LDSS-3969A (Rev 5/16)

PART A

NOTICE OF ACTION ON YOUR APPLICATION/BENEFIT FOR THE CHILD ASSISTANCE PROGRAM, STATUS OF MEDICAL ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) 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 NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The action(s) taken on your Application/Benefit are explained below and on Part B, next to the checked box(es) ☑:

SEE PART B FOR SNAP BENEFITS AND FAIR HEARING INFORMATION.

☐ **APPROVE** your request to transfer to the Child Assistance Program (CAP) effective ____________ with assistance as follows:

Effective ____________ you will get a semi-monthly benefit of $____________.

Effective ____________ you will also get a semi-monthly payment of $____________ to pay for Child Care.

☐ **DENY** your request to transfer to the Child Assistance Program. You will continue to receive FA benefits until further notice.

☐ **REDUCE** your Child Assistance Program benefit effective ____________ from $__________to $__________.

☐ **INCREASE** your Child Assistance Program benefit effective ____________ from $__________to $__________.

☐ **CONTINUE** your Child Assistance Program benefit unchanged at $____________.

☐ A RECOUPMENT of 10% is being taken against your Child Assistance Program benefits.

CAP is a voluntary program. You may withdraw from it at any time and reapply for the Family Assistance Program (FA). To come back into CAP, you must be getting FA benefits and must wait for a period of three (3) months from the date you withdraw from CAP. You may ask for a comparison of CAP benefits and FA benefits at any time.

☐ **DISCONTINUE** your Child Assistance Program 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 cover 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 ____________

____________.

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

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

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

Enclosure

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.

☑ If you are getting Public Assistance, SNAP Benefits, or Medical Assistance you may be able to get a discount on your phone service. For information on LIFELINE, call Verizon, toll free, at 1-800-555-5000.

☑ Although you may no longer be able to get Public Assistance, SNAP 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.

<u>SEE THE BACK OF PART B</u>

<u>FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.</u>