BROWNSVILLE CENTER
94 FLATBUSH AVENUE
BROOKLYN, NY 11217

PROGRAM CODE = 073

NOTICE OF DECISION ON YOUR PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE AND MEDICAL ASSISTANCE.

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS EN ESPANOL, POR FAVOR PONGASE EN CONTACTO CON SU TRABAJADOR(A).

NOTICE NUMBER:	DATE:	CASE NUMBER:
N0300J1407	June 6, 2014	008011813G

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
073		00912	BERNARD SHAW	718-876-4567

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	718-237-7202
OR Agency Conference	212-555-0073
Fair Hearing information and assistance	212-620-9893
Record Access	212-555-0073
Child/Teen Health Plan	212-555-0073

CASE NAME / AND ADDRESS

SAMUALJAMES
1074 LAFAYETTE AVE, 2ND
BROOKLYN, NY 11221

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

In the fall of 2014, there will be a period of time when your EBT card will not work for cash or food purchases, or to withdraw cash for as long as 24 hours while NYS changes EBT vendors. You will need to plan your cash and food purchases, and cash withdrawals, accordingly. When known, the exact date(s) and projected timeframe for the downtime will be posted on OTDA's (www.otda.ny.gov), on myBenefits (www.mybenefits.ny.gov), on the EBT helpline (1-888-328-6399) and on the OTDA helpline (1-800-342-3009).

PUBLIC ASSISTANCE

You will continue to get the **SAME AMOUNT** of public assistance benefits: $468.00. Even though we figured your public assistance benefits again, it did not change the amount of public assistance benefits you get.

Your monthly public assistance benefit of $468.00 will be distributed as follows:

- Restricted shelter payment : $657.60

If you have any changes in your household such as increased housing costs or someone else moving in, tell your worker right away. A change in your household could mean a change in your benefit amount.

Please see the budget calculation section of this notice for an explanation of how we figured your benefit amount.

This decision is based on Regulation 18 NYCRR 352.29 and Social Services Law 131-a(14).

How we figured your Public Assistance Benefits:

Check the information below and let us know if something is wrong. If there is a mistake, it could mean that this decision we made about your benefit is not correct.

CONTINUED ON THE NEXT PAGE ...

- Your gross income of is more than , which is 185% of your needs. The way we figure your gross income and needs is shown below:

Person's Name	Type of Income	Monthly Gross Amount

- Your income of is more than , which is the amount of your needs. The way we figure your income and needs is shown below:

Person's Name	Type of Income	Monthly Amount

- Your net income of includes a lump sum and is more than , which is the amount of your needs. This makes you ineligible for assistance from to . This period of ineligibility is calculated by dividing your monthly needs into the amount of your net income to determine the number of months your income should be enough to meet your needs. In the first month following this period, you should still have of income to be applied toward your needs. The way we figure your income and needs is shown below:

Person's Name	Type of Income	Monthly Amount

- Your income of is more than , which is the amount of your needs. The way we figure your income and needs is shown below:

Person's Name	Type of Income	Monthly Amount

- The way we figure your income and needs is shown below:

Person's Name	Type of Income	Monthly Amount

Total Earmed Income we count.....

Total Unearmed Income we count...

Total We Count.....

- Your needs are based on the following information:
- To figure your monthly income, we multiply your weekly income by 4 & 1/3, or your bi-weekly income by 2 & 1/6, or your semi-monthly income by 2, or use the monthly income amount which you provided.
- We do not count the first $90 of gross earned income from . Individuals in Safety Net Assistance cases, with no dependent children receiving assistance in the case, do not receive an additional disregard of gross earnings.
- There is 1 person in your Public Assistance case.
- There are people in your Public Assistance case.
- There are children under 18 years old in your case.
- There is one child under 18 years old in your case.
- There is 1 person in your Public Assistance suffix.
- There are people in your Public Assistance suffix.
- There is at least one person in your household who gets public assistance in a different case. You have told us that no members of either case are legally responsible for a member(s) of the other case. You have also told us that you and the member(s) of the other public assistance case do not pool your money, or do not share expenses, or do not eat meals together.

  This means that your basic allowances are figured on , the number of people in your case. However, your shelter allowance is figured on / of the limit for a person household. This is because you are not in a temporary housing situation.

CONTINUED ON THE NEXT PAGE ...

- There is at least one person in your household who gets public assistance in a different case. You have told us that you and the member(s) of the other public assistance case pool your money, share expenses and eat meals together. For that reason, your case and the other public assistance case(s) must be figured together.

  This means that your basic allowances are figured on / of the limit for a household of .

  Your allowance for shelter is figured on the limit for a person household. This is because you are in a temporary housing situation.

- A person in the case is a minor parent (an 18, 19 or 20 year old parent) who lives with his or her own parent(s). Because parents are responsible for their children until they reach age 21, this person's needs are not included in the shelter allowance.

- There is at least one person in your household that gets public assistance in a different case.

  When a member of one case is legally responsible for a member(s) of the other case or if you tell us that you and the people in the other public assistance case pool your money, share expenses and eat meals together and you are not in a temporary housing situation, the case budgets must be figured together.

  Your allowance is figured on / of the limit for a person household.

- There is at least one person in your household who is not on public assistance and who is a legally responsible relative (LRR) to a member of your case. A LRR is a spouse, or a parent of a child under age 21.

  If the LRR is a person who receives SSI, the person's needs are subtracted from the public assistance limit and the SSI income is NOT counted in the public assistance budget. This is true only if the case is non-federally funded Safety Net Assistance. For example, if a wife is eligible for public assistance and the husband receives SSI, the needs limit for the wife would be 1/2 of the limit for two people.

  If the LRR does NOT receive SSI, but has income that is more than his or her needs, the LRR's needs are included in the public assistance limit and the income is counted in the budget.

- Your household includes a pregnant woman, or child under age 18, or an 18-year-old child attending full time secondary school.

- Your household does not include a pregnant woman, or child under age 18, or an 18-year-old child attending full time secondary school.

- There is 1 person not living with you now, who is included to figure what we allow for housing and fuel.

- There are people not living with you now, who are included to figure what we allow for housing and fuel.

- There is 1 person not living with you now, who is included to figure what we allow for housing.

- There are people not living with you now, who are included to figure what we allow for housing.

- is being taken from your public assistance benefit due to 0 person(s) not complying with a public assistance rule.

- is being taken from your public assistance limit due to Learnfare requirements.

- Your household pays for housing.

- Your household pays for water.

- We allow for your share of the water expense.

- According to our records, you are homeless.

- We allow for housing.

CONTINUED ON THE NEXT PAGE ...

- Your household must pay for housing. This payment includes a 30% contribution limit on the amount of income that certain individuals pay toward housing.
- You pay for heat.
- You pay for heat.
- Your heat is included in your housing costs.
- Someone else pays for your heat.
- is included for Refrigerator Rental.
- is included for Chattel Mortgage.
- is included for Child Care Allowance For Non-PA Non Legally Responsible Caretaker.
- is included for Home Delivered Meals.
- is included for Pregnancy Allowance.
- No one in your suffix is at least four months pregnant.
- is included for Restaurant Allowances.
- is included for Essential Persons.

- The shelter supplement is not included in the amount of your needs when we decide if your income is enough to meet your needs.
- person(s) in your household did not help to establish paternity or get child support for your child(ren), so is subtracted from your needs.

SUPPLEMENTAL NUTRITION ASSISTANCE

Beginning June 6, 2014, your SNAP benefits will be **CHANGED** from $189.00 to $91.00. This is because:

- The federal standards used to calculate your SNAP benefits have changed.

  This decision is based on Regulation 18 NYCRR 387.12(f).

How we figured your SNAP Benefits:

Check the information below and let us know if something is wrong. If there is a mistake, it could mean that this decision we made about your benefit is not correct.

- You will get $91.00 for the month of July, 2014.
- There is 1 person in your SNAP household.
- You pay $625.74 for housing.
- According to our records, your type of housing is known as Unfurnished Apartment Or Room.
- Because you have phone costs, we allow the standard of $33.00.
- You have no allowable medical expenses.
- You have no individuals in your household that are enrolled in a Medicare approved Prescription Drug Discount Card program.
- No one in your household pays legally-obligated child support.
- We allow expenses for child care or dependent care while you are employed or seeking employment through job search, or are in training. You do not pay for child care or dependent care.
- We count the following monthly income:

Person with income	Type of Income	Monthly Amount
STEVEN W. SAMUALJAMES	SSI	$808.00

CONTINUED ON THE NEXT PAGE ...

Public Assistance	$0.00
Total Income:	**$808.00**
Countable Income:	**$325.26**

MEDICAL ASSISTANCE

We will continue Medical Assistance coverage unchanged for:

Name	Client I.D. #
STEVEN W. SAMUALJAMES	**XG42738A**

These persons will continue to be entitled to full services under the Medical Assistance Program.

This decision is based on Regulation 18 NYCRR 360-2.6.

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CONFERENCE AND FAIR HEARING SECTION

DO YOU THINK WE ARE WRONG?

If you think our decision was wrong, you can request a review of our decision. If we made a mistake, we will correct it. You can do both of the following:

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

CONFERENCE (Informal meeting with us)

If you think our decision was wrong or if you do not understand our decision, or need additional information about the reason for our decision, please call us to arrange a meeting. To do this, call the conference telephone number listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice. Sometimes this is the fastest way to solve any problems 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)

STATE FAIR HEARING

Deadline for Requesting a Fair Hearing

If you want the State to review our decision about your public assistance, you must ask for a fair hearing by **August 5, 2014**. This is the deadline even if you asked for a meeting (conference) with us.

If you want the State to review our decision about your medical assistance, you must ask for a fair hearing by **August 5, 2014**. This is the deadline even if you asked for a meeting (conference) with us.

If you want the State to review our decision about your SNAP benefits, you must ask for a fair hearing by **September 4, 2014**. This is the deadline even if you asked for a meeting (conference) with us.

