 4 9	NYC					
Attachment Avail Line:	lable On –					

Filing References

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

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- 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.

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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:
	☐ <u>DENIED</u> 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):
	Name(s):
REVI	ERSE:
Th	ne Revision Date was changed to 11/06.
	O and LDSS-3620 NYC: "Notice of Intent To Change Food Stamp Benefits" and Adequate)
FRON	NT:
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.
REVE	RSE:
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 2 nd paragraph of the "Access To Your File and Copies of Documents" was updated.
LDSS-362 (Adequate	1 and LDSS-3621 NYC: "Notice of Intent To Change Food Stamp Benefits" Only)
FRON	Т:
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
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	·
	□ [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:
	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:
	\square We cannot add the following individuals to your case:
	Name: Reason(s) Name: Reason(s)
REVE	RSE:
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 2 nd paragraph of the "Access To Your File and Copies of Documents" was updated.
	3A and LDSS-4013A NYC: "Action Taken on Your Application: Public Assistance, Food nefits and Medical Assistance Coverage – PART A"
FRON'	Γ:
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:
	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:

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	Name(s):	Reason(s)	
	Name(s):	Reason(s)	
		Reason(s)	
	Name(s):	Reason(s)	
REVE	ERSE:		
1.	The Revision Date was cha	anged to 11/06.	
2.	changed to make clear tha	at you must be approved to re-	ol Program (APCP)" section were ceive benefits to participate in this on was changed. The APCP section
	Public Assistance, Medical State Department of Agric dog or cat spayed/neutered can have their cat or dog spreceive Public Assistance, of this notice is proof that program. To receive an appropriate the program of th	Assistance Coverage and/or Fulture and Markets has a prograd. Through the animal population payed/neutered for \$20.00. If the Medical Assistance Coverage at you are eligible to participate oplication voucher for this program.	
	113B and LDSS-4013B NYC enefits and Medical Assistance		lication: Public Assistance, Food
FRON	NT:		
1	. The Revision Date was ch	nanged to 11/06.	
2		O UP" were changed to "NOT Upens to Food Stamp Benefits after	JSED" at the top of the notice in the er 270 Days.
3.			section to list the name(s) of the efits. The changes reads as follows:
	☐ <u>APPROVED</u> for Food	Stamp Benefits from	to
	for [name(s)]		

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.

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3.			ude a section to list the name(s) of the mp Benefits. The changes read as follows:
			to
4.			e listing of several individuals and the he changed section now reads:
	□ <u>DENIED</u> for the follow	ving individuals:	
	If ALL is listed in the for the same stated Rea		nember of your household was DENIED
	Name(s):	Reason(s)
	Name(s):	Reason(s)
)
REV	VERSE:		
TL	a Davisian Data was abone	- d to 11/06	
1 n	e Revision Date was chang	ged to 11/00.	
			Change Benefits: Public Assistance, Food – PART A" (Timely and Adequate)
FRO	ONT:		
1.	The Revision Date was ch	nanged to 11/06.	
2.	add 2 additional check be individuals that have bee	oxes. The first check box n added to the case. The	e "RECERTIFIED" section was changed to allows the worker to list the name(s) of the 2 nd check box allows the worker to list the reason(s) why not. This section now reads as
		nthly Public Assistance ber to \$	nefit for that period effective
	[name(s)]		has been added to your case.
	☐ We cannot add the foll	owing individuals to your	case:
	Name(s):	Reason(s)	
	Name(s):	Reason(s)	
	manucioi.	reason s /	

REVERSE:

The Revision Date was changed to 11/06.

<u>LDSS-4015B and LDSS-4015B NYC:</u> "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:

	☐ <u>INCREASE</u> your Food	d Stamp Benefits from \$	to \$
	effective		·
	- , , -		has been
	added to your case ☐ Your Food Stamp inow end in	Benefits certification period has been ex	tended. Your benefits will
4.		"CONTINUE" section was changed to a good Stamp Benefits. The change section	* *
		od Stamp Benefits for [name(s)] effective	
5.		dded to accommodate a listing of individ This addition reads as follows:	uals and reasons why they
	☐ We cannot add the foll	lowing individuals to your case:	
	Name(s):	Reason(s)	
		Reason(s)	
		Reason(s)	
		Reason(s)	

REVERSE:

The Revision Date was changed to 11/06.

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

FRONT:

	☐ INCREASE vour Publ	ic Assistance Benefit effective from
		has been added to your case.
	☐ We cannot add the f	following individuals to your case:
	Name(s):	Reason(s)
	Name(s):	Reason(s)
		Reason(s)
		Reason(s)
RE	EVERSE:	
7	Γhe Revision Date was chan	ged to 11/06.
		NYC: "Notice of Intent To Change Benefits: Public Assistance, Food
Stamp	Denemis, Medicai Assistan	ce Coverage and Services – PART B" (Adequate Only)
FR	ONT:	
1.	The Revision Date was ch	anged to 11/06
		unged to 11/00.
2.		D UP" were changed to "NOT USED" at the top of the notice in the pens to Food Stamp Benefits after 270 Days.
	statement about what happed The Food Stamp Benefits	O UP" were changed to "NOT USED" at the top of the notice in the
2.	The Food Stamp Benefits of individuals added to the	O UP" were changed to "NOT USED" at the top of the notice in the pens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads:
2.	The Food Stamp Benefits of individuals added to the ☐ INCREASE your Food	O UP" were changed to "NOT USED" at the top of the notice in the pens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s)
2.	The Food Stamp Benefits of individuals added to the ☐ INCREASE your Food effective	O UP" were changed to "NOT USED" at the top of the notice in the bens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads: Stamp Benefits from \$
2.	The Food Stamp Benefits of individuals added to the ☐ INCREASE your Food effective	O UP" were changed to "NOT USED" at the top of the notice in the bens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads: Stamp Benefits from \$ to \$
2.	The Food Stamp Benefits of individuals added to the INCREASE your Food effective	D UP" were changed to "NOT USED" at the top of the notice in the bens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads: Stamp Benefits from \$ to \$
2.	The Food Stamp Benefits of individuals added to the INCREASE your Food effective	D UP" were changed to "NOT USED" at the top of the notice in the bens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads: Stamp Benefits from \$
2.	The Food Stamp Benefits of individuals added to the INCREASE your Food effective	D UP" were changed to "NOT USED" at the top of the notice in the bens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads: Stamp Benefits from \$
2.	The Food Stamp Benefits of individuals added to the INCREASE your Food effective Iname(s)] Your Food Stamp Benefits of individuals added to the Increase of Increase	O UP" were changed to "NOT USED" at the top of the notice in the bens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads: Stamp Benefits from \$
2.	The Food Stamp Benefits of individuals added to the INCREASE your Food effective	D UP" were changed to "NOT USED" at the top of the notice in the bens to Food Stamp Benefits after 270 Days. "INCREASE" section was changed to allow for the listing of name(s) e case. The change section now reads: Stamp Benefits from \$

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-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

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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.

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE (NYC)

NOTICE DATE:				NAME AND ADDRESS OF AGEN	CY/CENTER OR DISTRICT OFFICE
CASE NUMBER CIN NUMBER			R		
0.405		** D	10000		
CASE	NAME (And C/O Na	me if Present) AND	ADDRESS	GENERAL TELEPHONE NO. FOR	R
I			l	QUESTIONS OR HELP	`
				OR Agency Conference	
				Fair Hearing information and assistance	
1				Record Access	
<u> </u>				Legal Assistance informa	ation
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAM		TELEPHONE NO.
	ken on your appli r, next to the che			d Stamp Benefits dated	is
explained below				N 270 DAYS CANNOT BE	PEDI ACED
					<u> </u>
for [name(s)]				
1. 🗌 You v	vill get \$		for the month	of	because we
must	figure your first n	nonth's benefit f	rom:		
1a. 🗌 🗎	The date you app	lied to the end o	of the month. You may	y access your benefit on	·
				because you gave us proof	
2. ☐ You v	viii get \$	wnic	n is a combined bene This is because.	efit for the months ofe	and after the 15 th of the month. Your
first n the m	nonth's benefit of nonth. Your secor	\$	was	s figured from the date you a	applied/provided proof to the end of
You r	nay access your	combined bene	fit on		·
3. Begir	nning		you will get \$ _	n	nonthly in Food Stamp Benefits.
You r	may access these	e benefits on the	e day of e	ach month.	
4. 🗌 Begir	nning		you will get \$	mor	nthly in Food Stamp Benefits.
5. ☐ So yo	ou could get Food	d Stamp Benefits		ulated your benefit without al	Il the necessary proof. Listed here
	mine the Food St				oof. This proof will be used to due to this proof, you will not be
				Food Stamp Benefits might	go down or might stop. If this happens,
_ ′	· ·	,	ood Stamp Benefits.		
of Ag popu appro progr	riculture and Mar lation control progoved to receive be am. To receive a	kets has a prog gram, eligible pe enefits, a copy o n application vou	ram that can help pay ople can have their can f this notice is proof the cher for this program,	y to have your dog or cat sp at or dog spayed/neutered fo nat you are eligible to particip	efits, the New York State Department bayed/neutered. Through the animal r \$20.00. If this notice says you are poate in the animal population control
	u than fallan 'e '	م مازر با مار د ما -			
·	r the following i		ioni mambar af va	household was DENIED	for the same stated Reason(s) .
		• •	•		or the same stated Reason(s) .
☐ You did	not give us the	proof we need t	o see if you can get	Food Stamp Benefits. If you	give us this proof we listed above by
		, you will ı	not have to reapply. A	fter that date, you will have	to reapply.
□ OVERPAYM	ENT INFORMAT	TON (check all t	hat apply)		
Bene	fits than you sho	uld have. See th	e Demand Letter (an	ecause you or your househod d also, if your case is closing ased on 18 NYCRR 387.19.	g, the Repayment Agreement) for
☐ You o	currently have a F	Food Stamp Ber	nefits overpayment. If		e Demand Letter and Repayment
☐ The b	enefit in Section	3 above reflects	•	(recoupment) of \$	in your benefits in order to
☐ The b	enefit in Section	4 above reflects		ecoupment) of \$	in your benefits in order to
			on is based on to N		
The above dea	ision(s) is hase	on 18 NVCBB	,		

FS App/Reapp/OP Recoup/Ad Only				
NA	ME:	ADDRESS:	CASE NUMBER:	
she		ams - The child(ren) listed below are approved to red National School Lunch and/or Breakfast Programs. Tour child attends.		
		ree meals if they attend a program such as a school y for your records so you can provide it to the sponsor		
Li	ist Child(ren)'s name(s):			
<u> </u>	Responsibility To Report Changes – Se report changes.	ee the enclosed LDSS-3151: "Food Stamp Change	Report Form" for information on when to	
$\overline{\mathbf{V}}$	If you were denied Food Stamp Benefits	s, please tell this agency if you are later approved fo	or Supplemental Security Income (SSI) or	

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

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

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.
- **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.

TO ASK FOR A FAIR HEARING. You can ask for a fair fleating by.	
<u>Mail:</u> Send a copy of the entire notice completed to the Office of Administrative Hearings, New York State Office of Temporary a Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.	nd
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 include a written explanation.)	to
	- -

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

Family Assistance (FA), since this may mean you can get Food Stamp Benefits.

by calling the general telephone number on the **front** of this notice.

