George E. Pataki
Governor

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

Robert Doar
Commissioner

Informational Letter

Section 1

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

Filing References

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

Section 2

I. Purpose

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

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

The following are the notices that now include that information.

LDSS-3152: "Action Taken on Your Food Stamp Benefits Case" (Rev.5/05)
LDSS-3152 NYC: "Action Taken on Your Food Stamp Benefits Case" (Rev.5/05) (NYC)
LDSS-4013A: "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev.5/05)
LDSS-4013B: "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev.5/05)
LDSS-4013A NYC: "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev.5/05) (NYC)
LDSS-4013B NYC: "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev.5/05) (NYC)
LDSS-4014A: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-A" (Rev.5/05)
LDSS-4014B: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-B" (Rev.5/05)
LDSS-4014A NYC: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-A" (Rev.5/05) (NYC)
LDSS-4014B NYC: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-B" (Rev.5/05) (NYC)

II. Program Implications:

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

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

FRONT

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

2. The title of the form was **changed** to "Action Taken on Your Food Stamp Benefits Case".

3. The following checked box and information was **added** after number "5" of the "Approved" section.

   The information reads as follows:

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

4. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

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

REVERSE:

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

2. The following "Free Lunch Program" information was **added** below the "case name" and "address" section at the top of the page.

   The information reads as follows:

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

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

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

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

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

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

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

FRONT

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

2. The title of the form was **changed** to "Action Taken on Your Food Stamp Benefits Case"(NYC).

3. The following checked box and information was **added** after number "5" of the "Approved" section.

   The information reads as follows:

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

4. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

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

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   The information reads as follows:

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

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

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

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

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

5. The 2nd paragraph in the "Access to Your File and Copies of Documents" was **changed** to mirror the same paragraph that appears on the Upstate version of this notice.

   That second paragraph now reads:

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

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

FRONT:

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

REVERSE:

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

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

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

FRONT:

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

2. The following checked box and information was **added** directly after number “5” of the “Approved” section.

   The information reads as follows:

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

3. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

4. The prechecked box regarding “Responsibility to Report Changes” was **moved** to the reverse side of the notice.

REVERSE:

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

2. The following Free Lunch information was **added** directly below the case name and address section at the top of the page.

   The information reads as follows:

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

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

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

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

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

FRONT:

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

REVERSE:

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

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

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

FRONT:

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

2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

   The information reads as follows:

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

3. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

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

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

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

FRONT:

The Revision Date was **changed** to5/05.

REVERSE:

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

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

FRONT:

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

The information reads as follows:

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

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

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

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

FRONT:

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

REVERSE:

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

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

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

FRONT:

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

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4. The 2nd paragraph in the "Access to Your File and Copies of Documents" was **changed** to mirror the same paragraph that appears on the Upstate version of this notice.

   That second paragraph now reads:

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

III. Forms Implications:

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

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

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

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

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

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

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

Issued By _____

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

Previous ADMs/INFs	**Releases Cancelled**	**Dept, Regs.**	**Soc. Serv. Law & Other Legal Ref.**	**Manual Ref.**	**Misc. Ref.**
89 ADM-21 89 ADM-8 89 ADM-6 88 ADM-4 87 ADM-48 87 ADM-4 86 ADM-10 86 ADM-7 85 ADM-45 85 ADM-17 82 ADM-55 82 ADM-5 81 ADM-55 80 ADM-90 04 INF-26 03 INF-41 03 INF-15 01 INF-17 99 INF-05 92 INF-46 92 INF-42 92 INF-34 91 INF-57 89 INF-28 88 INF-83		350.5,351.22 351.23 355,358-3.3 360-2.4,2.5, 2.6,6.4,7.5 369.6 387.14 387.20 505.14 (b) (5) (v),(viii),(x) 385.3 385.14	SSL 22 SSL 366-a	MARG pp. 374-382 TASB Section 8 A-J FSSB Sections 4.3.b; 5; 5.2; 5.3.h; 5.3.i; 5.6; 6.2; 6.5; 7.1; 7.1.e; 7.2; 7.2.b; 7.3; 7.4; 7.6; 7.7; 15.3; 15.1.c; 15.1.D; 15.1.e; 15.3; 15.4; 15.5; 15.1.c	GIS 89 MA007 DCL 7/13/83 89 LCM-155 89 LCM-22

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE

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

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

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

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

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

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

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

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

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

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

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

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: _____
   _____
   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.

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

7. ☐ Other Information: _____
   _____

☐ **DENIED** for Food Stamp Benefits because:

_____
_____
_____

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

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

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

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

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

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

☐ Other: _____
_____

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

☑ If you were denied Food Stamp Benefits, please tell this agency if you are later approved for Supplemental Security Income (SSI) or Family Assistance (FA), since this may mean you can get Food Stamp Benefits.

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

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

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

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

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

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

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

Writing : Send a copy of both sides of this notice *completed* to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

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

_____

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT NOTICE

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

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

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

重要通知：如需幫助閱讀此通知，請與您的個案負責人接洽。

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

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

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

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

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

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

Enclosure

LDSS-3152 NYC (Rev. 5/05)

FS App/Reapp/OP Recoup/Ad Only

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE (NYC)

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

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

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

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

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

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

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

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

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

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

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

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: _____
   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.