Keeping your Benefits the Same

We will restore your SNAP benefits to the same level they were before this notice if you ask for a fair hearing by **June 16, 2014**. However, if you lose the hearing you will have to pay back any SNAP benefits you got, but should not have gotten, while you were waiting for the decision.

If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you write or call for a fair hearing.

How to Request a Fair Hearing

You can ask for a fair hearing in writing, by telephone, by fax, electronically or in person.

WRITE: Complete the "tear-off" Request for a Fair Hearing at the bottom of this page and send it to the address on the bottom of the next page.

OR CALL: **(800) 342-3334**

When you call, please tell the worker the number of this notice which is

(Read the next page for more of your Rights)

REQUEST FOR A FAIR HEARING

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.)

_____

_____

_____

Name : SAMUALJAMES
Address : 1074 LAFAYETTE AVE, 2ND
BROOKLYN, NY 11221

District/Office No: 66/073
Notice No. : N0300J1407
Case Number: 008011813G
Telephone : 718-231-3371

/_/ **I do not want to "keep my benefits the same" until the Fair Hearing decision is issued.**

ONLY USE THIS TEAR-OFF TO REQUEST A HEARING ABOUT THIS NOTICE.

CONTINUED ON THE NEXT PAGE ...

N0300J1407.

OR FAX: Send a copy of this notice to fax no. **(518) 473-6735.**

OR ONLINE: Complete the online request form at:
http://www.otda.ny.gov/oah/forms.asp

OR WALK-IN: Bring a copy of this notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, NY.

If you cannot reach the State electronically, by phone or fax, please write to request a fair hearing before the deadline for requesting a fair hearing.

What to Expect at a Fair Hearing

The State will send you a notice which 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 or 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 which explain why we are wrong.

To help you explain at the hearing why you think our decision is 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 obtain a lawyer at no cost to you by contacting:

BEDFORD-STUYVESANT COMMUNITY LEGAL SERVICES CORPORATION, 1368-90 FULTON STREET, 2ND FLOOR, BROOKLYN, NY 11216
Telephone: (718) 636-1155
LEGAL AID SOCIETY, 166 MONTAGUE ST, BROOKLYN, NY 11201
Telephone: (718) 722-3100

For the names of other lawyers check your Yellow Pages under "LAWYERS".

ACCESS TO YOUR FILES AND COPIES OF DOCUMENTS

To help you get ready for the hearing, you have a right to look at your case files. If you call, write or fax 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 us, we will send you free copies of 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 your 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.

Send this "Request for a Fair Hearing" to:

The Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, New York 12201

F15 FOOD STAMP SITE
25 HUDSON ST
NEW YORK, NY 10013

NOTIFICACION LA DECISION
DE SU ASISTENCIA NUTRICIONAL
SUPLEMENTARIA.

ESTA NOTIFICACION EN ESPANOL NO LLEVA ACENTOS
DEBIDO A QUE NUESTRO SISTEMA DE COMPUTADORAS
NO OFRECE LA CAPACIDAD PARA INCORPORARLOS

PROGRAM CODE = F15

NUMERO DEL AVISO:	FECHA:	NUMERO DE CASO:
N0600G3777	Mayo 28, 2014	010006886F

OFICINA	UNIDAD	TRABAJADOR(A)	NOMBRE DEL TRABAJADOR(A) O DE LA UNIDAD	NO. DE TELEFONO
F15				

NUMEROS TELEFONICOS DE LA AGENCIA

NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA	212-222-2222
O Para Conferencia con la Agencia	212-222-2222
Información y asistencia sobre Vista Imparcial	212-222-2222
Acceso a archivos/récords	212-222-2222
Plan de Salud Infantil/Adolescente	212-222-2222

NOMBRE DEL CASO Y DIRECCION

TW
1000 LENOX
NEW YORK, NY 10027

SI USTED NO ESTA DE ACUERDO CON NINGUNA DE LAS DECISIONES EXPLICADAS EN ESTA NOTIFICACION, USTED TIENE EL DERECHO DE SOLICITAR UNA CONFERENCIA Y/O PEDIR AL ESTADO UNA VISTA IMPARCIAL. LEA LA SECCION SOBRE LA CONFERENCIA Y/O LA VISTA IMPARCIAL PARA AVERIGUAR COMO SOLICITAR UNA CONFERENCIA Y/O UNA VISTA IMPARCIAL.

En el otono del 2014, durante un periodo de tiempo la tarjeta EBT no funcionara para dinero en efectivo ni para la compra de alimentos, ni tampoco para retirar dinero en efectivo en un lapso de hasta 24 horas mientras que el Estado de Nueva York hace el cambio de los contratistas de tarjetas EBT. Usted necesitara planificar adecuadamente la obtencion de dinero en efectivo, la compra de alimentos y el retiro de dinero en efectivo. Una vez que se tenga la fecha exacta y el tiempo estimado de la suspension de este servicio, se publicara en el sitio web de: OTDA www.otda.ny.gov ; myBenefits www.mybenefits.ny.gov ; en la linea de atencion al cliente de EBT: 1-888-328-6399) y en linea de atencion al cliente de la OTDA: 1-800-342-3009.

ASISTENCIA NUTRICIONAL SUPLEMENTARIA

Su solicitud para la continuacion del subsidio SNAP se **APRUEBA** de Junio 1, 2014 a Mayo 31, 2018.

Las siguientes personas han sido aprobadas para recibir el subsidio SNAP:

FSCASE AUGTSTX

Usted recibira $189.00 mensualmente en subsidio SNAP.

Si no retira el monto del subsidio SNAP en un periodo de 365 dias consecutivos, todo monto acreditado de subsidio SNAP remanente en la cuenta con un periodo minimo de antiguedad de 365 dias, sera extraido de la cuenta (retirado). Todo monto de subsidio SNAP extraido no se reintegrara.

Esta decision se basa en Reglamentacion Departamental 387.8, 387.14 y 387.15.

Como calculamos sus el subsidio SNAP:

Fijese en la informacion de abajo y notifiquenos si algo esta incorrecto. Si hay un error, este podria significar que la decision que tomamos acerca de su beneficio no es correcta.

o Usted no recibe ingresos ganados u otro tipo de ingresos aparte del

CONTINUADO EN LA PROXIMA PAGINA ...

Ingreso Suplementario del Seguro Social (SSI).

- Usted recibira $189.00 para el mes de Junio, 2014.
- Usted paga $242.01 o MAS por costos de alojamiento y reune los requisitos para recibir la asignacion estandar de servicios publicos para calefaccion o aire acondicionado (SUA) del programa SNAP.

SERVICIOS Y OTRA INFORMACION

RECORDATORIO IMPORTANTE

Proteja de los ladrones su Tarjeta de Transferencia Electronica de Beneficios (EBT)

Si alguien le llama nunca de sus datos personales tal como su numero de seguro social, numero de tarjeta EBT o el numero PIN de esta. Aunque la persona que llame diga ser un trabajador de una agencia local o funcionario del gobierno estatal, federal o del programa de EBT, NO DE su informacion personal. Si pierde, le roban o se le dana la tarjeta de EBT, debe primero llamar al Centro de Servicio y Atencion al Cliente de EBT al 1-888-328-6399 para anularla de manera que ya no se pueda usar. Despues comuniquese con el centro local de asistencia para que le expidan una nueva.

Recuerde: la persona que tenga sus datos personales y tenga su tarjeta EBT (o sepa su numero de tarjeta) puede robarle todos los beneficios acreditados a la cuenta de tarjeta EBT.

Informacion gratis sobre nutricion

Todo beneficiario de SNAP habilita para el programa **Eat Smart New York (ESNY)** - clases gratis sobre nutricion donde le ensenan como comprar y sacarle el maximo al dinero destinado para los gastos de comida. Si desea mas informacion o averiguar si el programa ESNY se ofrece en su condado, llame al 1-800-342-3009 o en linea en: **http://www.otda.state.ny.us/main/programs/nutrition/.**

CONTINUADO EN LA PROXIMA PAGINA ...

SECCION PARA LA CONFERENCIA Y LA VISTA IMPARCIAL

CREE USTED QUE NOS HEMOS EQUIVOCADO?

Si usted cree que nuestra decision es incorrecta, puede solicitar una revision de nuestra decision. Si cometimos algun error, lo corregiremos. Puede apelar de las dos maneras siguientes:

1. Solicitando una reunion (conferencia) con uno de nuestros supervisores; y
2. Solicitando una audiencia imparcial estatal con un funcionario estatal de audiencias.

CONFERENCIA (reunion informal con nosotros)

Si usted cree que nuestra decision fue equivocada o si no comprende nuestra decision, o si necesita mas informacion sobre la razon de nuestra decision, sirvase llamarnos y solicitar una reunion. Para hacer esto, llame al numero de telefono para conferencias indicado al comienzo de la pagina 1 de este aviso o escribanos a la direccion impresa al comienzo de la pagina 1 de este aviso. En ciertas ocasiones, esta es la manera mas rapida de resolver problemas. Le recomendamos hacer esto incluso si ha solicitado.

VISTAS IMPARCIALES ESTATALES

Fecha limite para solicitar una vista imparcial

Si desea que el Estado revise nuestra decision sobre sus el subsidio SNAP, debe solicitar una vista imparcial hasta el **Agosto 26, 2014**. Esta es la fecha limite incluso si usted ha solicitado una reunion (conferencia) con nosotros.

Como solicitar una vista imparcial

Usted puede solicitar una audiencia imparcial por escrito, por telefono, por facsimil, por electronico o visitando en persona.

ESCRIBA: Complete la seccion que se puede arrancar de la Solicitud para una Audiencia Imparcial en la parte de abajo de esta pagina y enviela a la direccion que aparece en la parte de abajo de la proxima pagina.