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

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

<u>Online</u>: Complete an online request form at: 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

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

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

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE

NOTICE DATE:					NAME AND ADDRESS OF AC	GENCY/CENTER OR DISTRICT OFFICE
CASE NUMBI	ER		CIN NUMBE	R	_	
	CASE	NAME (And C/O Na	me if Present) AND	ADDRESS	_	
	CAGE	TVAINE (AND 0/0 NO	ine in resem, AND		GENERAL TELEPHONE NO.	
ı				ı	OR Agency Conference	
					Fair Hearing informa	tion
					and assistance	
					Record Access	
OFFICE NO.		UNIT NO.	WORKER NO.	UNIT OR WORKER NAM	, and the second	TELEPHONE NO.
		ken on your appl , next to the che			d Stamp Benefits dated _	is
explained	below		` '		IN 270 DAYS CANNOT E	BE REPLACED.
	OVFD	<u> </u>				
		-				
1. 🗆	Vauv	ill act C		for the month	o of	bagayaa wa
1. ⊔		figure your first r			1 01	because we
1a	. 🗆 T	he date you app	olied to the end o	of the month. You ma	ay access your benefit on	·
1b		•	•		because you gave us pro	
2. 🗆		-	-			 and
∠. ⊔		/iii geι ψ	WITIC	This is becaus	se you applied/provided pr	roof after the 15 th of the month. Your
	first m the m	onth's benefit of onth. Your seco	f \$ nd month's bene	wa efit of \$	is figured from the date yo is for the er	roof after the 15 th of the month. Your bu applied/provided proof to the end of other month.
3. 🗆						_ monthly in Food Stamp Benefits.
4. 🗆		=		e day of e		monthly in Food Stamp Benefits.
⊣. ⊔	_	-		· · · · · ·	of each month.	monthly in 1 dod stamp benefits.
5. 🗆	So yo	u could get Food	d Stamp Benefits	s right away, we calc	ulated your benefit withou	ut all the necessary proof. Listed here
		mine the Food S				s proof. This proof will be used to ge due to this proof, you will not be
6. 🗹				d are approved, your ood Stamp Benefits.	r Food Stamp Benefits mi	ght go down or might stop. If this happens
7. ☑ 8. □	Depa Throu this n the ar	rtment of Agricuingh the animal potice says you animal population	ulture and Mark opulation contro are approved to control program	ets has a program Il program, eligible p receive benefits, a c I. To receive an app	that can help pay to ha eople can have their cat copy of this notice is proc	Stamp Benefits, the New York State ve your dog or cat spayed/neutered. or dog spayed/neutered for \$20.00. If of that you are eligible to participate in rogram, call 1-888-669-0870.
	ED fo	r the following	individuals:			
		_		ery member of your	r household was DENIE I	D for the same stated Reason(s).
				Reason(s)		
	ou did	not give us the	proof we need to	see if you can get		you give us this proof we listed above by
			-		ny. Aiter that date, you wil	тпаче то теарріу.
OVER	We ar Benef	its than you sho	Food Stamp Be uld have. See th	nefits overpayment le e Demand Letter (ar	nd also, if your case is clo	sehold got more in Food Stamp sing, the Repayment Agreement) for
	You c	urrently have a f	Food Stamp Ber	nefits overpayment. I	ased on 18 NYCRR 387. f your case is closing, see nd how you will repay this	e the Demand Letter and Repayment
	The b	enefit in Section	3 above reflects		(recoupment) of \$	in your benefits in order to
	The b	enefit in Section	4 above reflects		recoupment) of \$	in your benefits in order to
		• •				
The abov		sion(s) is base				

1	DSS-3	152	(Pay	11/06)	Reverse	
	.ഗരര-ം	132	ıkev	11/06)	Reverse	

LD	SS-3152 (Rev. 11/06) Reverse		FS App/Reapp/OP Recoup/Ad Only/No A/C		
NA	ME:	ADDRESS:	CASE NUMBER:		
she	e attends a school that participand a copy of this notice to the s	ates in the National School Lunch and/ chool that your child attends.	below are approved to receive free lunch and/or breakfast if he or or long breakfast Programs. To receive this benefit, you must take or program such as a school, club or camp that participates in the		
		Make a copy for your records so you ca			
Li	ist Child(ren)'s name(s):				
V	Responsibility To Report Chareport changes.	anges – See the enclosed LDSS-3151	I: "Food Stamp Change Report Form" for information on when to		
$\overline{\mathbf{A}}$,	mp Benefits, please tell this agency if ye this may mean you can get Food Star	you are later approved for Supplemental Security Income (SSI) or np Benefits.		
V	help with your heating costs b		Stamp Benefits or Medical Assistance, you still may be able to get cance Program (HEAP). You can get more information on HEAP		
	CONF	ERENCE AND FAIR HEARING SECT	ION – DO YOU THINK WE ARE WRONG?		
If y	ou think our decision was wron	g, you can ask for a review of our decis	sion. 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 fo	r a State fair hearing with a State hearing officer.		
1.	call us to set up a meeting.	To do this, call the conference phone netimes this is the fastest way to solve	cision was wrong, or if you do not understand our decision, please number on the front of this notice or write to us at the address on any problem you may have. We encourage you to do this even		
2.	STATE FAIR HEARIN	IG – You have 90 days from the date	of this notice to ask for a fair hearing.		
НО	OW TO ASK FOR A FAIR HEA	RING: You can ask for a fair hearing by	y:		
		notice <i>completed</i> to the Office of Ac 30, Albany, New York 12201. Please k	dministrative Hearings, New York State Office of Temporary and seep a copy for yourself.		
	I want a fair hearing. I do include a written explanati		You may explain why you disagree below, but you do not have to		
<u>Ph</u>	one: 800-342-3334 (PLEASE	HAVE THIS NOTICE WITH YOU WHE	:N YOU CALL.)		
Fa	x: Fax a copy of the front and r	everse of this notice to: (518) 473-6735	i 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

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

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help get ready for the hearing, you have a right to look at your case file. If you call or write 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. LDSS-3620 NYC (Rev. 10/06) FS Red/Closing/OP/Timely

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

			(TIMELT ANL	ADEQUATE)	
NOTICE DATE:				NAME AND ADDRESS OF AGE	ENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER CIN NUMBER			ER .		
CASE N	AME (And C/O Nar	me if Present) AND AD	DDRESS	GENERAL TELEPHONE NO. F	OR
				QUESTIONS OR HELP	
				OR Agency Conference	
				Fair Hearing inform and assistance	ation
				Record Access	-
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER N	Legal Assistance in	formation TELEPHONE NO.
OTTIOL NO.	ONIT NO.	WORKER NO.	ONIT OR WORKER	/ WIL	TELETHONE NO.
	•	·		lained below, next to t	
				HIN 270 DAYS CANN	
				to \$	
☐ Your F	ood Stamp I	Benefits certific	cation period ha	is been extended. You	r benefits will now end in
2. DISCO	NTINUE you	ur Food Stamp	Benefits as of_		
3. 🗆 OVER	PAYMENT I	NFORMATIO	<u>N</u>		
m Ca	ore in Food ase is closing	Stamp Benefit g, the Repaym	ts than you shou	uld have. See the Dem	e you or your household got and Letter (and also, if your on this overpayment. This
Le		payment Agre			ase is closing, see the Demand ount you owe and how you will
				on (recoupment) of \$ _ ecision is based on 1	in your benefits 8 NYCRR 387.19.
4. If you a benefit		ublic Assistan	ce and/or Medio	cal Assistance, this cha	ange will NOT affect those
The reason for	r this action i	is:			
					_
-					
The above de	ecision(s) is	based on 18	NYCRR		
☑ Respons	ibility To Rep		- See enclosed		amp Change Report Form" for
morman	O.I OII WIIGH	o roport orially	you.		

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

LD	SS-3620 NYC (Rev. 10/06) REVERSE			FS Red/Closing/OP/A/C-Timely		
NAN		ADDRESS:		CASE NUMBER:		
<u> </u>	, , , , , , , , , , , , , , , , , , , ,	for the Home Energy Ass		al Assistance, you still may be able to get ou can get more information on HEAP by		
	CONFERENCE	AND FAIR HEARING SEC	CTION – DO YOU THINK W	<u>E ARE WRONG?</u>		
If y	ou think our decision was wrong, you can a	ask for a review of our deci	sion. We will correct our mis	stakes. You can do both 1 and 2:		
	1. Ask for a meeting (conference) with on	ne of our supervisors;	2. Ask for a State fair hea	ring 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 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 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 you ask for a State fair hearing. (See "Ke			al. Your benefits will stay the same only if		
2.	STATE FAIR HEARING – You have 90 c	days from the date of this n	otice to ask for a fair hearing	g.		
				u ask for a fair hearing before the effective enefits you got, but should not have gotten,		
	If you do not want your benefits to stay the you send back this notice, check the box		is issued, you must tell the	State when you call for a fair hearing or, if		
	☐ I do not want to keep my Food Stam	p Benefits the same until the	ne fair hearing decision is is:	sued.		
но	W TO ASK FOR A FAIR HEARING: You	can ask for a fair hearing b	y mail , by phone , by fax, b	y walk-in or online .		
	il: Send a copy of the entire notice to the 0. Box 1930, Albany, New York 12201. Ple			ce of Temporary and Disability Assistance,		
	I want a fair hearing. I do not agree with the written explanation.)	he agency's action. (You m	nay explain why you disagre	e below, but you do not have to include a		

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

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

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

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

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

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

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

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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-3620 (Rev.10/06) FS Red/Closing/OP/Timely

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

NOTICE DATE:			(111112171112	NAME AND ADDRESS OF AGE	ENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER		CIN NUMBE	ER .	-	
CASE NA	ME (And C/O Nam	e if Present) AND AD	DRESS	-	
				GENERAL TELEPHONE NO. FO	OR
				OR Agency Conference	
				Fair Hearing information and assistance	ation
			I	Record Access	
	T	1		Legal Assistance in	
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER N	AME	TELEPHONE NO.
We are CHAN	NGING your	Food Stamp E	Benefits, as exp	lained below, next to t	he checked boxes ☑:
FC	OD STAMD	DENEETE A	IOT LICED WIT	THIN 270 DAYS CANA	
				THIN 270 DAYS CANN to \$ _	
					
					a bana fita will mass and in
□ Your Fo	Stamp B	enents certino 	cation period na	is been extended. You	r benefits will now end in
2. DISCO	NTINUE you	r Food Stamp	Benefits as of_		
3. OVERF	PAYMENT IN	IFORMATION	<u>1</u>		
mo ca	ore in Food S se is closing	Stamp Benefit , the Repaym	s than you shoເ	uld have. See the Dem	e you or your household got and Letter (and also, if your on this overpayment. This
Le		ayment Agree			ase is closing, see the Demand ount you owe and how you will
				on (recoupment) of \$ _ ecision is based on 1	in your benefits 8 NYCRR 387.19.
4. ☐ If you a benefits	•	ıblic Assistanı	ce and/or Medic	cal Assistance, this cha	ange will NOT affect those
The reason for	this action is	s:			_
The above de	cision(s) is I	based on 18	NYCRR		
		ort Changes - o report chanç		LDSS-3151: "Food Sta	amp Change Report Form" for