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

7. ☐ Other Information: _____
   _____

☐ **DENIED** for Food Stamp Benefits because:

_____
_____
_____

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

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

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

☑ If you were denied Food Stamp Benefits, please tell this agency if you are later approved for Supplemental Security Income (SSI) or Family Assistance (FA), since this may mean you can get Food Stamp Benefits.

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

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

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

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

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

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

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

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

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

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LDSS-4013A (Rev.5/05)

ACTION TAKEN ON YOUR APPLICATION: PART A

PA, MA, FS App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE

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

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

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

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **ACCEPTED** for the period from _____ to _____. You will get $_____ which will cover the period _____ to _____. After this you will get $ _____.

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

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

☐ **DENIED** for [name(s)]_____ because_____

_____

☐ **OTHER**_____

_____

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

MEDICAL ASSISTANCE

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

_____

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

_____

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

The difference between these figures is your monthly net income for Medical Assistance. This is $ _____. The allowable income standard for a family household your size is $ _____. The difference between your net income and this standard ($_____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program.

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

_____

In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department.

☐ **PENDED**

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

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

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

☐ **OTHER**_____

This above decision(s) is based on _____.

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

Enclosure

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

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

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

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

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

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

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013B (Rev. 5/05)

ACTION TAKEN ON YOUR APPLICATION: PART B

PA, MA, FS, App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE

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

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

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

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

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

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

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

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

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

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

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

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

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: _____ _____ You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.

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

7. ☐ Other Information: _____ _____

☐ **DENIED** for Food Stamp Benefits for [name(s)] because:_____ _____ _____

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

☐ **OTHER**: _____ _____

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

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

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

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

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

LDSS-4013A NYC (Rev. 5/05)

ACTION TAKEN ON YOUR APPLICATION: PART A

PA, MA, FS App

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

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

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

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

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

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

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

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

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

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

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

☐ screening ☐ assessment ☐ rehabilitation

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

☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance. The reason for this recoupment is: _____.

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

☐ **DENIED** for [name(s)]_____ because_____

_____

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

MEDICAL ASSISTANCE

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

_____

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

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

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

_____

In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department.

☐ **PENDED**

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

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

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

☐ **OTHER**_____

This above decision(s) is based on _____.

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

Enclosure

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

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

A sanction for non-cooperation with a child support requirement is open-ended and will continue until _____contacts the Child Support Enforcement Unit and cooperates.
When _____ contacts the Child Support Enforcement Unit, he or she will be told what action(s) must be taken to end the sanction. The sanction will end when he or she takes the required actions(s). If _____ did not cooperate but now wants to report a good reason for not cooperating with child support he or she should call (_____)_____.

Some examples of a good reason for not cooperating with child support are:

- fear of emotional or physical harm to you or the children in your family; or,
- the child was born due to rape or incest; or,
- the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three months.

To find out more information about how to end the sanction, call (_____)_____.

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

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

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

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

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

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013B NYC (Rev. 5/05) **ACTION TAKEN ON YOUR APPLICATION: PART B** PA, MA, FS, App

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

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

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

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

SEE PART A FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE INFORMATION.

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED.

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

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

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

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

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

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

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

5. ☐ So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: _____
   _____
   You will **not** be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will **not** be notified.

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

7. ☐ Other Information: _____
   _____

☐ **DENIED** for Food Stamp Benefits for [name(s)] because:_____
_____
_____

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

☐ **OTHER**: _____
_____

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

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

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

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

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LDSS-4014A (Rev. 5/05)

ACTION TAKEN ON YOUR RECERTIFICATION: PART A

PA, MA, FS, Serv-Recert

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

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

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

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

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **RECERTIFIED** for the period from _____ to _____ .

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

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

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

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

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

The **REASON** for this action is _____
_____.

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

MEDICAL ASSISTANCE

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

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

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

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

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

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

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

The above decision(s) is based on _____ .

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4014B (Rev. 5/05)

ACTION TAKEN ON YOUR RECERTIFICATION: PART B

PA, MA, FS, Serv Recert

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

NOTICE DATE:	CASE NUMBER	CIN NUMBER	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE

CASE NAME (And C/O Name if Present) AND ADDRESS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

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

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

FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED

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

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

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

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

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

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

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

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

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

   _____

   _____

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

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

7. ☐ Other information: _____

   _____ .

☐ **DENIED** for Food Stamp Benefits because:_____

_____

_____ .

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

☐ **OTHER**:_____

_____

☐ **OVERPAYMENT INFORMATION**

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

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

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

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

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

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

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

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **RECERTIFIED** for the period from _____ to _____ .

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

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

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

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

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

The **REASON** for this action is _____
_____.

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

MEDICAL ASSISTANCE

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

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

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

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

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

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

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

The above decision(s) is based on _____ .

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

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

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

NOTICE DATE:		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 PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED

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

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

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

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

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

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

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

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

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

   _____

   _____

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

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

7. ☐ Other information: _____

   _____ .

☐ **DENIED** for Food Stamp Benefits because:_____

_____.

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

☐ **OTHER**:_____

_____

☐ **OVERPAYMENT INFORMATION**

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

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

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

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

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

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

Enclosure

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

NAME:	ADDRESS:	CASE NUMBER:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

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

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

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

_____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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