O LLAME AL: **(800) 342-3334**

Cuando llame, por favor comunique al empleado(a) el numero de esta notificacion, el cual es N0600G3777.

O POR FACSIMIL: Envie una copia de esta notificacion al numero de facsimil **(518) 473-6735.**

O Envie su peticion llenando el formulario electronico en: **http://www.otda.ny.gov/oah/forms.asp**

O VISITANDO EN PERSONA: Traiga una copia de esta notificacion al Oficina de Asistencia Temporal y Asistencia para Incapacitados del Estado de Nueva York al 14 Boerum Place, Brooklyn, NY.

Si no puede comunicarse con el Estado por electronico, por telefono o por facsimil, por favor escriba una carta solicitando una audiencia imparcial antes de la fecha limite para solicitar una audiencia imparcial.

(Lea la siguiente pagina para mas informacion acerca de sus derechos)

SOLICITUD PARA UNA VISTA IMPARCIAL

Yo deseo una vista imparcial. Yo no estoy de acuerdo con la accion de la agencia. (Puede ser util explicar la razon por la que usted esta en desacuerdo abajo, pero usted no tiene que incluir una explicacion por escrito.)

_____

_____

_____

Nombre : **TW**
Direccion: **1000 LENOX**
NEW YORK, NY 10027

No. de Distrito/Oficina: **66/F15**
No. de Notificacion: **N0600G3777**
No. de Caso : **010006886F**
Telefono :

SOLO UTILICE LA PARTE QUE PUEDE SEPARARSE DE ESTA PAGINA (DEBAJO DE LOS PUNTOS) PARA SOLICITAR UNA VISTA ACERCA DE ESTA NOTIFICACION.

CONTINUADO EN LA PROXIMA PAGINA ...

Que esperar en una vista imparcial

El Estado le enviara un aviso informandole cuando y donde se hara la vista imparcial.

En la vista, usted tendra oportunidad de explicar por que piensa que nuestra decision es equivocada. Usted puede traer un abogado, un familiar o amistad o alguien mas que pueda ayudarle a explicar esto. Si usted no puede venir personalmente, puede enviar a alguien para que le represente. Si en lugar suyo, usted envia a la vista una persona que no es abogado, debe enviar con esta persona una carta demostrando al funcionario de vistas que usted desea que tal persona le represente en la vista.

En la vista, usted y su abogado o cualquier otro representante suyo tendran la oportunidad de explicar por que nos hemos equivocado y de entregar al funcionario de vistas documentos escritos que demuestren por que estamos equivocados.

Usted puede traer a la vista cualquier testigo que pueda ayudarle a explicar por que piensa que nuestra decision es equivocada. Tambien debe traer documentos tales como: Recibos de pago, Contratos de arrendamiento, Recibos, Facturas, Declaraciones de sus medicos.

En la vista, usted y su abogado u otros representantes suyos pueden interrogar a los testigos que nosotros presentemos o que usted traiga como ayuda para su caso.

ASISTENCIA LEGAL

Si usted cree que necesita la ayuda de un abogado para resolver este problema, puede obtener un abogado sin costo alguno de su parte, comunicandose con:

THE LEGAL AID SOCIETY (HARLEM), 2090 ADAM CLAYTON POWELL, JR. BLVD., NEW YORK, NY 10027
Telefono: (212) 663-3293
HARLEM LEGAL SERVICES, 144 WEST 125TH STREET, NEW YORK, NY 10027
Telefono: (212) 222-7800

Para averiguar los nombres de otros abogados, puede ver las Paginas Amarillas de la Guia de telefonica bajo el titulo "LAWYERS".

ACCESO A SUS ARCHIVOS Y COPIAS DE DOCUMENTOS

Como asistencia en preparacion para la audiencia, usted tiene el derecho a inspeccionar los archivos de su caso. Si usted nos llama, nos escribe o nos manda un fax, le proporcionaremos copias gratuitas de los documentos que se encuentran en su archivo, los mismos que se entregaran al funcionario de audiencias durante la audiencia imparcial. Ademas, si usted nos llama, nos escribe o nos manda su peticion por facsimil, le enviaremos copias gratuitas de documentos especificos contenidos en su archivo y los cuales usted considere necesarios al prepararse para la audiencia imparcial. Para solicitar documentos o para averiguar como revisar su archivo, llamenos al **(718) 722-5012**, o por facsimil al **(718) 722-5018** o escriba a: **HRA Division of Fair Hearing, 14 Boerum Place, Brooklyn, New York 11201.** Si desea copias de documentos contenidos en su archivo, debe solicitarlas con anticipacion. Estos le seran provistos dentro de un periodo razonable de tiempo antes de la fecha de la audiencia. Los documentos se le enviaran a usted solamente si usted pide especificamente que estos sean enviados por correo.

Envie esta "Solicitud para una Vista Imparcial" a:

The Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, New York 12201

Una Mano para los Necesitados

Verifique si reúne los requisitos para una amplia gama de apoyos económicos en el sitio web *www.myBenefits.ny.gov*. **Los siguientes recursos económicos están disponibles para ayudarle con los gastos de fin de mes. Si tiene preguntas adicionales sobre la siguiente información, puede llamar al número de teléfono de la línea directa de información del Estado de Nueva York al: 1-800-342-3009.**

Asistencia con cuestiones de nutrición: ayuda con los alimentos para su familia como también consejos sobre cómo estirar el presupuesto para alimentos. Visite el sitio web www.myBenefits.ny.gov.

- **Orientación:** todo beneficiario de cupones para alimentos puede recibir orientación gratuita sobre temas de nutrición con motivo de ayudarle a tomar decisiones sensatas sobre nutrición.
- **Desayunos y almuerzos escolares:** comidas gratis o a precios reducidos para niños de edad escolar de familias de bajos ingresos.
- **Mujeres, Bebés y Niños (WIC):** comida para mujeres embarazadas de bajos ingresos, mujeres en etapa postparto o amamantando como también para los niños de hasta la edad de 5 años, llame al **1-800-522-5006.**

Créditos tributarios: con motivo de suplementar su salario y ayudarle a mantener a su familia. ***Visite www.myBenefits.ny.gov.***

- **Créditos tributarios sobre ingresos estatales y federales (EITC)** – los contribuyentes de bajos ingresos pueden recibir ambos créditos, el crédito federal y el crédito estatal EITC. Los residentes de la Ciudad de Nueva York pueden recibir el crédito adicional.
- **Crédito tributario federal por menores y créditos tributarios adicionales por menores** – los contribuyentes con niños menores de 17 años podrían habilitar para recibir este crédito tributario adicional. El **Crédito Tributario por Menores del Estado Imperio** es un crédito reembolsable para los que residen el año completo en el estado de Nueva York y que tienen niños entre las edades de 4 a 16 años. Llame al **1-800-829-1040.**
- **Crédito Federal Tributario por Cuidado de Menores y Dependientes** – es una desgravación tributaria que ofrece el gobierno federal. **El Crédito por Cuidado de Menores y Dependientes del Estado de Nueva York** ayuda a más familias de bajos ingresos porque, a diferencia del crédito federal, éste es reembolsable. Los residentes de la Ciudad de Nueva York habilitan para recibir el crédito adicional de la ciudad. Llame al (518) 457-5181
- **Centro de Asistencia Voluntaria al Contribuyente (VITA)** – es un programa que ofrece servicios gratis de preparación de planillas de impuestos los neoyorquinos aptos según sus ingresos. Los centros VITA se ubican en cada condado del estado y una lista de las direcciones se puede encontrar en el sitio web myBenefits.

Programa de Subsidio de Energía para el Hogar (HEAP): ***Visite www.myBenefits.ny.gov.***
El programa HEAP ayuda a los hogares con los gastos energéticos del hogar, entre ellos, gastos de reparación o reemplazo de la unidad de calefacción y con servicios de climatización. Si desea someter una solicitud, comuníquese con la oficina local de servicios sociales o con la oficina para asuntos de la vejez de su condado.

Programas de Seguro de Salud: ayuda a las familias que no pueden pagar los gastos de cuidados de salud. Visite el sitio web www.myBenefits.ny.gov.

- **Medicaid** se ofrece a los individuos y familias de bajos recursos que reúnen el requisito de límite de ingresos, y de ser pertinente el requisito de ciudadanía estadounidense o situación de inmigración. Llame al **1-800-541-2831 o en la Ciudad de Nueva York llame al 1-718-557-1399 al 1-877-472-8411.**
- **Child Health Plus (CHP)** es para los niños menores de 19 años cuyas familias perciben ingresos demasiado elevados para recibir Medicaid. Llame al **1-800-698-4543**
- **Family Health Plus (FHPlus)** es un programa de seguro médico para personas adultas de bajos ingresos que no tienen un seguro, que están entre las edades de 19 a 64 años de edad (con o sin niños), que no pueden recibir Medicaid y que tampoco tienen otro tipo de seguro de salud. Llame al **1-877-934-7587**

Servicios de colocación de empleos: visite ***www.myBenefits.ny.gov*** **y haga clic sobre** ***Recursos para Familias Trabajadoras.***

- **El Programa de Empleo y Capacitación para Beneficiarios de Cupones para Alimentos** ofrece capacitación laboral y servicios de apoyo a los beneficiarios de cupones para alimentos. Comuníquese con su departamento local de servicios sociales.
- **El sistema conocido como Centros Vocacionales (One Stop)** brinda servicios por medio de una red de centros vocacionales locales y oficinas afiliadas.

Seguro Social por Incapacidad y Seguridad de Ingreso Suplementario (SSI): solamente aquellas personas que tienen una incapacidad y reúnen ciertos requisitos médicos pueden recibir beneficios bajo uno de los programas. Llame al **1–800–772–1213 o visite** ***www.socialsecurity.gov***

Programa de Sustento de Menores: ayuda al padre custodio a establecer la paternidad y a obtener, modificar y hacer cumplir las órdenes de sustento y de seguro médico. Visite el sitio web www.childsupport.ny.gov o llame al **1-800-846-0773.**

Subsidio de Cuidado de Niños: permite que los padres o cuidadores puedan trabajar, desempeñar tareas laborales o asistir a cursos de capacitación para obtener la equivalencia de la escuela secundaria. Si quiere obtener más información, llame al departamento local de servicios sociales o visite el sitio web: ***www.ocfs.ny.us***, y haga clic en «Child Care».