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

LDS	SS-3620 (Rev. 10/06) REVERSE			FS Red/Closing/OP/A/C-Timely
NAM	E:	ADDRESS:		CASE NUMBER:
V	help with your heating costs by applying calling the general telephone number of	g for the Home Energy Ass n the front of this notice.		al Assistance, you still may be able to get ou can get more information on HEAP by
If yo	ou think our decision was wrong, you can			
,	Ask for a meeting (conference) with or			ring with a State hearing officer.
1.	to set up a meeting. To do this, call the	conference phone number	on the front of this notice o	not understand our decision, please call us r write to us at the address on the front of urage you to do this even when you have
	If you only ask for a meeting with us, we you ask for a State fair hearing. (See "Ke			al. Your benefits will stay the same only if
2.	STATE FAIR HEARING – You have 90	days from the date of this r	notice to ask for a fair hearing	g.
				u ask for a fair hearing before the effective enefits you got, but should not have gotten,
	If you do not want your benefits to stay t you send back this notice, check the box		is issued, you must tell the	State when you call for a fair hearing or, if
	I do not want to keep my Food Stam	p Benefits the same until t	he fair hearing decision is is:	sued.
НΟ\	W TO ASK FOR A FAIR HEARING: You	can ask for a fair hearing b	by mail , by phone , by fax or	on-line.
<u>Mai</u> Assi	<u>I</u> : Send a copy of this notice <i>completed</i> istance, P.O. Box 1930, Albany, New Yor	to the Office of Administ k 12201. Please keep a co	trative Hearings, New York ppy for yourself.	State Office of Temporary and Disability
[I want a fair hearing. I do not agree w a written explanation.)	ith the agency's action. (Yo	ou may explain why you disa	gree below, but you do not have to include
<u> Ph</u> c	one: 800-342-3334 (PLEASE HAVE	THIS NOTICE WITH YO	OU WHEN YOU CALL.)	_
	······································		,	

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, 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 "Lawvers".

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

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

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

OF NILINA					NAME AND ADDRESS	S OF AGENCY/CENTER OR DISTRICT OFFICE
E INUIVI	1BER		CIN NUMBE	ER	-	
		ASE NAME (And C/O Name	if Present) AND A	DDRESS	_	
		AGE WAVE (AND GAO NAME	ii i resent, rive re		GENERAL TELEPH	
				I	OR Agency C	
					Fair Hear	Conference
					and assis	
						ccesssistance information
FICE NO) .	UNIT NO.	WORKER NO.	UNIT OR WORKER N		TELEPHONE NO.
e are	e CF	·	·			e checked boxes ☑ .
	IN					CANNOT BE REPLACED effective
	<u> </u>	VORLAGE YOU TOOK	a Stamp Ben	ents nom	το φ	enective
						has been added to your case.
	l Y	our Food Stamp Ber	efits certifica	tion period has b	een extended. Yo	ur benefits will now end in
2. 🗆	<u>C</u>	CONTINUE your Foo	d Stamp Ber	nefits for [name(s)]	
		at \$		effecti	ve	
]	Your Food Stamp B	enefits certifi	cation period has	been extended.	Your benefits will now end in
3. □]	REDUCE your Food	d Stamp Bene	efits from \$		to \$
		effective	•			•
	1				heen extended \	Your benefits will now end in
	1		··	cation period had	been extended.	rour serions will now one in
4 🗆	,	DISCONTINUE	r Food Stom	a Danafita as of		
4. □	1	DISCONTINUE you	r rood Stam	b benefits as of _		
5. □]	OVERPAYMENT IN	<u>IFORMATIO</u>	<u>N</u>		
		Food Stamp B	enefits than the than the thick that	you should have.	See the Demand	ause you or your household got more in Letter and also, if your case is closing, ayment. This decision is base on 18
		and Repayme		•		ur case is closing, see the Demand Lett nt you owe and how you will repay this
		OVERDOVIMENT	nic / igroomon			
			ove reflects a			f \$ in your benefits in 18 NYCRR 387.19.
6. □]	□ The benefit ab	ove reflects a	ment. This deci	sion is based on	
6. 🗆	N	☐ The benefit ab order to repay We cannot add the fame:	ove reflects a your overpay ollowing indiv	yment. This deci viduals to your ca Reason(s)	sion is based on se:	
6. 🗆	N	☐ The benefit ab order to repay We cannot add the fame:	ove reflects a your overpay ollowing indiv	yment. This deci viduals to your ca Reason(s)	sion is based on se:	18 NYCRR 387.19.
	N: N:	☐ The benefit ab order to repay We cannot add the fame: ame:	ove reflects a your overpay ollowing indiv	yment. This deci viduals to your ca Reason(s) Reason(s)	sion is based on se:	18 NYCRR 387.19.
7. 🗆	Na Na —	☐ The benefit ab order to repay We cannot add the fame: ame:	ove reflects a your overpay ollowing indiv	yment. This deci yiduals to your ca Reason(s) Reason(s) ace and/or Medica	sion is based on se:	18 NYCRR 387.19. change will NOT affect those benefits.
7.	Na Na	The benefit ab order to repay We cannot add the fame: ame: If you are getting Pu	ove reflects a your overpay ollowing indiv	yment. This deci yiduals to your ca Reason(s) Reason(s) ace and/or Medica	sion is based on se: al Assistance, this	18 NYCRR 387.19. change will NOT affect those benefits.
7.	Na Na	The benefit ab order to repay We cannot add the fame: ame: If you are getting Pu	ove reflects a your overpay ollowing indiv	yment. This deci yiduals to your ca Reason(s) Reason(s) ace and/or Medica	sion is based on se: al Assistance, this	18 NYCRR 387.19. change will NOT affect those benefits.
7. □ 8. □	Na Na	The benefit ab order to repay We cannot add the fame: ame: If you are getting Pu	ove reflects a your overpay ollowing indiv	yment. This deci yiduals to your ca Reason(s) Reason(s) ace and/or Medica	sion is based on se: al Assistance, this	18 NYCRR 387.19. change will NOT affect those benefits.
7.	Na Na 	The benefit ab order to repay We cannot add the fame: ame: If you are getting Pu OTHER on for this action is:	ove reflects a your overpay ollowing individual individ	yment. This deci- yiduals to your ca Reason(s) Reason(s) ace and/or Medica	sion is based on se:	thange will NOT affect those benefits.
7. 🗆 8. 🗆 — The re	Na Na 	The benefit ab order to repay We cannot add the fame: ame: If you are getting Pu OTHER on for this action is:	ove reflects a your overpay ollowing individual individ	yment. This deci- yiduals to your ca Reason(s) Reason(s) ace and/or Medica	sion is based on se:	18 NYCRR 387.19. change will NOT affect those benefits.

NAME:	ADDRESS:	CASE NUMBER:
help with your heating costs b		I I Stamp Benefits or Medical Assistance, you still may be able to get stance Program (HEAP). You can get more information on HEAP by
CONFERENCE	AND FAIR HEARING SECTION	ON – DO YOU THINK WE ARE WRONG?
If you think our decision was wrong,	you can ask for a review of our decis	ion. We will correct our mistakes. You can do both 1 and 2:
1. Ask for a meeting (conference) w	ith one of our supervisors;	2. Ask for a State fair hearing with a State hearing officer.
call us to set up a meeting. To do	this, call the conference phone num	ecision was wrong or if you do not understand our decision, please ber on the front of this notice or write to us at the address on the blem you may have. We encourage you to do this even when you
	us, we will not keep your benefits the Keeping your Benefits the Same)	e same while you appeal. Your benefits will stay the same only if you
2. STATE FAIR HEARING –	You have 90 days from the date of th	is notice to ask for a fair hearing:
ask for a fair hearing within ten (1		Stamp Benefits to the same level they were before this notice, if you g of this notice. If you lose the fair hearing, you will have to pay back ou were waiting for the decision.
If you do not want your benefits t you send back this notice, check		ssued, you must tell the State when you call for a fair hearing or, if
\square I do not want to keep m	y Food Stamp Benefits the same unti	I the fair hearing decision is issued.
HOW TO ASK FOR A FAIR HEARI	NG: You can ask for a fair hearing by	mail, by phone, by fax, by walk-in or online.
	ce to the Office of Administrative Hear 2201. Please keep a copy for yoursel	rings, New York State Office of Temporary and Disability Assistance f.
	ee with the agency's action. (You ma	y explain why you disagree below, but you do not have to include a

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

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

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

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

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, 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:				<u> </u>	NAME AND		NCY/CENTER OR DISTRICT OFFICE
CASE NUME	BER		CIN NUMBE	R			
	CASE NAM	E (And C/O Name	if Present) AND AD	DDRESS			
						L TELEPHONE NO. I	
						Fair Hearing informa and assistance Record Access	ation
						Legal Assistance inf	formation
OFFICE NO.	. U	INIT NO.	WORKER NO.	UNIT OR WORKER	NAME		TELEPHONE NO.
We are				fits, as explaine			ed boxes 🗹 . T BE REPLACED.
1. 🗆 🖠	INCREAS	SE your Food	Stamp Benef	its from \$	to \$	effe	ective
•			-				has been added to your case.
							r benefits will now end in
2. 🗆							
	Your Fo	od Stamp Be	nefits certifica	tion period has	been exten	ded. Your bene	efits will now end in
3. 🗆			Stamp Benefi			to \$	
					been exten	ded. Your bene	efits will now end in
			·				
4. 🗌	DISCON	ITINUE your	Food Stamp I	Benefits as of _			·
5. 🗌	<u>OVERP</u>	AYMENT IN	ORMATION				
	Fo Re	od Stamp Be	nefits than yo eement for m	u should have.	See the De	mand Letter an	or your household got more in ad also, if your case is closing, the decision is based on 18
	and						s closing, see the Demand Letter ve and how you will repay this
				% reduction decision is ba			in your benefits in order to
6. 🗆	We cann	ot add the fo	llowing individ	uals to your ca	se:		
	Name:			Reason(s)			
	Name:			Reason(s)		
7. 🗆	If you ar	e getting Pub	olic Assistance	e and/or Medica	al Assistance	e, this change v	will NOT affect those benefits.
8. 🗆	OTHER						
The re	ason for the	nis action is:					
The at	oove deci	sion(s) is ba	sed on 18 N				
							Change Report Form" for
	informatio	on on when to	report chang	es.			