Violencia Doméstica: si usted o alguien que usted conoce se encuentra en una situación de abuso y desea recibir más información sobre lo que puede hacer para protegerse o proteger a su familia o vecinos, llame al **1-800-942-6906.**

ALBANY CO DSS
100 FIRST ST
40 HOWARD ST
ALBANY, NY 12202

NOTIFICACION SOBRE LA RECERTIFICACION
DE SU ASISTENCIA MEDICA.

ESTA NOTIFICACION EN ESPANOL NO LLEVA ACENTOS
DEBIDO A QUE NUESTRO SISTEMA DE COMPUTADORAS
NO OFRECE LA CAPACIDAD PARA INCORPORARLOS

NUMERO DEL AVISO:	FECHA:	NUMERO DE CASO:
U0102C4984	Junio 20, 2013	TST307SMW

OFICINA	UNIDAD	TRABAJADOR(A)	NOMBRE DEL TRABAJADOR(A) O DE LA UNIDAD	NO. DE TELEFONO
Z61	TEST	FONT	DEFAULT MA	518-474-9440

NUMEROS TELEFONICOS DE LA AGENCIA

NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA	518-473-1000
O Para Conferencia con la Agencia	518-473-1000
Información y asistencia sobre Vista Imparcial	518-473-1000
Acceso a archivos/récords	518-473-1000
Plan de Salud Infantil/Adolescente	518-473-1000

NOMBRE DEL CASO Y DIRECCION

Z61/TEST/FONT

HAYNER, MATTHEW
307 WEST ST,
ALBANY, NY 12345

ASISTENCIA MEDICA

FORMULARIO DE RENOVACION DE MEDICAID,
FAMILY HEALTH PLUS, PROGRAMA DE PLANIFICACION FAMILIAR

- Es tiempo de renovar sus beneficios de seguro de salud.
- Usted debe contestar **todas** las preguntas y devolver este formulario y toda documentacion solicitada a la siguiente direccion para el **Martes, Septiembre 24, 2013.**

  ABC OFFICE NAME FOR TESTING, ABC FIRST LINE ADDRESS FOR TESTING, ABC SECOND LINE ADDRESS FOR TESTING, ABC CITY TESTIN NY 10009

- Si usted no rellena y devuelve este formulario, perdera su seguro de salud. Si actualmente estamos pagando sus primas del seguro de salud de Medicare o de otro seguro de salud, tambien dejaremos de hacer esos pagos.
- Usted debe devolver este formulario aunque ya nos haya informado que se mudo a otro condado.
- Este formulario no se considera completamente rellenado hasta que usted lo firme y lo feche.
- Favor de leer los Terminos, Derechos y Obligaciones.

CONTINUADO EN LA PROXIMA PAGINA ...

****
* Intrucciones importantes - Lea esta pagina *
****

- Para que podamos determinar si usted reune los requisitos, la cantidad de ingresos que usted nos reporte se comparara por medio de un cruzamiento de datos computarizados. En algunos casos, a consecuencia del cruzamiento de datos computarizados su cobertura de salud puede cambiar de Medicaid a Family Health Plus.
- **No necesita enviar comprobante de ingresos por el momento, a no ser que el formulario de renovacion indique que debe hacerlo.**
- **Sin embargo, dado que el monto que usted reporte quizas no concuerde con el monto del cruzamiento de datos, le sugerimos someter comprobante de sus ingresos para asegurarnos que usted recibe la cobertura apropiada.**
- Posiblemente se le pida someter comprobante de sus ingresos mas adelante. Nos comunicaremos con usted para indicarle lo que necesita someter. La adjunta "Lista de verificacion de documentacion" le indica lo que puede usar como comprobante de estas cosas.

Puede llamar a la oficina de servicios sociales si necesita ayuda para rellenar este formulario. Tambien existen organizaciones comunitarias y planes de salud que pueden ayudarle. **Llame al 1-877-934-7587 o al 1-800-698-4543** para averiguar el plan de salud u organizacion comunitaria en su area que brinde asistencia. Si acude a una de esas organizaciones para solicitar ayuda, lleve esta carta con usted. En todo caso, todavia necesita regresar el formulario y la documentacion a la direccion indicada arriba para la fecha senalada. Quedese con una copia del formulario para sus archivos personales.

**ASEGURESE DE CONTESTAR TODAS LAS PREGUNTAS
Y DE FIRMAR EL FORMULARIO.
REGRESE EL FORMULARIO Y LA DOCUMENTACION REQUERIDA
POR CORREO O EN PERSONA
A LA OFICINA DE SERVICIOS SOCIALES.
NO NECESITA PRESENTARSE EN PERSONA
PARA UNA ENTREVISTA.**

CONTINUADO EN LA PROXIMA PAGINA ...

NUMERO DE CASO: TST307SMW NOMBRE DEL CASO: HAYNER, MATTHEW

FORMULARIO DE RENOVACION DE MEDICAID, FAMILY HEALTH PLUS, PROGRAMA DE PLANIFICACION FAMILIAR.

1. La ultima vez usted reporto que vive en el:
   307 WEST ST
   ALBANY, NY 12345

   Todavia vive en esta direccion?

   [__] Si
   [__] No. Yo vivo en el:

   No. de Casa | Calle | Apto. No.

   Ciudad | Estado | Codigo Postal

   Someta comprobante de su nueva direccion.

   [__] Marque aqui si es una persona sin hogar.

   Si no recibe correspondencia en la direccion donde vive, escriba la direccion de correo a continuacion:

   No. de Casa | Calle | Apto. No. | PO Box#

   Ciudad | Estado | Codigo Postal

   Mi numero de telefono es el: _____
   [_] Casa [_] Celular [_] Trabajo [_] Otro

   Tambien se me puede localizar en el siguiente numero: _____
   [_] Casa [_] Celular [_] Trabajo [_] Otro

2. Usted esta renovando la cobertura de salud para las siguientes personas. **(Haga las correciones necesarias del nombre y la fecha de nacimiento a continuacion).** Si un numero de seguro social (SSN) se lista como "no en archivo", escribalo en el espacio a continuacion. Si esta persona no tiene un numero de seguro social, deje el espacio en blanco. Si las siguientes personas no reunen los requisitos de Medicaid o Family Health Plus, marque la casilla en la ultima columna si dichas personas estan interesadas en recibir cobertura del Programa de Beneficios de Planificacion Familiar (FPBP).

Nombre	Fecha de Nacimiento	SSN (Si tiene uno)	Todavia vive con usted?	FPBP
MARK HAYNER	6/15/1996	EN ARCHIVO	_Si _No	[_]
_____	___/___/_____	___-___-_____		
HELEN MOYER	8/15/1973	EN ARCHIVO	_Si _No	[_]
_____	___/___/_____	___-___-_____		
MARTY MOYER	3/14/1970	EN ARCHIVO	_Si _No	[_]
_____	___/___/_____	___-___-_____		
MARK MOYER	5/12/1997	EN ARCHIVO	_Si _No	[_]
_____	___/___/_____	___-___-_____		
MOLLY MOYER	4/18/1993	EN ARCHIVO	_Si _No	[_]
_____	___/___/_____	___-___-_____		
MADISON MOYER	9/15/2003	EN ARCHIVO	_Si _No	[_]
_____	___/___/_____	___-___-_____		

CONTINUADO EN LA PROXIMA PAGINA ...

3. Quien mas vive con usted? Escriba el / los nombre(s) completo(s) legal(es) a continuacion y el parentesco con la persona senalada en la primera pregunta 2. (Por ejemplo, conyuge, padre / madre / madrastra / padrastro / hijo[a], y la fecha de nacimiento y el genero).

   o alguna de las personas senaladas a continuacion quiere solicitar seguro de salud, escriba el numero de seguro social de dichas personas a continuacion.

Nombre	Parentesco	Fecha de nacimiento	Genero (M/F)	SSN (Si tiene uno)	Desea seguro de salud esta persona?
_____	_____	_____	___	_____	___Si ___No
_____	_____	_____	___	_____	___Si ___No
_____	_____	_____	___	_____	___Si ___No
_____	_____	_____	___	_____	___Si ___No

   o Identidad y ciudadania estadounidense o situacion migratoria aprobada deben ser documentadas. Si alguna de las personas nombradas anteriormente que solicitan seguro de salud declara que es ciudadano(a) estadounidense o nacional y suministra su numero de seguro social o comprobante de que lo ha solicitado, Medicaid verificara su numero de seguro social y fecha de nacimiento, inclusive los datos de identidad por medio de un cruzamiento electronico de datos con los archivos de la Administracion del Seguro Social. Si el cruzamiento de datos no da resultado, es posible que se le exija comprobante de identidad y ciudadania estadounidense.

   o Toda persona que este nombrada arriba que solicite seguro de salud y que no sea ciudadano(a) estadounidense, **debe enviar comprobante** de identidad y situacion migratoria.

   o Tambien se exige comprobante de ingresos.

   o Incluya a las personas que estan solicitando seguro de salud al contestar el resto de las preguntas de este formulario.

   Nota: solamente ciertos miembros de familia pueden solicitar usando este formulario. Le dejaremos saber si se necesita de otro formulario.

4. Alguna de las personas citadas en las preguntas 2 o 3 esta embarazada?
   [__] No.
   [__] Si. Quien? _____ Fecha estimada de parto: _____

   Si respondio que si, **debe enviarnos comprobante** de fecha estimada de parto. Vea la lista de documentacion.

CONTINUADO EN LA PROXIMA PAGINA ...

5. SEGURO DE SALUD NUEVO O MODIFICADO DESDE LA ULTIMA VEZ QUE USTED SOMETIO LA SOLICITUD O LA RENOVACION:

a. Alguna de las personas que tenia cobertura de seguro de salud **perdio** dicha cobertura?
[__] No.

[__] Si. Quien?	Nombre de la compania de seguro de salud:	Fecha que termino la cobertura:
_____	_____	_____

b. Ha **comenzado** alguien a recibir cobertura de seguro de salud (inclusive Medicare o seguro de cuidados de salud a largo plazo), aparte de Medicaid / Family Health Plus? Si es mas economico, quizas paguemos las primas de su seguro de salud.
[__] No.

[__] Si. Nombre del asegurado	Monto de la Prima:	Cada cuanto la paga:
_____	$_____	_____

Debe enviar una copia del anverso y reverso de la tarjeta del seguro y/o la tarjeta de Medicare (tarjeta roja, blanca y azul) de cada persona y una copia de la poliza de seguro.

C. Si por el momento usted no tiene seguro de salud por parte de su empleador, ofrece seguro de salud su empleador? Si es mas economico, quizas paguemos las primas de su seguro de salud.
[__] No.

[__] Si.

Si contesto Si, indique el nombre del empleador, la direccion y numero de telefono a continuacion:

_____
_____
_____
_____

6. ENFERMEDAD, LESION O INCAPACIDAD

a. Desde la ultima vez que usted sometio una solicitud/renovacion, alguna de las personas ha sido declarada ciega, o incapacitada o sufre de una enfermedad cronica o tiene una necesidad especial de cuidado de la salud? Ejemplos de enfermedades cronicas seria no poder trabajar por un periodo de 12 meses debido a una enfermedad o lesion, o el tener una enfermedad o impedimento incapacitante que ha durado o se espera que dure por 12 meses.

[__] No Si [__] Si contesto si, Quien? _____

Explique: _____
_____

b. Si usted es una persona ciega o discapacitada, tiene gastos especiales (no medicos) necesarios para que le permitan trabajar?
[__] No Si [__] **(Debe enviar recibos de esos gastos).**

c. Acaso alguna de las personas que estan renovando o sometiendo una solicitud tiene una demanda judicial pendiente a raiz de una lesion?
[__] No Si [__]

Si contesto si, quien? _____

d. Acaso alguna de las personas que estan renovando o sometiendo una solicitud tiene un caso de compensacion laboral o una lesion, enfermedad o discapacidad ocasionada por otra persona, (que puede cubrirla un seguro medico)?
[__] No Si [__]

Si contesto si, quien? _____

CONTINUADO EN LA PROXIMA PAGINA ...

7. Si uno de los padres o conyuge no viven en el hogar, conteste las siguientes preguntas.

A. Desde la ultima vez que solicito/renovo, se ha mudado del hogar uno de los padres o el conyuge de alguna de las personas que estan renovando?

[__] No (Pase a la pregunta B)

[__] Si. De los siguientes datos, si los sabe.
Nombre Padre/Madre_____Conyuge _____
Fecha de nacimiento _____ No. de Seguro Social _____
Direccion _____
Padre/Madre/Conyugue de _____

Nota: las familias que estan haciendo la renovacion por sus hijos y las mujeres embarazadas NO se les exige rellenar esta seccion. Todas las demas personas que estan sometiendo una solicitud y que tienen 21 anos de edad o mas, deben estar listas para dar informacion sobre los padres de un menor solicitante, o un conyuge que no viva en el hogar para que se les pueda considerar si habilitan para recibir seguro de salud, salvo que exista motivo justificado para no hacerlo.

[__] Marque esta casilla si tiene un motivo justificado. Tengo un motivo justificado por el cual ustedes no deberian comunicarse con este padre/madre/conyuge (miedo a amenazas de danos fisicos o emocionales). Ello se conoce como "motivo justificado". Si usted marco este casillero, nos comunicaremos con usted para que nos explique el motivo y nos suministre comprobante.

B. Desde la ultima vez que usted solicito/renovo, tiene informacion que no nos suministro anteriormente y que nos pueda ayudar a localizar al padre/madre/coyuge que vive fuera del hogar (por ejem., domicilio o lugar de trabajo).

[__] No.
[__] Si. **De los siguientes datos, si los sabe.**
Nombre Padre/Madre_____Conyuge _____
Domicilio _____
Direccion del lugar de trabajo _____
Padre/Madre/Conyugue de _____

Nombre Padre/Madre_____Conyuge _____
Domicilio _____
Direccion del lugar de trabajo _____
Padre/Madre/Conyugue de _____

CONTINUADO EN LA PROXIMA PAGINA ...

8. a. Escriba los tipos de ingresos (dinero) y el monto recibido por cada persona listada en las preguntas 2 y 3. Consulte la lista de verificacion de documentacion para ver ejemplos de ingresos. **Escriba el monto adecuado antes de la deduccion de impuestos u otras deducciones; incluya propinas/comisiones. Envie talones de cheques salariales o demas comprobantes.**

Marque esta casilla si usted o alguna de las personas que solicita una renovacion o esta sometiendo una solicitud es trabajador autonomo: [_]

Nombre	Tip de Ingreso/ Fuente	Nombre del Empleador (si el ingreso es del trabajo)	Cuanto? (antes de impuestos/ deducciones incluya propinas/ comisiones)	Frecuencia Semanal/ Mensual/ Cada 2 semanas
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____

Marque la casilla si la afirmacion aplica a su caso:
[_] No recibo cheques de sueldo o talonario de cheques.
[_] Me pagan en efectivo.

b. Acaso usted o alguna de las personas adultas listadas en la pregunta 2 o 3 no recibe ingresos? [_] No Si [_] Quien? _____

Si no ha indicado un monto de ingresos arriba, explique como se sostiene: (Por ejemplo: vive con amistades o parientes).

_____

c. Acaso usted o alguna de las personas que esta sometiendo una solicitud ha cambiado de empleo o ha dejado de trabajar en los ultimos tres meses?
[_] No Si [_] Si contesto si, Quien? _____
Si respondio que si, su ultimo empleo fue: Fecha: _____/_____/_____
Nombre del empleador: _____

d. Acaso usted o alguna de las personas que someten una solicitud es estudiante de un programa vocacional, de pregrado o de postgrado?
[_] No Si [_]
Si contesto si:
[_] Tiempo completo [_] Tiempo parcial [_] Pregrado [_] Postgrado [_]
Nombre del estudiante: _____

e. Acaso usted o alguna de las personas que estan renovando o sometiendo una solicitud paga primas de seguro de salud, primas de Medicare, sustento de menores por orden judicial o gastos de cuidado de ninos o adultos?
[_] No Si [_] Si respondio que si, rellene los siguientes espacios y envie comprobante de cada gasto.

Tipo de gasto	Nombre de la persona que paga el gasto	Cantidad	Cada cuanto paga el gasto (p. ej., semanal, mensual)
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____

El Programa de Adquisicion de Beneficios de Medicaid para Trabajadores Incapacitados (MBI-WPD) ofrece cobertura de Medicaid a personas incapacitadas que gozan de un empleo y que tienen por lo menos 16 anos de edad pero menos de 65. El programa tiene limites mas elevados de ingresos que el programa regular de Medicaid, de manera que las personas con incapacidades puedan ganar mas y mantener su cobertura de Medicaid.

Esta usted actualmente inscrito en el Programa de Adquisicion de Beneficios de Medicaid para Trabajadores Incapacitados, o lo esta solicitando?
[_] No Si [_]

Si respondio "Si", debe suministrar comprobante de empleo. Consulte la lista

CONTINUADO EN LA PROXIMA PAGINA ...

de verificacion de documentacion para informarse sobre los documentos que usted puede usar para comprobar que usted tiene empleo.

Si usted esta inscrito en el programa de MBI-WPD pero ya no trabaja, favor de indicar el motivo y la fecha de su ultimo dia de trabajo.
Motivo por el cual ya no trabaja: _____
Fecha de ultimo dia de trabajo: _____

9. Ha cambiado su porcion del pago mensual de vivienda (tal como alquiler o hipoteca, incluyendo impuestos de propiedad) desde la ultima vez que solicito/renovo su cobertura de seguro de salud?

   [_] No
   [_] Si. Mi nueva porcion de pago mensual de vivienda es de $_____

   Si paga el agua por separado, cuanto paga? $_____ **Envie comprobante de la factura del agua.**

   Recibe vivienda gratis por parte de su empleador? [_] Si [_] No

10. **El presentar un comprobante de identidad, de ciudadania estadounidense o de situacion aprobada de inmigracion, es uno de los requisitos de habilitacion de Medicaid.**

    Si usted declara que es ciudadano estadounidense, pero no ha sometido comprobante de ciudadania, suministre su numero de seguro social o comprobante de que ha solicitado uno; Medicaid verificara su numero de seguro social y fecha de nacimiento, inclusive los datos de identidad por medio de un cruzamiento electronico de datos con los archivos de la Administracion del Seguro Social. Si el cruzamiento de datos no da resultado, es posible que se le exija comprobante de identidad y ciudadania estadounidense. Comprobante de identidad y de ciudadania estadounidense requiere de documentos originales o de copias certificadas por la agencia emisora.

    a. Alguna de las personas que solicita una renovacion no ha suministrado comprobante de ciudadania estadounidense? Quien? SSN (No. de Seguro Social si tiene uno)

    _____ _____
    _____ _____
    _____ _____

    Si usted es un inmigrante pero todavia no ha sometido comprobante de identidad y estado migratorio, o si su situacion de inmigracion ha cambiado, debe enviarnos comprobante. Envie comprobante de la agencia federal de inmigracion que muestre su situacion migratoria actual.

    b. Ha cambiado la situacion migratoria de alguna de las personas que solicita una renovacion? Quien? SSN (si tiene uno)

    _____ _____
    _____ _____
    _____ _____

CONTINUADO EN LA PROXIMA PAGINA ...