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

LDSS-3621 (Rev. 10/06) Reverse	T	FS Red/Clos/Inc/Cont-A/C - Adequate
NAME:	ADDRESS:	CASE NUMBER:
	applying for the Home Energy	Food Stamp Benefits or Medical Assistance, you still may be able to get Assistance Program (HEAP). You can get more information on HEAP by ce.
CONFERENCE	AND FAIR HEARING SE	ECTION – DO YOU THINK WE ARE WRONG?
- ·	-	decision. We will correct our mistakes. You can do both 1 and 2:
 Ask for a meeting (conference) with 	th one of our supervisors;	2. Ask for a State fair hearing with a State hearing officer.
call us to set up a meeting. To do	this, call the conference phone	our decision was wrong or if you do not understand our decision, please number on the front of this notice or write to us at the address on the problem you may have. We encourage you to do this even when you
If you <u>only</u> ask for a meeting with ask for a State fair hearing. (See		its the same while you appeal. Your benefits will stay the same only if you e)
2. <u>State fair Hearing</u> – `	You have 90 days from the date	e of this notice to ask for a fair hearing:
ask for a fair hearing within ten (1	0) days of the postmark of the	Food Stamp Benefits to the same level they were before this notice, if you mailing of this notice. If you lose the fair hearing, you will have to pay back hile you were waiting for the decision.
If you do not want your benefits to you send back this notice, check to		on is issued, you must tell the State when you call for a fair hearing or, if
☐ I do not want to keep	my Food Stamp Benefits the	ne same until the fair hearing decision is issued.
HOW TO ASK FOR A FAIR HEARIN	NG: You can ask for a fair hear	ing by mail, by phone , by fax or online .
<i>Mail:</i> Send a copy of this notice to th Box 1930, Albany, New York 12201.		ings, New York State Office of Temporary and Disability Assistance, P.O. If.
I want a fair hearing. I do not agree written explanation.)	ree with the agency's action. (Y	ou may explain why you disagree below, but you do not have to include a
Phone : 800-342-3334 (PLEASE HA	AVE THIS NOTICE WITH YOU	WHEN YOU CALL.)

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

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

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

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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

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER CIN NUMBER	
OAGE NAME (A. J. O/O. Nov.) (For only AND ADDDESS	
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 WO	KER NAME TELEPHONE NO.
SEE <u>PART B</u> FOR FOOD STAMP I	is explained below and on Part B, next to the checked box(es) : ENEFITS AND FAIR HEARING INFORMATION.
PUBLIC ASSISTANCE	
	to
for [name(s)]	
	to After this you will get \$
•	operate with the Office of Child Support Enforcement (OCSE) on [18NYCRR 352.3(d)]:
To lift this sanction, call () Re	d the detailed instructions on the back of this notice.
	ng drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]:
□ screening □ assessment	□ rehabilitation
o	t to disclose treatment information to the agency.
	%) is being taken against your Public Assistance. The reason for this
your reason. An undue hardship means that a personecessary clothing, to buy general items of need, o will let you know what kind of proof you will need to decide that the recoupment will cause an undue hat the recoupment rate must be at least 5%. This decide	your family an undue hardship, you should contact your worker to explain a does not have enough income to eat, to pay for shelter or utilities, to get to pay for medical needs not covered by Medical Assistance. Your worker show that the recoupment at this rate will cause an undue hardship. If we dship, the recoupment rate will be changed to a rate between 5 and 10%. on is based on 18 NYCRR 352.31(d).
□ DENIED for the following individuals:	() DENIED (II) ()
	r of your household was DENIED for the same stated Reason(s) .
Name(s):Reason(s)	
· · · · · · · · · · · · · · · · · · ·	
	·
MEDICAL ASSISTANCE	
□ ACCEPTED for Medical Assistance effective	for [name(s)]
□ ACCEPTED for Medical Assistance with a SF	ENDDOWN, effective for [name(s)]
Your total monthly income is \$	Your total monthly deductions are \$
The difference between these figures is your mont	ly net income for Medical Assistance. This is \$
	old your size is \$ The difference
between your net income and this standard (\$_) is your monthly excess income (18 ligibility under the Excess Income Program and Optional Pay-In
	for [name(s)]
	ligible for Medical Assistance and should contact this Department.
contact us no later than	de your eligibility under the Medical Assistance program. Please at so we can tell you
·	g reviewed. We will send you our decision within thirty days. not indicate on the application that you wanted to apply for Medical
□ OTHER	

A sanction for no	n-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 ch	oild support he or she should call (
cooperating with Cr	nild support he or she should call ()
	a good reason for not cooperating with child support are:
Some examples of fear of emotions	a good reason for not cooperating with child support are: al or physical harm to you or the children in your family; or,
Some examples of fear of emotions the child was be	a good reason for not cooperating with child support are:

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:		<u> </u>	<u> </u>		NAME AND		NCY/CENTER OR DISTRICT OFFICE
CASE NUME	BER		CIN NUMBE	R			
	CASE NAME (And C/O Name	if Present) AND AD	DDRESS			
						L TELEPHONE NO. DNS OR HELP Agency Conference	
						Fair Hearing information and assistance Record Access	ation
						Legal Assistance inf	formation
OFFICE NO.	. UNI	T NO.	WORKER NO.	UNIT OR WORKER	NAME		TELEPHONE NO.
We are				fits, as explaine			ed boxes ☑ . T BE REPLACED.
1. 🗆	INCREASE	your Food	Stamp Benef	its from \$	to \$_	effe	ective
·		-	-				has been added to your case.
							r benefits will now end in
2. 🗆							
	Your Food	Stamp Be	nefits certifica	tion period has	been exter	nded. Your ben	efits will now end in
3. 🗆		•	Stamp Benefi			to \$	
					been exter	nded. Your ben	efits will now end in
		·		•			
4. 🗆			·	Benefits as of _			·
5. ⊔			ORMATION				
	Food Repa	I Stamp Be	nefits than yo eement for m	u should have.	See the De	mand Letter an	or your household got more in ad also, if your case is closing, the decision is based on 18
	and I						s closing, see the Demand Letter we and how you will repay this
				% reduction decision is ba			in your benefits in order to
6. 🗆	We cannot	add the fol	lowing individ	uals to your ca	se:		
	Name:			Reason(s))		
	Name:			Reason(s	s)		
7. 🗆	If you are	getting Pub	lic Assistance	e and/or Medica	al Assistanc	e, this change v	will NOT affect those benefits.
8. 🗆	OTHER						
The re	ason for this	action is:_					
-							
The al	oove decisi	on(s) is ba	sed on 18 N				
	•		_		LDSS-3151	: "Food Stamp	Change Report Form" for
	information	on when to	report chang	es.			

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

LDSS-3621 (Rev. 10/06) Reverse		FS Red/Clos/Inc/Cont-A/C - Adequate
NAME:	ADDRESS:	CASE NUMBER:
help with your heating costs b		Food Stamp Benefits or Medical Assistance, you still may be able to get Assistance Program (HEAP). You can get more information on HEAP by ce.
CONFERENCE	AND FAIR HEARING SE	ECTION – DO YOU THINK WE ARE WRONG?
		decision. We will correct our mistakes. You can do both 1 and 2:
 Ask for a meeting (conference) w 	rith one of our supervisors;	2. Ask for a State fair hearing with a State hearing officer.
call us to set up a meeting. To de	o this, call the conference phone	our decision was wrong or if you do not understand our decision, please number on the front of this notice or write to us at the address on the y problem you may have. We encourage you to do this even when you
If you <u>only</u> ask for a meeting with ask for a State fair hearing. (See		its the same while you appeal. Your benefits will stay the same only if you e)
2. <u>State fair Hearing</u> –	You have 90 days from the date	of this notice to ask for a fair hearing:
ask for a fair hearing within ten (10) days of the postmark of the	food Stamp Benefits to the same level they were before this notice, if you mailing of this notice. If you lose the fair hearing, you will have to pay back hile you were waiting for the decision.
If you do not want your benefits you send back this notice, check		on is issued, you must tell the State when you call for a fair hearing or, if
☐ I do not want to kee	p my Food Stamp Benefits th	ne same until the fair hearing decision is issued.
HOW TO ASK FOR A FAIR HEAR	ING: You can ask for a fair hear	ng by mail , by phone , by fax or online .
<i>Mail:</i> Send a copy of this notice to t Box 1930, Albany, New York 12201		ings, New York State Office of Temporary and Disability Assistance, P.O. lf.
I want a fair hearing. I do not a written explanation.)	gree with the agency's action. (Y	ou may explain why you disagree below, but you do not have to include a
-		
Phone : 800-342-3334 (PLEASE H	AVE THIS NOTICE WITH YOU	WHEN YOU CALL.)

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

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

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

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER CIN NUMBER	
OAGE NAME (A. J. O/O. Nov.) (For only AND ADDDESS	
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 WO	KER NAME TELEPHONE NO.
SEE <u>PART B</u> FOR FOOD STAMP I	is explained below and on Part B, next to the checked box(es) : ENEFITS AND FAIR HEARING INFORMATION.
PUBLIC ASSISTANCE	
	to
for [name(s)]	
	to After this you will get \$
•	operate with the Office of Child Support Enforcement (OCSE) on [18NYCRR 352.3(d)]:
To lift this sanction, call () Re	d the detailed instructions on the back of this notice.
	ng drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]:
□ screening □ assessment	□ rehabilitation
o	t to disclose treatment information to the agency.
	%) is being taken against your Public Assistance. The reason for this
your reason. An undue hardship means that a personecessary clothing, to buy general items of need, o will let you know what kind of proof you will need to decide that the recoupment will cause an undue hat the recoupment rate must be at least 5%. This decide	your family an undue hardship, you should contact your worker to explain a does not have enough income to eat, to pay for shelter or utilities, to get to pay for medical needs not covered by Medical Assistance. Your worker show that the recoupment at this rate will cause an undue hardship. If we dship, the recoupment rate will be changed to a rate between 5 and 10%. on is based on 18 NYCRR 352.31(d).
□ DENIED for the following individuals:	() DENIED (II) ()
	r of your household was DENIED for the same stated Reason(s) .
Name(s):Reason(s)	
· · · · · · · · · · · · · · · · · · ·	
	·
MEDICAL ASSISTANCE	
□ ACCEPTED for Medical Assistance effective	for [name(s)]
□ ACCEPTED for Medical Assistance with a SF	ENDDOWN, effective for [name(s)]
Your total monthly income is \$	Your total monthly deductions are \$
The difference between these figures is your mont	ly net income for Medical Assistance. This is \$
	old your size is \$ The difference
between your net income and this standard (\$_) is your monthly excess income (18 ligibility under the Excess Income Program and Optional Pay-In
	for [name(s)]
	ligible for Medical Assistance and should contact this Department.
contact us no later than	de your eligibility under the Medical Assistance program. Please at so we can tell you
·	g reviewed. We will send you our decision within thirty days. not indicate on the application that you wanted to apply for Medical
□ OTHER	

A sanction for no	n-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 ch	oild support he or she should call (
cooperating with Cr	nild support he or she should call ()
	a good reason for not cooperating with child support are:
Some examples of fear of emotions	a good reason for not cooperating with child support are: al or physical harm to you or the children in your family; or,
Some examples of fear of emotions the child was be	a good reason for not cooperating with child support are:

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.

PA, MA, FS App **ACTION TAKEN ON YOUR APPLICATION:** PART A

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE NOTICE DATE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP Agency Conference Fair Hearing information and assistance Record Access is explained below and on Part B, next to the checked box(es) 🗹 : The action(s) taken on your application dated ____ SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION. **PUBLIC ASSISTANCE** ☐ **ACCEPTED** for the period from for [name(s)] _____ You will get \$___ _____, which will cover the period from ____ 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 _ 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 \$ _____ 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)]_____ In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department. We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than _____ 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

This above decision(s) is based on _

- 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.

PA, MA, FS, App

ACTION TAKEN ON YOUR APPLICATION:

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC) NOTICE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE DATE: CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information OFFICE NO LINIT NO WORKER NUMBER LINIT 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 ____ for [name(s)] _____ for the month of __ 1. ☐ You will get \$ your first month's benefit from: 1a.

The date you applied to the end of the month. You may access your benefit on 1b. \square The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _ 2. You will get \$ which is a combined benefit for the months of . This is because you applied/provided proof after the 15th of the month. Your first 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. __ day of each month. You may access these benefits on the ___ 5.
So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will not be 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits. 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). _____Reason(s)_ Name(s): Name(s): __ ___Reason(s)_ Name(s): Reason(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:

LDSS-4013B NYC (Rev. 11/06) (Part B) Reverse	PART B - NY	PA. MA. FS	App – No A/C – Adequate
NAME:	ADDRESS:	CASE NUMBER:	1,
National School Lunch/or Breakfast Prog she attends a school that participates in the send a copy of this notice to the school that y	National School Lunch and/or E		
This notice also entitles your child(ren) to free Food Service Program. Make a copy for your			cipates in the Summer
List Child(ren)'s name(s):			
Responsibility To Report Changes - when to report changes.	– See enclosed LDSS-3151: "l	Food Stamp Change Report Form" f	or information on
CONFERENCE AND F	AIR HEARING SECTION -	DO YOU THINK WE ARE WRO	NG?
If you think our decision is wrong, you can as	k for a review of our decision. We	will correct our mistakes. You can do bo	oth 1 and 2:
1. Ask for a meeting (conference) with o	one of our supervisors;	2. Ask for a State fair hearing with a Stat	e hearing officer.
 <u>CONFERENCE</u> (Informal meeting please call us to set up a meeting. To do t the <u>front</u> of this notice. Sometimes this is you have asked for a fair hearing. 	his, call the conference phone nu	mber on the front of this notice or write	to us at the address on
2. STATE FAIR HEARING – You have	e the following number of days from	n 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 H	earings, New York State Office of Ter	mporary and Disability
Assistance, P.O. Box 1930, Albany, New Yor	k 12201. Please keep a copy of e	acii fiolice foi yoursell.	

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.

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

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.

LDSS-4013B (Rev. 11/06)

ACTION TAKEN ON YOUR APPLICATION: PART I

PART B PA, MA, FS, App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE

NOTICE DATE:			OBLIO AC	01017	MOL, I C	<i>,</i>	IAWI L	<u> </u>) ADDRESS (R OR DIS	TRICT OF	FICE
CASE NUM	ИВЕГ	₹			CIN NUMI	BER									
	(CASE NAM	E (And C/O Na	me if Pro	esent) AND	ADDRE	SS								
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									OR	Agency Con Fair Hearing	iterence information	-			
										and assistar		-			
1								1		Record Acc	ess	-			
L							_			Legal Assist	ance informat	tion			
OFFICE N	Э.	UN	T NO.	WOR	KER NUME	ER U	NIT OR W	ORKER N	IAME			TE	LEPHONE	NUMBER	?
The act	ion((s) taken	on vour ann	lication	n dated					is expla	ained helow	v and	on Part	A next	to the checked
box(es)					·					ICAL ASSI					to the encored
										DAYS CAN					
ПАРІ	PRC	OVFD for	Food Stam												
													h	0001100	we must figure
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	•		date you a			d of th	e month	n. You m	nay acces	s your bene	efit on				
	1b.		latest date may acces		•						•	fter it	was due	∍.	
2.			get \$	-			which	n is a co	ombined I	penefit for t	he months	of _			
		and				1	This is b	ecause	you app	lied/provide	ed proof aft	ter th	e 15 th o	f the mo	onth. Your first
		month's	benefit of \$ oth Your se		month's	henefi	t of \$	W	as figure	d from the	date you a	applie is f	ed/provid or the e	led proo	f to the end of onth. You may
			our combir									_ 13 1	or the e	indie inc	Titil. Tod Illay
3.		Beginni	ng			у	ou will g	et \$			ı	montl	hly in Fo	od Stam	p Benefits.
		You ma	y access the	se be	nefits on	the		day o	of each m	onth.					
4.		Beginni	ng				you	will get	\$		m	onthl	y in Foo	d Stamp	Benefits.
		You ma	y access the	ese be	nefits on	the		da	y of each	month.					
5.			could get For												Listed here is
															vill be used to rou will not be
6.	V		onlied for Pu	ıblic A	ssistance	and a	re appro	oved vo	our Food S	Stamp Bene	efits might (ao do	wn or m	iaht stor	o. If this happens
0.	_		not get a no							Jump Born	omo imgrit ;	go ac	01 111	igiii olop	i uno nappone
7.		Other Info	rmation:												
☐ <u>D</u> I	<u>ENI</u>	IED for	the following	ng ind	ividuals:										
If A	٩LL	is listed	in the first	Name	(s) field,	every	membe	er of yo	ur house	hold was C	ENIED fo	r the	same s	tated R e	eason(s).
Na	me	(s):		_	_	Rea	son(s)_							·	
			ot give us th											oof we I	isted above by
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□ <u>0</u>	ГНЕ	<u>:R</u> :													
_ ov			IT INFORM												
	th	an you s	should have	. See	the Der	nand	Letter (a	and als	o, if your	case is c					Stamp Benefits nent) for more
			on this ove								sing soo ti	he D	amand I	l attor o	nd Repayment
Ш			for more in											∟euei ai	iu nepayiilelii
	Tr	ne benefi	t in Section	3 abo	ve reflec	ts a _	% :	reductio	n (recoup	ment) of \$				our bene	fits in order to
П			overpayme										in vo	nur hene	fits in order to
_	re	epay you	overpayme	nt. Th	is decisio	n is ba					·		iii yC	ai Delle	and in Older IU

NAME:	PART B	PA, MA, FS App – No A/C – Adequate
	ADDRESS:	CASE NUMBER:
		proved to receive free lunch and/or breakfast if he o
end a copy of this notice to the school t		Programs. To receive this benefit, you must take of
	to free meals if they attend a program such as a your records so you can provide it to the spons	a school, club or camp that participates in the Summe for.
List Child(ren)'s name(s):		
Responsibility To Report Changes changes.	See enclosed LDSS-3151: "Food Stamp Char	nge Report Form" for information on when to report
CONFERENCE AN	ID FAIR HEARING SECTION – DO YO	OU THINK WE ARE WRONG?
f you think our decision was wrong, and 2:	, you can ask for a review of our decision.	We will correct our mistakes. You can do both
I. Ask for a meeting (conference) wi	ith one of our supervisors; 2. Ask for	a State fair hearing with a State hearing officer
 CONFERENCE (Informal meeting 	ng with us) If you think our decision was w	wana ay if yay da nat wadayatand ayy daalalay
the address on the front of thi	g. To do this, call the conference phone nu	umber on the front of this notice or write to us a
the address on the front of thi encourage you to do this even wh	g. To do this, call the conference phone nu s notice. Sometimes this is the fastest v	umber on the front of this notice or write to us a way to solve any problem you may have. W
the address on the front of thi encourage you to do this even wh	g. To do this, call the conference phone nu s notice. Sometimes this is the fastest w nen you have asked for a fair hearing.	umber on the front of this notice or write to us a way to solve any problem you may have. W
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the address on the front of thi encourage you to do this even what 2. STATE FAIR HEARING – You have Public Assistance, Medical Assistance Food Stamp Benefits HOW TO ASK FOR A FAIR HEARI Mail: Send a copy of Part A and For Disability Assistance, P.O. Box 1930	g. To do this, call the conference phone number of sometimes this is the fastest when you have asked for a fair hearing. ave the following number of days from the distance, Social Services ING: You can ask for a fair hearing by mail Part B to the Office of Administrative Heard, Albany, New York 12201. Please keep a agree with the agency's action. (You may express the source of the source o	mber on the front of this notice or write to us a way to solve any problem you may have. W date of this notice to ask for a fair hearing: TIME LIMIT 60 days 90 days , by phone , by fax or online . rings, New York State Office of Temporary an
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Fax: Fax a copy of the front and reverse of this notice to: (518) 473-6735 or

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

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

LDSS-4014A NYC (Rev. 11/06) ACTIO

ACTION TAKEN ON YOUR RECERTIFICATION:

PART A PA, MA, FS, Serv-Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC) NOTICE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE DATE: CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information OFFICE NO. UNIT NO. WORKER NUMBER | UNIT OR WORKER NAME TELEPHONE NUMBER The action(s) taken on your recertification dated _____ _is explained below and on Part B, next to the checked box(es) $oxdit{2}$: SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION. **PUBLIC ASSISTANCE** □ **RECERTIFIED** for the period from _ □ **REDUCE** your monthly Public Assistance benefit for that period effective ____ from \$ ☐ The above grant is based on a reduced budget because: _____ failed without good cause to cooperate with the Office of Child Support Enforcement (OCSE) on ____ [18NYCRR 352.3(d)]: . Read the detailed instructions on the back of this notice. To lift this sanction, call (___ failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]: □ 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 \$ __has been added to your case. [name(s)] We cannot add the following individuals to your case: Reason(s) _____ Reason(s)__ Name(s): Reason(s)_ Name(s): Reason(s)_ Name(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)] ___ **CONTINUE** the Medical Assistance coverage for [name(s)] pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _ _____ so we can tell you the information we need. at **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 _____. Your total monthly deductions are coverage with a SPENDDOWN. Your total gross monthly income is \$_____ \$______. The difference between these is your monthly net income for Medical Assistance. This is \$_____ allowable income standard for a family household your size is \$ ______ . The difference between your net income and this __) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program. **DISCONTINUE** Medical Assistance for [name(s)]_ _____ because _ ☐ Medical Assistance coverage will continue 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.

NAME:	ADDRESS:	CASE NUMBER:					
To Lift a Sanction for Non-cooperation with a Child Support Requirement							

PART A - NYC

PA, MA, FS, Serv – Recert

LDSS-4014A NYC (Rev. 11/06) (Part A) Reverse

To Lift a Sanction for Non-cooperation with a Child Support Requirement
A sanction for non-cooperation with a child support requirement is open-ended and will continue untilcontacts the Child Support Enforcement Unit and cooperates.
When contacts the Child Support Enforcement Unit, he or she will be told what action(s) must be taken to end the sanction. The sanction will end when he or she takes the required
actions(s). If did not cooperate but now wants to report a good reason for not
cooperating with child support he or she should call ()
Some examples of a good reason for not cooperating with child support are:
fear of emotional or physical harm to you or the children in your family; or,
the child was born due to rape or incest; or,
 the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three months.
To find out more information about how to end the sanction, call ()

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

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

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

- $\mathbf{\Lambda}$ 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.
- \square Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.
- $\overline{\mathbf{V}}$ 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.
- $\mathbf{\Lambda}$ 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

PART A PA, MA, FS, Serv-Recert

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

NOT D/	ICE ATE:				NAME AND ADDR	ESS OF AGENCY/CE	NTER OR DISTRICT OFFIC	E
CASE	NUMBER		CIN NUMBER					
	CASE N	NAME (And C/O Nam	e if Present) AND ADD	RESS				
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OFFI	CE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER	NAME		TELEPHONE NUMBER	
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	reason. An u	ındue hardship m	eans that a persor	n does not have	enough income to	eat, to pay for sh	nelter or utilities, to get	necessary
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]			IYCRR 352.31(d).					
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ME	DICAL ASSI	STANCE						
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	the receipt of	f information nece	essary to decide co	ntinued eligibility.			ř	
]	at						ll you the information w	e need.
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	REDUCE the	e Medical Assista	nce coverage effec			-		
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	support payr	nents.						
		ion(s) is based o		200 Vous Dublic A	ocietopos and M	lical Assistance De	onofite we will need to	coo if ye
still	can get Socia	al Services at you	ur next scheduled	recertification. Th	is does not neces	sarily mean that y	enefits, we will need to you will no longer be a	ble to get
			ation, we will do a vices worker or call				Social Services. If you	nave any

BE SURE TO READ THE BACK OF $\underline{\mathsf{PART}\;B}$ FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

LDSS-4014A (Rev. 11/06) (Part A) Reverse	PART A	PA, MA, FS, Serv – Recert
NAME:	ADDRESS:	CASE NUMBER:

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

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

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

- If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
- Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.
- Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.
- Animal Population Control Program (APCP) If you have been approved to continue to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for \$20.00. 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

LDSS-4014B NYC (Rev. 11/06) **ACTION TAKEN ON YOUR RECERTIFICATION:**

PA, MA, FS, Serv Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC) NOTICE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE 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 _____ for [name(s)] ____ because we must figure your first 1. ☐ You will get \$ for the month of month's benefit from: 1a.