11. RECURSOS

Indique todos los recursos (recursos incluye dinero en el banco o en una cooperativa de credito, acciones, bonos, fondos mutualistas, certificados de deposito, cuentas de mercado, planes de ahorro 401K, fondos de fideicomiso, el valor liquido de polizas de seguro o propiedades a posesion de terceros. No incluya su propia casa).

Si no cuenta con ningun tipo de recurso, escriba "Ninguno" debajo de la linea que lee "Tipo de recurso".

Cuales son sus recursos actuales?

Tipo de recurso	Valor	Propietario	Banco/Nombre de la empresa
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____

Desea continuar recibiendo cobertura de Medicaid para cubrir los servicios de cuidado a largo plazo, tales como: cuidados a domicilio o servicios de cuidado personal? ____ Si ____ No

Si su respuesta es afirmativa, envie comprobante de recursos.

Al firmar este formulario, comprendo que cada persona citada en el mismo sera inscripta en el programa correspondiente siempre y cuando reuna los requisitos. Tambien he leido y comprendo los Terminos, Derechos y Obligaciones citados en las proximas paginas. Certifico so pena de perjurio que todo lo expresado en esta solicitud es verdadero hasta donde yo se.

_____ _____
FIRMA del postulante o representante FECHA

_____ _____
FIRMA del otro adulto solicitante FECHA

ESPACIO DE USO OFICIAL SOLAMENTE

Worker Signature	Supervisor Signature	Case Disposition

CONTINUADO EN LA PROXIMA PAGINA ...

CONTINUADO EN LA PROXIMA PAGINA ...

ESTA CARTA DESCRIBE COMO SE PUEDE USAR Y DIVULGAR SU INFORMACION MEDICA CONFIDENCIAL Y COMO USTED PUEDE OBTENER ESA MISMA INFORMACION.
LEALA ATENTAMENTE.

El programa de salud Medicaid del Estado de Nueva York debe informarle como utiliza, comparte y protege su informacion medica. Los siguientes seguros medicos forman parte del programa de Medicaid del Estado de Nueva York: Medicaid regular, Programa de Cuidados Administrados de Medicaid, y Family Health Plus. El programa es administrado por el Departamento de Salud del Estado de Nueva York y por los departamento locales de servicios sociales.

Puede obtener una copia de la notificacion en la oficina local del departamento de servicios sociales,o tambien de:

http://nyhealth.gov/health_care/medicaid/program/hipaa/noteprivspan.htm

CONTINUADO EN LA PROXIMA PAGINA ...

CONTINUADO EN LA PROXIMA PAGINA ...

PROGRAMA DE SALUD PARA NINOS Y ADOLESCENTES CHILD/TEEN HEALTH

Como averiguo donde puedo encontrar un profesional de salud que pueda realizarle examenes de rutina a mi hijo?

El programa de Medicaid conocido como Child Teen Health Program (C/THP), es un seguro medico para ninos, desde su nacimiento hasta la edad de 21 anos. Este programa ofrece examenes regulares y visitas de seguimiento si se detecta un problema medico. Toda persona, desde su nacimiento hasta la edad de 21 anos que reciba Medicaid, Cuidados Administrados de Medicaid , inclusive las personas de 19 y 20 anos de edad que reciben Family Health Plus, pueden recibir este tipo de beneficio.

Los ninos y los jovenes deben consultar un medico con regularidad, aunque esten sanos. El programa Child/Teen Healh aconseja que los ninos tengan visitas medicas regulares 10 veces antes de la edad de tres anos. De ahi en adelante, visitas medicas anuales. El programa C/THP ayuda a establecer un "centro de cuidados medicos". Un "centro de cuidados medicos" es una situacion en la que cada paciente tiene una relacion activa con el medico responsable de su salud, y, de ser necesario, hace los arreglos pertinentes para obtener cuidados medicos de otros profesionales competentes.

Dependiendo de la edad del nino, los examenes de rutina de Child/Teen Health son los siguientes:

- Historial clinico
- Deteccion de salud dental
- Reconocimientos medicos completos
- Vacunacion
- Deteccion de asma, diagnostico y tratamiento
- Pruebas auditivas y visuales
- Pruebas de sangre (inclusive la deteccion de anemia falciforme)
- Pruebas de evaluacion del desarrollo/comportamiento
- Deteccion de plomo en la sangre - ninos de entre 1 a 2 anos de edad y ninos de 3 a 6 anos de edadque todavia no se han hecho la prueba.

Consejos y sugerencias a preguntas sobre cuestiones de salud

No se exige un copago de Medicaid con este tipo de beneficio. Entre las prestaciones que ofrece, se encuentra la prestacion de servicios que normalmente el medico regular o clinica del nino no ofrece. El profesional medico hara las citas de seguimiento necesarias si se detecta un problema en la visita de rutina.

Si usted se suscribe a un plan de cuidados administrados, dicho plan incluye el seguro de salud para ninos y adolescentes Child/Teen Health. Obtenga mas informacion sobre estos servicios hablando con un representante del plan.

Si usted no esta inscrito en un plan de cuidados administrados y vive en la parte norte del estado de Nueva York, llame al departamento local de servicios sociales para que le ayuden a ubicar medicos, dentistas, servicios de cuidados prenatales, servicios de planificacion familiar y otros suministradores que aceptan Medicaid y ofrecen servicios de transporte, si se necesitan.

Si usted vive en la Ciudad de Nueva York, llame al 1-888-692-8662 para ubicar los medicos, dentistas, servicios prenatales, servicios de planificacion familiar y otros proveedores que aceptan Medicaid y ofrecen ayuda con servicios de transporte, de necesitarlos.

PROGRAMA ESPECIAL DE NUTRICION COMPLEMENTARIA PARA MUJERES, BEBES Y NINOS (WIC)

Esta embarazada? Recien dio a luz? Tiene un bebe o ninos pequenos?
El programa WIC puede ayudar a su familia. El programa WIC ofrece orientacion gratis a las familias de Nueva York facilitandoles la obtencion de alimentos nutritivos; orientacion gratis sobre temas de salud y nutricion; apoyo y consejos sobre el amamantamiento y derivaciones gratis a oficinas de cuidados de la salud y servicios sociales de Nueva York.

Si desea localizar la clinica WIC mas cercana a usted, llame al 1-800-522-5006.

XL218B (09/97)

TERMINOS, DERECHOS Y OBLIGACIONES

Al completar y firmar este formulario estoy solicitando la renovacion de Medicaid o Family Health Plus.

Comprendo que debo proporcionar la informacion necesaria para probar si yo reuno los requisitos de cada programa. Acepto informar cualquier cambio sobre la informacion contenida en este formulario. Si no puedo reunir la informacion, avisare al departamento local de servicios sociales. Es posible que el departamento local de servicios sociales me pueda ayudar a obtener esa informacion.

Comprendo que los asistentes sociales de los programas, para los cuales los miembros de mi familia o yo estamos solicitando, o estamos renovando, pueden verificar la informacion proporcionada por mi en este formulario. Las agencias que llevan a cabo estos programas mantendran esta informacion en forma confidencial de conformidad con las disposiciones 42 U.S.C. 1396a (a) (7) y 42 CFR 431.300-431.307, asi como de conformidad con toda otra ley y norma federal y estatal.

Comprendo que Medicaid y Family Health Plus no pagaran gastos medicos que el seguro u otra persona deba pagar, y que le estoy confiriendo a la agencia todos mis derechos de buscar y recibir apoyo medico de un conyuge, o padre de una persona menor de 21 anos de edad, y mi derecho de buscar y recibir pagos de terceras partes durante todo el tiempo que reciba los beneficios.

Presentare reclamos para recibir beneficios de seguro de salud, accidente, o de todo otro recurso al cual tenga derecho. Comprendo que tengo derecho a interponer un motivo justificado por el cual no pueda cooperar para que se use mi seguro de salud si creo que ello causara dano a mi salud o integridad fisica, o a la salud e integridad fisica de toda persona de la cual yo soy legalmente responsable.

Comprendo que mi habilitacion para recibir beneficios de estos programas no se vera afectada de manera negativa por mi raza, color o nacionalidad de origen. Tambien comprendo que dependiendo de los requisitos individuales de estos programas, mi edad, sexo, discapacidad y si soy o no ciudadano estadounidense, pueden ser factores que determinen si reuno o no los requisitos.

Comprendo que si mi hijo/a recibe Medicaid, el o ella puede recibir atencion preventiva y primaria integral, incluyendo todo tratamiento necesario que se pueda recibir por medio del programa de Child/Teen Health.

Comprendo que cualquier persona que miente deliberadamente u omite la verdad con el proposito de recibir servicios bajo estos programas esta cometiendo un delito y quedara sujeto a las penalidades federales y estatales, siendo tambien posible que deba devolver el monto de los beneficios recibidos y pagar multas civiles. El Departamento de Impuestos y Finanzas del Estado de Nueva York tiene derecho a revisar la informacion sobre mis ingresos contenida en este formulario.