The date you applied to the end of the month. You may access your benefit on _ 1b. \square The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _ 2. ☐ You will get \$ which is a combined benefit for the months of . This is because you applied/provided proof after the 15th of the month. Your first 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. ____ you will get \$_ 4. Beginning _ ____ 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). Reason(s) Name(s): Reason(s) Name(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 ___, 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. % reduction (recoupment) of \$ in your benefits in order to The benefit in Section 3 above reflects a repay your overpayment. This decision is based on 18 NYCRR 387.19. The benefit in Section 4 above reflects a ______% reduction (recoupment) of \$____ repay your overpayment. This decision is based on 18 NYCRR 387.19. The above decision(s) is based on 18 NYCRR:

.DSS-4014B NYC (Rev. 11/06) (Part B) Rev		PART B – NYC		erv Recert - Timely - A/C No FS
NAME:	ADDRESS:		CASE NUMBER:	
ational School Lunch/or Breakfast Pro ttends a school that participates in th opy of this notice to the school that you	e National School Lunch and/o			
his notice also entitles your child(ren) ood Service Program. Make a copy fo			ol, club or camp that	participates in the Summe
List Child(ren)'s name(s):		·		
Responsibility To Report Changes - changes.	- See enclosed LDSS-3151: "Fo	ood Stamp Change Repo	ort Form" for information	on on when to report
CONFERE	NCE AND FAIR HEARING SEC	CTION - DO YOU THINK	WE ARE WRONG?	
you think our decision is wrong, you o	an ask for a review of our decis	sion. We will correct our n	nistakes. You can do l	ooth 1 and 2:
. Ask for a meeting (conference) with o	one of our supervisors; 2. A	ask for a State fair hearing	g with a State hearing	officer.
CONFERENCE (Informal meeting with set up a meeting. To do this, call the notice. Sometimes this is the fastest was fair hearing.	conference phone number on	the front of this notice of	or write to us at the a	ddress on the front of the
you <u>only</u> ask for a meeting with us, w or a State fair hearing. (See "Keeping `			I. Your benefits will sta	ay the same only if you as
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, S	Social Services			60 days
Food Stamp Benefits				90 days
this notice is telling you that you owe or a fair hearing within 60 days of the c laim in the future that the agency's dec	late of this notice. If you do not	call for a fair hearing wit		
EEPING YOUR BENEFITS THE SAME: Voney were before this notice, if you as earing, your Food Stamp Benefits cathown in this notice. If you lose the faith while you were waiting for the decision.	k for a fair hearing before the nnot be continued in the sar r hearing, you will have to pay	effective date stated in me amount as before yo back any Public Assistar	this notice. However, our recertification, but	, even if you ask for a fa will be in the new amou
you do not want your benefits to stay end back this notice, check the box or		issued, you must tell the	e State when you call	for a fair hearing or, if yo
do not want to "keep my benefits the s	same" until the Fair Hearing dec	cision is issued:		
☐ Public Assistance	☐ Medical Assistance	☐ Social Serv	vices	
OW TO ASK FOR A FAIR HEARING: You	can ask for a fair hearing by ma	ail, by phone, by fax, by	walk-in or online.	
nil: Send a copy of Part A and Part B O. Box 1930, Albany, New York 12201			e Office of Temporary	and Disability Assistance
I want a fair hearing. I do not agrewritten explanation.)	e with the agency's action. (You	ı may explain why you di	sagree below, but you	do not have to include a
<u>Phone</u> : 800-342-3334 (PLEASE HAVE T	THIS NOTICE WITH YOU WHE	N YOU CALL.)		
ax: Fax a copy of the front and reverse	e of this notice to: (518) 473-673	35.		
<i>Valk-In:</i> Bring a copy of this entire notic 30 West 34 th Street, NYC.	e to the New York State Office	of Temporary and Disabi	ility Assistance at 14 E	Boerum Place, Brooklyn or
Online: Complete an online request form	n at: http://www.otda.state.ny.us	s/oah/forms.asp		
f you cannot reach the New York State	Office of Temporary and Disab	ility Assistance by phone	e. fax. walk-in or online	e, please write to ask for a

2

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.

NOTICE	Р	UBLIC ASSISTA	ANCE, FOOD STA	MP BENEFIIS, I	NAME AND ADDRESS OF AGENCY/CEN	
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					OR Agency Conference Fair Hearing information and assistance	
					Record Access	
					Legal Assistance information	
OFFICE NO.		UNIT NO.	WORKER NUMBER	UNIT OR WORKER N	NAME	TELEPHONE NUMBER
		en on your rece	rtification dated		is explained below	and on Part A, next to the checked
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3. 🗆	_	-			II get \$	monthly in Food Stamp Benefits.
			se benefits on the			
3a.		Stamp Benefits. during your trans application in ore	You are not requing sition period that maked to receive any	red to report any c nay increase your increase. Early re	ecertifications that result in a bene	tion period. If you have changes orker to file an early recertification fit increase will end your transition
4. 🗆		-	-	-	it will continue as described above get \$	
4. 🗆			se benefits on the			monthly in Food Stamp Benefits.
5. 🗆	So y	ou could get Foo	od Stamp Benefits	right away, we ca		e necessary proof. Listed here is the
			•		ture unless you provide this proof p Benefits change due to this proof	This proof will be used to determine of, you will not be notified.
6. V	you	will not get a not	tice about your Fo	od Stamp Benefits	S.	down or might stop. If this happens,
7.	Other	information:				
☐ DENI	ED f	or the following	ı individuals:			· ·
		_		every member of	your household was DENIED fo	r the same stated Reason(s)
				•	your nodeonoid was beined to	• •
Name	e(s):		R	eason(s)		
				- ·		
		-	•		t Food Stamp Benefits. If you give eapply. After that date, you will ha	e us this proof we listed on the above
					eappiy. Aiter that date, you will have	уе to теарріу тог benefits.
OVERE	PAYM	ENT INFORMAT	ION			
□ W	/e are	establishing a Fould have. See th	ood Stamp Benefi	(and also, if your o	case is closing, the Repayment Ag	more in Food Stamp Benefits than greement) for more information on
					your case is closing, see the Demad how you will repay this overpayn	
			above reflects a _ t. This decision is		n (recoupment) of \$ CRR 387.19.	in your benefits in order to
			above reflects a _ t. This decision is		n (recoupment) of \$/CRR 387.19.	in your benefits in order to
The above	decis	ion(s) is based o	on 18 NYCRR:			

NAME:	PART B	PA, MA, FS, Serv Recert - Timely – A/C No FS
NAME:	ADDRESS:	CASE NUMBER:
		oproved to receive free lunch and/or breakfast if he or strams. To receive this benefit, you must take or send a cop
f this notice to the school that your child a		
	free meals if they attend a program such a our records so you can provide it to the spon	as a school, club or camp that participates in the Summasor.
List Child(ren)'s name(s):		
hanges.	·	nge Report Form" for information on when to report
<u></u>	D FAIR HEARING SECTION – DO	<u> </u>
you think our decision is wrong, you can a	ask for a review of our decision. We will cor	rect our mistakes. You can do both 1 and 2:
1. Ask for a meeting (conference) with o	one of our supervisors; 2. Ask for	a State fair hearing with a State hearing officer.
to set up a meeting. To do this, call the	conference phone number on the front of	ong or if you do not understand our decision, please call this notice or write to us at the address on the front of the encourage you to do this even when you have asked for
If you only ask for a meeting with us, we for a State fair hearing. (See "Keeping Y		you appeal. Your benefits will stay the same only if you a
. 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	e, Social Services	60 days
Food Stamp Benefits		90 days
	e of this notice. If you do not call for a fair h	do not agree that you owe this overpayment, you must clearing within 60 days of the date of this notice, you cannot
evel they were before this notice, if you as	sk for a fair hearing before the effective da	edical Assistance and Social Services Benefits to the sar te stated in this notice. However, even if you ask for a f before your recertification, but will be in the new amou
hown in this notice. If you lose the fair he	o, we may recover Medical Assistance Ben	
hown in this notice. If you lose the fair he hile you were waiting for the decision. Also you do not want your benefits to stay the	e same until the decision is issued, you m	efits.
hown in this notice. If you lose the fair he hile you were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box	e same until the decision is issued, you m	
hown in this notice. If you lose the fair he hile you were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box do not want to "keep my benefits the same	e same until the decision is issued, you mixes below:	efits. ust tell the State when you call for a fair hearing or, if yo
hown in this notice. If you lose the fair he while you were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box do not want to "keep my benefits the same. Public Assistance Med	e same until the decision is issued, you makes below: e" until the Fair Hearing decision is issued:	efits. ust tell the State when you call for a fair hearing or, if you call for a fair hearing or a fair hearin
hown in this notice. If you lose the fair he while you were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box do not want to "keep my benefits the same Public Assistance Med IOW TO ASK FOR A FAIR HEARING: You Mail: Send a copy of Part A and Part B to	e same until the decision is issued, you makes below: e" until the Fair Hearing decision is issued: lical Assistance Social Servicus can ask for a fair hearing by mail, by	efits. ust tell the State when you call for a fair hearing or, if y ices y phone, by fax or online. y York State Office of Temporary and Disability Assistance
hown in this notice. If you lose the fair he while you were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box do not want to "keep my benefits the same Public Assistance Med HOW TO ASK FOR A FAIR HEARING: You Mail: Send a copy of Part A and Part B to P.O. Box 1930, Albany, New York 12201.	e same until the decision is issued, you makes below: e" until the Fair Hearing decision is issued: lical Assistance Social Serviou can ask for a fair hearing by mail , by the Office of Administrative Hearings, New Please keep a copy of each notice for yourse	efits. ust tell the State when you call for a fair hearing or, if you call for a fair hearing or, if you call for a fair hearing or, if you call the State of York State Office of Temporary and Disability Assistance of Temporary and Disability Assistan
hown in this notice. If you lose the fair he while you were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box do not want to "keep my benefits the same Public Assistance Med MOW TO ASK FOR A FAIR HEARING: You Mail: Send a copy of Part A and Part B to Down 1930, Albany, New York 12201. For a light want a fair hearing. I do not agree we written explanation.)	e same until the decision is issued, you makes below: e" until the Fair Hearing decision is issued: lical Assistance Social Servicus Couran ask for a fair hearing by mail, by the Office of Administrative Hearings, New Please keep a copy of each notice for yourse with the agency's action. (You may explain	efits. ust tell the State when you call for a fair hearing or, if you call for a fair hearing or, if you call for a fair hearing or, if you call the State of th
hown in this notice. If you lose the fair her hille you were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box do not want to "keep my benefits the same Public Assistance Med IOW TO ASK FOR A FAIR HEARING: You Do Box 1930, Albany, New York 12201. For I want a fair hearing. I do not agree was written explanation.) Phone: 800-342-3334 (PLEASE HAVE THE	e same until the decision is issued, you makes below: e" until the Fair Hearing decision is issued: lical Assistance Social Servicus Cou can ask for a fair hearing by mail, by the Office of Administrative Hearings, New Please keep a copy of each notice for yourse with the agency's action. (You may explain	efits. ust tell the State when you call for a fair hearing or, if you call for a fair hearing or, if you call for a fair hearing or, if you call the State of York or online. York State Office of Temporary and Disability Assistance elf. why you disagree below, but you do not have to include
hown in this notice. If you lose the fair he while you were waiting for the decision. Also by you do not want your benefits to stay the end back this notice, check the box or box do not want to "keep my benefits the same Public Assistance Med Med IOW TO ASK FOR A FAIR HEARING: You Mail: Send a copy of Part A and Part B to P.O. Box 1930, Albany, New York 12201. For I want a fair hearing. I do not agree was written explanation.) Phone: 800-342-3334 (PLEASE HAVE The Fax: Fax a copy of the front and reverse of	e same until the decision is issued, you makes below: e" until the Fair Hearing decision is issued: lical Assistance Social Servicus Courcan ask for a fair hearing by mail, by the Office of Administrative Hearings, New Please keep a copy of each notice for yourse with the agency's action. (You may explain HIS NOTICE WITH YOU WHEN YOU CALL of this notice to: (518) 473-6735 or	efits. ust tell the State when you call for a fair hearing or, if y ices y phone, by fax or online. y York State Office of Temporary and Disability Assistance elf. why you disagree below, but you do not have to include
chown in this notice. If you lose the fair he while you were waiting for the decision. Also feed you do not want your benefits to stay the gend back this notice, check the box or box do not want to "keep my benefits the same Public Assistance Med HOW TO ASK FOR A FAIR HEARING: You Mail: Send a copy of Part A and Part B to P.O. Box 1930, Albany, New York 12201. For I want a fair hearing. I do not agree was written explanation.) Phone: 800-342-3334 (PLEASE HAVE THEAX: Fax a copy of the front and reverse of Online: Complete an online request form a	e same until the decision is issued, you makes below: e" until the Fair Hearing decision is issued: lical Assistance Social Servicus Courcan ask for a fair hearing by mail, by the Office of Administrative Hearings, New Please keep a copy of each notice for yourse with the agency's action. (You may explain HIS NOTICE WITH YOU WHEN YOU CALL of this notice to: (518) 473-6735 or	efits. ust tell the State when you call for a fair hearing or, if y ices y phone, by fax or online. y York State Office of Temporary and Disability Assistance elf. why you disagree below, but you do not have to include