CERTIFICACION DE CONDICION DE CIUDADANO E INMIGRACION: Certifico so pena de perjurio, firmando este formulario de mi puno y letra, que yo, y/o por la persona que estoy firmando, soy/es ciudadano estadounidense o ciudadano nacionalizado de los Estados Unidos o que cuenta con una condicion de inmigracion satisfactoria. El termino "condicion de inmigracion satisfactoria" significa una condicion de inmigrante que no impide que la persona pueda recibir beneficios. **Informacion Importante:** la **agencia federal de inmigracion** ha establecido que la inscripcion de una persona en los programas de Medicaid/Family Health Plus NO PUEDE afectar la habilitacion de dicha persona para obtener una tarjeta de residencia permanente (green card), obtener la ciudadania estadounidense, patrocinar a un miembro de su familia o viajar dentro o fuera del pais (excepto si Medicaid paga por servicios de salud a largo plazo en un hogar de convalecencia (nursing home) o en una institucion de salud mental). **El Estado no compartira los datos contenidos en esta solicitud con la agencia federal de inmigracion.**

NUMERO DEL SEGURO SOCIAL (SSN): Se exige el numero de seguro social de todo solicitante, a menos que la persona este embarazada o se trate de un extranjero no calificado. No se requiere numero de seguro social de los miembros de mi familia que no estan solicitando los beneficios. Comprendo que este requisito es exigido por la Ley Federal: 42 U.S.C. 1320b-7 (a) y por las disposiciones de Medicaid: 42 CFR 435.910. Los numeros de seguro social se usan con diversos fines, tanto dentro del Departamento de Servicios Sociales (DSS) como entre este y las agencias federales, estatales y locales, de Nueva York y otras jurisdicciones. Algunos de los usos del numero de seguro social son: verificacion de identidad; identificacion y verificacion de ingresos trabajados y no trabajados; para averiguar si los padres no custodios pueden brindar cobertura de seguro medico para los solicitantes; para determinar si los solicitantes pueden solicitar asistencia medica, dinero y otros tipos de asistencia. El numero de seguro social puede tambien utilizarse para identificar al beneficiario dentro de la agencia central gubernamental de Medicaid y entre las agencias de Medicaid con motivo de cerciorarnos que el beneficiario recibe los servicios adecuados disponibles.

REVELACION DE INFORMACION MEDICA: yo autorizo la divulgacion de toda informacion medica que me concierna a mi y a los miembros de mi familia por quienes puedo dar consentimiento. Dicha informacion puede ser divulgada por mi medico de cabecera, por el profesional de servicios de salud o por el Departamento de Salud del Estado de Nueva York (SDOH por su sigla en ingles); a mi plan de salud y a todo profesional a cargo del cuidado de la salud de mi persona o de mi familia, segun sea razonablemente necesario, para que mi plan de salud o profesionales de la salud lleven a cabo tratamientos, pagos u acciones dirigidas al cuidado de la salud. Tambien puede ser divulgada por mi plan de salud y por todo profesional de la salud al Departamento de Salud y a otras autoridades federales, estatales o agencias locales, con el fin de administrar los programas de Medicaid y los programas de Family Health Plus; y por mi plan de salud a otras personas u organizaciones, segun sea razonablemente necesario, para que mi plan de salud lleve a cabo tratamientos, pagos u acciones dirigidas al cuidado de la salud. Ademas, acepto que la informacion que se divulgue incluya datos sobre VIH, salud mental, abuso de sustancias o alcohol que me concierna a mi o a miembros de mi familia, en la medida permitida por ley. Si mas de un adulto en la familia se une a Family Health Plus o a un plan de salud Medicaid, la firma de cada adulto solicitante es necesaria para el consentimiento de la divulgacion de informacion.

CUIDADOS DIRIGIDOS DE MEDICAID: si estoy anadiendo a un miembro de la familia a un caso de Medicaid y vivo en un condado que requiere que el beneficiario de Medicaid se una a un plan de salud, entiendo que dicho miembro de la familia se inscribira en el mismo plan de salud que mi familia, al menos que el o ella este exento o excluido de hacerlo.

REVELACION DE REGISTROS ESCOLARES: doy mi permiso al departamento local de servicios sociales y al Estado de Nueva York a obtener toda informacion sobre los registros educativos de mi(s) hijo(s), citados en el presente documento, necesarios para reclamar reintegros de Medicaid por servicios educativos relacionados con la salud, y brindar a la agencia gubernamental federal que corresponda acceso a esta informacion con el unico proposito de realizar una auditoria.

PROGRAMA DE INTERVENCION TEMPRANA: si mi hijo participa o es evaluado para participar en el Programa de Intervencion Temprana del Estado de Nueva York, doy mi permiso al departamento local de servicios sociales y al Estado de Nueva York a compartir la informacion de habilitacion de mi hijo, con relacion al programa de Medicaid, con el Programa de Intervencion Temprana de mi condado con el proposito de facturar a Medicaid.

Doy mi consentimiento para compartir esta informacion con todo centro de atencion medica escolar que suministra servicios a los solicitantes.

LISTA DE CONTROL DE LA DOCUMENTACION

La presente es una lista de los documentos que acepta el programa de Medicaid. Favor de revisar el adjunto "FORMULARIO DE RENOVACION PARA MEDICAID, FAMILY HEALTH PLUS Y/O PROGRAMA DE PLANIFICACION FAMILIAR" para saber que documentos necesita presentar para que continue su cobertura de atencion medica.

COMPROBANTE DE INGRESO Toda persona que solicite por primera vez seguro medico debe enviar comprobante de ingreso actual. Sin embargo, todo beneficiario puede escoger enviar comprobante de ingreso actual si asi lo desea.

Ingresos devengados por empleo	Cheque salarial reciente o talon (de 4 semanas consecutivas) **o** carta del empleador
Ingresos de trabajo por cuenta propia	Declaracion actual de impuestos (firmada) y todos los adjuntos o registro de ganancias y gastos
Ingresos por alquiler o inquilinatos.....	Carta del inquilino, huesped o arrendatario, **o** talon de cheque
Beneficios de seguro por desempleo	Carta o certificado de adjudicacion de beneficios, estado mensual de emision de beneficios, correspondencia oficial del Departamento de Trabajo del Estado de Nueva York, un listado con los datos de la cuenta del beneficiario del sitio web (www.labor.state.ny.us) del Departamento de Trabajo del Estado de Nueva York, **o** una copia de la Tarjeta de Deposito Directo con un listado
Pensiones privadas/anualidades.....	Resumen de la pension o de las anualidades
Seguridad Social	Carta o certificado de adjudicacion de beneficios, resumen anual de emision de beneficios, **o** correspondencia oficial de la Administracion de la Seguridad Social
Pago salarial por licencia de enfermedad/Ingreso por Incapacidad	Carta o certificado de adjudicacion de beneficios, talon de cheque de beneficios **o** correspondencia oficial de la fuente de ingresos
Sustento de Menores/Pension Alimenticia	Carta de la persona que suministra el sustento, carta del juzgado, talon de cheque de sustento/pension alimenticia, o copia de la Tarjeta NY Eppicard con listado, copia de los datos de la cuenta de sustento de menores del sitio web www.newyorkchildsupport.com, **o** copia del estado de cuenta bancaria que muestre deposito directo
Indemnizacion por accidente de trabajo	Carta de adjudicacion de beneficios **o** talon de cheque
Beneficios de Veteranos	Carta de adjudicacion de beneficios, talon de cheque de beneficios **o** correspondencia oficial de la Administracion de Servicios a Veteranos.
Retribucion Militar	Carta de adjudicacion de beneficios **o** talon de cheque

Intereses/Dividendos/Regalias.....	Resumen actual de cuenta bancaria, cooperativa de credito o institucion financiera, carta del corredor, carta del agente, **o** 1099 o planilla de declaracion de impuestos (de no tener a mano ninguna otra documentacion)
Manutencion que se reciba de otros miembros de la familia ..	Carta firmada por el miembro de la familia que brinda la manutencion.
Ingresos provenientes de un fideicomiso	Documento de fideicomiso

COMPROBANTE DE EMPLEO (Los beneficiarios de Medicaid que actualmente estan inscritos en el Programa de Adquisicion de Beneficios de Medicaid para Trabajadores Incapacitados deben suministrar comprobante de empleo).

- Cheque/talon salarial mas reciente; **o**
- Formulario W-2; **o**
- Una declaracion escrita detallada del empleador; **o**
- Declaracion de impuestos

GASTOS POR CUIDADO DE NINOS O POR EL CUIDADO DE UNA PERSONA A CARGO Toda persona que solicite por primera vez seguro medico debe enviar comprobante de este gasto, si aplica.

- Carta de la guarderia o de la persona que cuida el nino o adulto; **o**
- Cheques cancelados o recibos que muestren lo que usted pago.

PRIMAS DE SEGURO DE SALUD (Proporcione, si corresponde).

Carta del empleador | Resumen de primas | Talon de cheque salarial

SEGURO DE SALUD PRIVADO O POR PARTE DEL EMPLEADOR (Proporcione solamente si es un nuevo seguro o si se han producido cambios desde la ultima vez que usted presento una solicitud o una renovacion).

- Poliza de seguro; **o**
- Tarjeta de Medicare (tarjeta roja, blanca y azul)
- Resumen de primas; **o**
- Tarjeta de seguro; **o**
- Carta de baja; **o**

EMBARAZO (Suministrar si es pertinente)

- Carta del profesional de salud (tal como medico o enfermera practicante) donde se indique la fecha estimado de parto; **o**

- Hoja de Reconocimiento Presunto Preventivo rellenado por el suministrador autorizado en la que se indique la fecha esperada de parto; **o**
- Formulario Medico de Derivacion a WIC que muestre la fecha esperada de parto.

Si no cuenta con comprobante de embarazo al momento de devolver este formulario de renovacion, favor de obtenerlo cuanto antes y enviarlo a la persona a cargo de su caso.

GASTOS ESPECIALES DE TRABAJO DE PERSONAS CIEGAS O DISCAPACITADAS

Si usted es una persona ciega o discapacitada y tiene gastos especiales, no medicos, relacionados con su trabajo (por ejemplo, necesita equipo o transporte especial) envie los recibos que demuestren los tipos de gastos y de quien los recibe.

CIUDADANIA ESTADOUNIDENSE/IDENTIDAD

NOTA: Toda persona que solicite por primera vez seguro medico, debe someter comprobante de identidad, aunque no tiene que enviar comprobante de ciudadania estadounidense o situacion de inmigracion si el/ella:

- esta embarazada; **o**
- es un inmigrante indocumentado que solicita cobertura de Medicaid debido a una situacion medica de emergencia. (Vea la seccion de Asistencia Medica del Libro 2, LDSS-4148B-SP DEPARTAMENTO LOCAL DE SERVICIOS SOCIALES para obtener mas informacion sobre ciudadania estadounidense o condicion migratoria).