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.

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

				(TIMELY & A	ADEQUATE) (NY	(C)		
NOTI DA	ICE ATE:				NAME AND AD	DRESS OF AGENCY/	CENTER OR DISTRICT	OFFICE
CASE	NUMBER		CIN NUMBE	R				
	CASE NAME	(And C/O Nan	ne if Present) AND AI	DDRESS				
	_				GENERAL TI QUESTIONS	ELEPHONE NO. FOR		
ı				ı		gency Conference		
					Fa	ir Hearing information		
						d assistance		
1						ecord Access		
OFFIC	CE NO. UNIT	NO.	WORKER NUMBER	R UNIT OR WORK		gal Assistance informa	TELEPHONE NUM	BER
We	are CHANGING y							
PUI	BLIC ASSISTANC		EE <u>PART B</u> FO	R FOOD STAME	AND FAIR HEA	RING INFORMA	TION.	
			ance Benefit effe	ective	from	\$	to \$	because:
		fail	ed without good	d cause to coo	perate with the	Office of Child	Support Enforcer	nent (OCSE) on
		by _					[18NYCRR 3	352.3(d)]:
						ructions on the b	eack of this notice	•
	Other:							·
	from \$	-						
							_has been added to	your case.
	We cannot add the						_	•
		· ·	•					
П	CONTINUE your	Public Ass	istance Renefit u	inchanged at \$				
	will cause your far does not have en medical needs no recoupment at this	mily an under ough income of covered or rate will carate betwood our Public	ue hardship, you se to eat, to pay f by Medical Assis luse an undue ha reen 5 and 10%. T Assistance grant	should contact your shelter or utility tance. Your work rdship. If we decirate recoupment it effective	our worker to explate, to get necessiver will let you know that the recouptate must be at lea	ain your reason. Ai sary clothing, to bu now what kind of oment will cause an ast 5%. This decision	you believe the recon undue hardship me uy general items of reproof you will need not undue hardship, the on is based on 18 N°	eans that a person need, or to pay for to show that the e recoupment rate
			I on 18 NYCRR					·
_	DICAL ASSISTAN		::-t	- f [(-)]				
	CONTINUE the	Medical	Assistance cov	erage for [nan	ne(s)] pending the	receipt of inform	ation necessary to	decide continued
	eligibility. Please	contact us	no later than			•		
	at					so we d	can tell you the infor	mation we need.
	pending our revie	_		-			()]	
	from full coverage	dical Assis	tance coverage (age with a SPEN	ettective JDDOWN Your	total gross mont	tor [nath]	ame(s)]	Your total
	monthly deduction Assistance. This	ons are \$ _ is \$		The	The difference ballowable incom	netween these is you	your monthly net in a family househol	come for Medical d your size is \$
		income (1		-		•	er the Excess Inco	
	effective			because				
	Medical Assistan	CA COVOTO	e will continue :::	nder Transitions	I Madical Assista	nce (See attached	d Medical Assistanc	e Fact Shoot)
		-				•	due to receipt of/in	•
The	spousal support إ above decision(oayments. s) is base	d on 18 NYCRR					
SEF	RVICES - If you are	getting So	cial Services and	lose your Public			Benefits, we will nee ou will no longer be Services. If you ha	

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.

NAME:	ADDRESS:	CASE NUMBER:	
		1	
To Li	ft a Sanction for Non-cooperation	on with a Child Support Requirement	
A sanction for non-o	cooperation with a child support _contacts the Child Support Enforce	t requirement is open-ended and will continue cement Unit and cooperates.	until
must be taken to end	the sanction. The sanction will e	t Enforcement Unit, he or she will be told what actiend when he or she takes the required actions(s to report a good reason for not cooperating with	s). Ìf
Some examples of a g	good reason for not cooperating with	ith child support are:	
the child was bornthe child is freed for	or physical harm to you or the childr due to rape or incest; or, or adoption; or, you are now being on and discussions have not gone o	g assisted by an agency to determine whether to po	ut the

PART A - NYC

PA, MA, FS, Serv Change - A/C - Timely

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

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.

To find out more information about how to end the sanction, call (_

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

NOTICE OF INTENT TO CHANGE BENEFITS: PART A

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 NOWBER	
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	\underline{B} , next to the checked box(es) $\mathbf{\overline{M}}$:
SEE <u>PART B</u> FOR FOOD STAMP A	ND FAIR HEARING INFORMATION.
PUBLIC ASSISTANCE	
☐ REDUCE your Public Assistance Benefit effective	from \$ to \$
	d effective
from \$ to \$	
☐ We cannot add the following individuals to your case:	
	n(s)
	n(s)
	n(s)
	n(s)
☐ CONTINUE your Public Assistance Benefit unchanged at \$	
at this rate will cause your family an undue hardship, you show means that a person does not have enough income to eat, to items of need, or to pay for medical needs not covered by Medi will need to show that the recoupment at this rate will cause a	aken against your Public Assistance. If you believe the recoupment uld contact your worker to explain your reason. An undue hardship pay for shelter or utilities, to get necessary clothing, to buy general cal Assistance. Your worker will let you know what kind of proof you an undue hardship. If we decide that the recoupment will cause an e between 5 and 10%. The recoupment rate must be at least 5%.
The REASON for this action is	
The above decision(s) is based on 18 NYCRR	<u> </u>
MEDICAL ASSISTANCE	ahan sa d
	unchanged.
eligibility. Please contact us no later than	
at	so we can tell you the information we need.
	delia delias de la
pending our review of eligibility. We will send you our decision v REDUCE the Medical Assistance coverage effective	for [name(s)]
	al gross monthly income is \$ Your total
monthly deductions are \$ Th	e difference between these is your monthly net income for Medical
Assistance. This is \$ The allowa	·
	net income and this standard (\$) is your letter explains eligibility under the Excess Income Program and
□ DISCONTINUE Medical Assistance for [name(s)]	
effective because	
Medical Assistance coverage will continue under Transitional M	edical Assistance (See attached Medical Assistance Fact Sheet).
-	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 A still can get Social Services at your next scheduled recertification. This Services. At your recertification, we will do a redetermination to see it please contact your services worker or call the general phone number a	does not necessarily mean that you will no longer be able to get Social f you can continue to get Social Services. If you have any questions,

	Timely	
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

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

OTIC! DAT				NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
SE N	IUMB	ER	CIN NUMBER	
		CASE NAME (And C/O Name in	f Present) AND ADDRESS	
	-			GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
				OR Agency Conference
				Fair Hearing information and assistance ————————————————————————————————————
1			ı	Record Access ——————————————————————————————————
FICE	-	UNIT NO. W	ORKER NUMBER UNIT OR WOR	Legal Assistance information KER NAME TELEPHONE NUMBER
FICE	INO.	ONIT NO.	TORRER NOMBER UNIT OR WORL	VER INAIVIE TELEFHONE NOIVIDER
√e a	are (CHANGING your benef	its, as explained below and	d on <u>Part A</u> , next to the checked box(es) 🗹 :
		SEE <u>PART A</u> FOR PU	BLIC ASSISTANCE, MED	DICAL ASSISTANCE AND SERVICES INFORMATION.
		FOOD STAM	P BENEFITS NOT USED	WITHIN 270 DAYS CANNOT BE REPLACED.
FO	OD	<u>STAMPS</u>		
1.		<u>INCREASE</u> your Food	Stamp Benefits from \$	to \$
		effective		·
		[name(s)]		has been added to your case.
		Your Food Stamp Ben	efits certification period ha	as been extended. Your benefits will now end in
2.		CONTINUE your Food	Stamp Benefits for [name(s)]
3.		REDUCE your Food S	Stamp Benefits from \$	to \$
		effective		
		Your Food Stamp Ben	efits certification period ha	as been extended. Your benefits will now end in
4.		DISCONTINUE your F	Food Stamp Benefits as of	
5.		OTHER		
6.		OVERPAYMENT INFO	ORMATION (Check All	Гhat Apply)
		Stamp Benefits than y	ou should have. See the D	rpayment because you or your household got more in Food Demand Letter (and also, if your case is closing the Repaymen Iment. This decision is based on 18 NYCRR 387.19.
		-		payment. If your case is closing, see the Demand Letter and the amount you owe and how you will repay this overpayment.
			ects a% reduction (Rent. This decision is base	decoupment) of \$ in your benefits in order to do n 18 NYCRR 387.19.
7 .		We cannot add the foll	lowing individuals to your o	case:
				son(s)
				son(s)
				son(s)
_				son(s)
8.		If you are getting Publ	ic Assistance and/or Medic	cal Assistance, this change will NOT affect those benefits.
9.		OTHER INFORMATION	<u> </u>	
The	e rea	ason for this action is:_		
		ove decision(s) is bas		

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

LDSS-4015 B (Rev. 11/06) (Part B) Reverse	PART B	PA, MA, FS, Serv Change - A/C - Timely
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. <u>CONFERENCE</u> (Informal meeting with us) If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

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:

send back this notice, check the box or boxe	es below:		
I do not want to keep my benefits the same u	until the fair hearing decision is i	ssued:	
☐ Public Assistance ☐	Medical Assistance	☐ Food Stamp Benefits	☐ Social Services
HOW TO ASK FOR A FAIR HEARING: You	u can ask for a fair hearing b	y mail , by phone, by fax or on l	line.
Mail: Send a copy of Part A and Part B Assistance, P.O. Box 1930, Albany, New Yo		G 1	e of Temporary and Disability
I want a fair hearing. I do not agree with written explanation.)	n the agency's action. (You may	explain why you disagree below, b	ut you do not have to include a

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

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

NOTICE OF INTENT TO CHANGE BENEFITS: PART A

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

NOTI	ICE ATE:				(71.5		NAME AND ADDRES	SS OF AGENCY/CEN	NTER OR DISTRICT	OFFICE
			CINI NII	MDED			-			
CASE	NUMBER		CIN NU	INDER						
	CASE I	NAME (And C/O Nam	ne if Present) AN	ID ADD	RESS		Ī			
Γ		<u>`</u>	·			$\overline{}$	GENERAL TELEPI QUESTIONS OR I			
							OR Agency Fair Hea and assi	Conference aring information		
						ı	Record A	Access		
L							Legal As	ssistance information	<u> </u>	
OFFIC	CE NO.	UNIT NO.	WORKER NU	MBER	UNIT OR	WORKER I	NAME		TELEPHONE NUMB	BER
We	are CHANG	ING your benefit	s as explaine	ed belo	ow and o	n <u>PART</u>	B, next to the che	ecked box(es)	1:	
			SEE <u>PART E</u>	S FOR	FOOD S	STAMP A	AND FAIR HEARI	NG INFORMATI	ION.	
PU	BLIC ASSIS	TANCE								
	REDUCE yo	our Public Assist	ance Benefit	effect	ive		fro	m \$	to \$	·
	INCREASE	E your Public Ass	sistance Ben	efit eff	ective _		fro	om \$	to \$	·
										ded to your case.
	_	nnot add the follo							nas been ade	ded to your case.
			•		•		s)			
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	CONTINUE	vour Public Assis	stance Benef	it unch	nanged a	at \$				
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me	KEASON 10	ir triis action is								
The	above decis	sion(s) is based	on 18 NYC	RR						
ME	DICAL ASSI	STANCE								
	CONTINUE	the Medical Ass	sistance cove	erage f	or [name	e(s)]				unchanged.
	CONTINUE	the Medical Ass	sistance cove	erage f	or [name	e(s)]				
							contact us no la	ter than		ding the receipt of at
							so we can tell you			
							view of eligibility.			
	REDUCE th	ne Medical Assist	tance covera	ge eff	ective				-	
							e is \$		Your	
										t income for Medical usehold your size is
	\$	11113 13 ψ				' . The	difference bet	ween your r	net income a	and this standard
	(\$				_) is yo	ur month	ly excess income	e (18 NYCRR 3	60-4.8). The end	closed letter explains
	eligibility un	der the Excess I	ncome Prog	ram ar	nd Option	nal Pay-Ir	n Program.			
	Medical Ass	sistance coverag	e will continu	ie und	er Trans	itional Me	edical Assistance	(See attached M	ledical Assistanc	e Fact Sheet).
			ge will contin	ue un	til			due to r	receipt of/increas	se in child or spousal
The	support pay above deci	ments. i sion(s) is base d	d on 18 NYC	RR						·
SEF	RVICES - If	you are getting S	Social Service	es and						vill need to see if you
	•	,						•	•	onger be able to get ces. If you have any
		•					•	_	•	es. If you have any

LDSS-4016A NYC (Rev. 11/06) (Part A) Reverse	PART A - NYC	PA, MA, FS, Serv – Change-A/C-Ad Only
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

NOTI DA	CE \TE:				NAME AND	ADDRESS OF AGENCY/CE	NTER OR DISTRICT OFFICE	
CASE	NUMBER		CIN NUMBER					
	CASE N	NAME (And C/O Nam	e if Present) AND ADD	RESS				
Γ	<u> </u>					L TELEPHONE NO. FOR DNS OR HELP		
					OR	Agency Conference		
						Fair Hearing information and assistance		
						Record Access		
L	_					Legal Assistance information		
OFFIC	CE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER	NAME		TELEPHONE NUMBER	
We.	are CHANG	ING your benefit	s as explained hel	ow and on PART	R next to	the checked box(es)	<u> </u> 	
***	arc 01 // 11 40	-	•			EARING INFORMATIO		
PUE	BLIC ASSIS		<u></u>		10 17			
	REDUCE y	our Public Assist	ance Benefit effec	tive		from \$	to \$	
	INCREASE	vour Public Assis	stance Benefit effe	ctive		from \$	to \$	
1							_has been added to your case.	
	- ` `	· -	ing individuals to y				-	
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	Name(s):			Reason(s)				
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	Name(s):			Reason(s)				
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	recoupment hardship me general item proof you w cause an ur least 5%. Th	at this rate will of eans that a persons of need, or to ill need to show indue hardship, that decision is based	cause your family a on does not have of pay for medical no that the recoupmon	an undue hardship enough income to eeds not covered ent at this rate wi e will be changed 3 352.31(d).	o, you shou eat, to pa by Medica Il cause ar d to a rate	Ild contact your worker y for shelter or utilities, Il Assistance. Your work undue hardship. If we between 5 and 10%.	c Assistance. If you believe the to explain your reason. An undue to get necessary clothing, to buy ker will let you know what kind of e decide that the recoupment will The recoupment rate must be at	
		-	-					
			I on 18 NYCRR _					
	DICAL ASSI		eistance coverage	for [name(s)]				
	unchanged.		istance coverage	ioi [name(3)]				
	CONTINUE	the Medical Ass	sistance coverage	for [name(s)]				
	of information	on necessary to o	decide continued e	eligibility. Please c	ontact us r	no later than	pending the receipt at	
					so we can	tell you the information	we need.	
	CONTINUE		_			otherities AAV- codil		
П	DEDITOE #						u our decision within thirty days.]	
	INEDUCE (I	io ivieuloai A55151	ande doverage en				I from full coverage	
					ome is \$		Your total monthly	
							r monthly net income for Medical	
							r a family household your size is income and this standard	
							4.8). The enclosed letter explains	
	-		ncome Program ar	•	-			
	enective			because				
	Medical Ass	sistance coverage	e will continue und	ler Transitional Me	edical Assi	stance (See attached M	ledical Assistance Fact Sheet).	
			ge will continue u	ıntil		due to	o receipt of/increase in child or	
The		port payments.	d on 18 NYCRR					
е								
you get	still can get Social Servi	Social Services a ces. At your rece	at your next sched ertification, we will	uled recertification do a redetermina	n. This doe ation to see	s not necessarily mean	ce benefits, we will need to see if that you will no longer be able to get Social Services. If you have notice.	

LDSS-4016 A (Rev. 11/06) (Part A) Reverse	PART A	PA, MA, FS, Serv – Change-A/C-Ad Only
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

LDSS-4016 B NYC (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) (NYC)

NOTICE DATE:	NAME AND ADDRESS	
	NAME AND ADDRES	S OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBE	MBER CIN NUMBER	
	CASE NAME (And C/O Name if Present) AND ADDRESS	
	GENERAL TELEPH QUESTIONS OR H	
	OR Agency (Conference
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	Record A	Access
		ssistance information
OFFICE NO.	O. UNIT NO. WORKER NUMBER UNIT OR WORKER NAME	TELEPHONE NUMBER
We are C	e CHANGING your benefits, as explained below and on <u>Part A</u> , next to	the checked hov(es) 🗸 :
SEE	E <u>PART A</u> FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANC	CE AND SERVICES INFORMATION.
	FOOD STAMP BENEFITS NOT USED WITHIN 270 DAYS	S CANNOT BE REPLACED.
FOOD	D STAMPS	
1. □	INCREASE your Food Stamp Benefits from \$to	o \$effective
		-
	'	
2. □	CONTINUE your Food Stamp Benefits for at \$ effective for at \$	ective
	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. □	·	
4. ⊔	□ <u>DISCONTINUE</u> your Food Stamp Benefits as of	·
5 . □	OTHER	
6. □	OVERPAYMENT INFORMATION (Check All That Apply)	
	□ We are establishing a Food Stamp Benefits overpayment be Food Stamp Benefits that you should have. See the Demand Repayment Agreement for more information on this overp NYCRR 387.19.	Letter and also, if your case is closing, the
	You currently have a Food Stamp Benefits overpayment. If you and Repayment Agreement for more information on the amount overpayment.	
	☐ The benefit above reflects a% reduction (recoupment) order to repay your overpayment. This decision is based on 1	of \$ in your benefits in 8 NYCRR 387.19.
7 . □	3	
	Name(s): Reason(s)	
	Name(s):	
	Name(s): Reason(s) Reason(s)	
8. □		
9. □	Other Information:	
. –		
The reaso	ason for this action is:	

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

If you <u>only</u> 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 benefi	ts the same until the fair hearing	g 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.

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

☐ I want a fair hearin have to include a w	g. I do not agree with the pritten explanation.)	ne agency's action.	(You may explain	why you disagre	e below, but yo	ou do not

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.

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

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.

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)

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LDSS-4016 B (Rev. 11/06) (Part B) Reverse	PART B	PA, MA, FS Serv – Change-A/C – Ad Only
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. <u>CONFERENCE</u> (Informal meeting with us) If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

If you <u>only</u> 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 no	ot want to keep my benefits the	e same until the fair hearing d	ecision is issued:	
	☐ Public Assistance	☐ Medical Assistance	☐ Food Stamp Benefits	☐ Social Services
HOW	TO ASK FOR A FAIR HEARIN	NG: You can ask for a fair h	nearing by mail , by phone , b	y fax or online.
			ministrative Hearings, New Yor p a copy of each notice for yours	k State Office of Temporary and Disability self.
	I want a fair hearing. I do not a a written explanation.)	agree with the agency's action	n. (You may explain why you dis	sagree below, but you do not have to include

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.