Documentos que establecen ambos, ciudadania estadounidense e identidad: Identidad y ciudadania estadounidense o situacion migratoria aprobada deben ser documentados si una nueva persona solicita seguro medico. Si usted esta solicitando seguro medico y declara que es ciudadano(a) estadounidense o nacional y suministra su numero de seguro social o comprobante de que lo ha solicitado, Medicaid verificara su numero de seguro social y fecha de nacimiento, inclusive los datos de identidad por medio de un cruzamiento electronico de datos con los archivos de la Administracion del Seguro Social. Si el cruzamiento de datos no da resultado, es posible que se le exija comprobante de identidad y ciudadania estadounidense. Todo documento presentado debe ser el original o copias certificadas por la agencia que los expide. En cuanto a la ciudadania estadounidense se refiere, se toman en cuenta los 50 Estados de la nacion, el Distrito de Columbia, Samoa Estadounidense, Islas Swain y, si nacio en determinadas fechas o posteriormente, Puerto Rico, Guam, las Islas Vírgenes Estadounidenses y las Islas Nortenas de Mariana. **(Si somete uno de los siguientes documentos, no necesita mas comprobantes para demostrar su ciudadania estadounidense o identidad).**

- Pasaporte/Tarjeta estadounidense; **o**
- Certificado de naturalizacion (N-550 o N-570); **o**
- Certificado de ciudadania estadounidense (N-560 o N-561); **o**
- Licencia Amplia de Conductor del Estado de Nueva York (EDL); **o**
- Documento tribal de americano autoctono, certificado de porcentaje de sangre indigena, u otro documento tribal de americano autoctono/o nativo de Alaska que contenga una fotografía.

Documentos que establecen ciudadania estadounidense pero que tambien exigen un documento de identidad

- Partida de nacimiento estadounidense
- Certificacion de nacimiento expedido por el Departamento de Estado (Formularios FS-545 o DS-1350); **o**

- Informe de nacimiento en el extranjero (FS-240); **o**
- Tarjeta de identificacion de ciudadano estadounidense (I-197 o I-179); **o**
- Registros religiosos/escolares; **o**
- Registro oficial de servicio militar que demuestre lugar de nacimiento en EE.UU; **o**
- Decreto definitivo de adopcion; **o**
- Comprobante de que la persona reune los requisitos para obtener la ciudadania estadounidense bajo el Acta de Ciudadania del Nino del 2000.

Documentos que establecen identidad

- Licencia de conductor o tarjeta de identificacion expedida por el Estado con fotografia; **o**
- Tarjeta de identificacion expedida por el gobierno federal, estatal o local; **o**
- Tarjeta del servicio militar estadounidense o registro de reclutamiento, tarjeta de guardacostas estadounidense de marina mercante; **o**
- Carne escolar con fotografia; **o**
- Registros oficiales escolares o constancias de la guarderia infantil o centro de cuidados diurnos (de los menores de 16 anos) ; **o**
- Expedientes del medico, clinica u hospital (para los menores de 16 anos).

Una situacion actual de inmigrante debe de ser suministrada por toda persona que solicite por primera vez o que solicite una renovacion, y cuyo estado migratorio haya sido modificado en los ultimos 12 meses; o debe comprobar que tiene un estado migratorio aprobado.

Estado migratorio/Identidad

- I-551 Tarjeta de Residente Permanente (Green Card); **o**
- I-766 Tarjeta de Autorizacion de Empleo.

Estado migratorio, pero tambien requiere un documento adicional de identidad

- I-94 Registro de entrada/salida; **o**
- Formulario I-797 Notificacion de Accion Tomada por la Oficina de Servicios de Ciudadania e Inmigracion (USCIS); **o**
- Comprobante de residencia ininterrumpida en EE.UU. previo al 1ero. de enero de 1972.

Estas listas no lo incluyen todo. Si usted no cuenta con uno de estos documentos, comuniquese con su departamento local de servicios sociales y pida informacion sobre otros documentos que se puedan usar.

Calificaciones para la inscripción

Puede usar este formulario para:

- inscribirse para votar en el estado de Nueva York;
- cambiar su nombre y/o domicilio, si hubo algún cambio desde la última vez que votó;
- afiliarse a un partido político o cambiar su afiliación.

Para inscribirse, debe:

- ser ciudadano de los EE.UU.;
- tener 18 años al 31 de diciembre del año en el que presente este formulario (Nota: debe tener 18 años en la fecha de las elecciones generales, primarias o de otro tipo en las que desee votar);
- ser residente del condado, o de la ciudad de Nueva York, al menos 30 días antes de la elección;
- no estar en la cárcel ni en libertad condicional (parole) por haber cometido un delito grave; y
- no tener derecho a votar en otro lugar.

¡Importante!

Si considera que alguien ha interferido con su derecho a inscribirse o a negarse a inscribirse para votar, con su derecho a decidir si inscribirse o a presentar la solicitud de inscripción para votar, o con su derecho a elegir su propio partido político u otra preferencia política, puede reclamar ante:

New York State Board of Elections, 40 Steuben Street,
Albany, New York 12207-2109
Teléfono: 1-800-469-6872;
Los usuarios de TDD/TTY deben comunicarse con el sistema retransmisor del estado de Nueva York o visitar nuestro sitio web:
www.elections.state.ny.us

Su decisión de inscribirse será confidencial y sólo se utilizará para inscribirlo como votante. Los que decidan no inscribirse para votarse y/o la información sobre la oficina ante la cual se presentó la solicitud serán confidenciales, y se utilizarán exclusivamente a los fines de la inscripción como votante.

Verificación de su identidad

Intentaremos verificar su identidad antes del día de las elecciones, mediante el número de **DMV (número de la licencia de conductor o número de ID de no conductor)**, o mediante **los cuatro últimos dígitos del número de su seguro social**, que usted escribirá en la casilla 9.

Si **no tiene número de DMV o de Seguro Social,** debe usar una identificación con foto válida, una factura actual de servicios públicos, un estado de cuenta bancario, su cheque de sueldo, un cheque del gobierno o algún otro documento del gobierno que muestre su nombre y domicilio. Con este formulario puede incluir una copia de uno de esos documentos de identificación.

Si no podemos verificar su identidad antes del día de las elecciones, se le pedirá una identificación cuando vote por primera vez.

Para completar el formulario:

Es delito procurar un registro falso o brindar información falsa a la Junta Electoral.

Casilla 9: Debe marcar una opción. Si tiene alguna duda, consulte *Verificación de su identidad* más arriba .

Casilla 10: Si nunca antes votó, escriba "Ninguna". Si no puede recordar cuándo votó por última vez, escriba un signo de interrogación (?). Si votó con un nombre diferente, anote ese nombre. De lo contrario, escriba "El mismo".

Casilla 11: Marque únicamente una casilla. Para votar en una elección primaria, debe estar afiliado en uno de los partidos que se enumeran; excepto por el Partido de la Independencia, que permite que votantes no afiliados participen en ciertas elecciones primarias.

Formulario de registro de votantes en una agencia del estado de NY

"Si no está registrado para votar donde vive actualmente, ¿le gustaría solicitar el registro para votar aquí hoy?"

☐ **Sí** (Si contesta que Sí, llene la SOLICITUD DE REGISTRO COMO VOTANTE en la parte inferior de esta página)

☐ NO porque opté por no registrarme O

☐ Ya estoy registrado para votar en mi domicilio actual O

☐ Solicité y recibí un formulario de registro por correo.

En caso de que no marque ninguna casilla, se considerará que decidió no registrarse para votar en este momento.

_____ ___/___/___
(Firma) (Fecha)

_____
(Escriba el nombre en letra de molde)

¡Importante!

Solicitar el registro o negarse al registro para votar no afectará la cantidad de ayuda que le proporcionará la agencia.

Si necesita ayuda para llenar la solicitud de registro como votante, lo ayudaremos. La decisión de pedir o aceptar ayuda es suya. Puede llenar el formulario de solicitud en privado.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料：如果你有興趣索取本中文資料表格，請電 1 - 800 - 367-8683

한국어: 한국어 양식을 원하시면 1-800-367-8683 으로 전화하십시오.

SOLICITUD DE REGISTRO COMO VOTANTE (instrucciones al dorso)

NVRA-05 (01/2011)

☐ Sí, necesito una solicitud para recibir una Boleta de votación por correo **Llene en letra de molde con tinta azul o negra** ☐ Sí, quisiera trabajar en una mesa electoral el día de las elecciones

1	¿Es usted ciudadano de los EE.UU.? Sí ☐ No ☐ Si respondió NO, no llene este formulario.	2	¿Tendrá 18 años cumplidos el día de la elección? Sí ☐ No ☐ Si respondió NO, no llene este formulario a menos que vaya a tener 18 años cumplidos a fin de año .
3	Apellido / Nombre / Inicial del segundo nombre / Sufijo		
4	Domicilio particular donde vive (no informe un P.O. Box) / Apt. N.° / Ciudad/Pueblo/Aldea / Código postal / Condado		
5	Domicilio donde recibe el correo (si es diferente del anterior) / P.O. Box, star route, etc / Oficina de correo / Código postal		
6	Fecha de nacimiento	7	Sexo (círculo) M F
8	Teléfono particular (optativo)	9	Número de ID: Marque la casilla que corresponda y escriba su número: ☐ Número de DMV del estado de Nueva York __ __ __ __ __ __ __ __ __ Si no tiene un número de DMV del estado de Nueva York, informe : ☐ Últimos cuatro dígitos de su número de Seguro Social __ __ __ __ ☐ No tengo licencia de conductor de Nueva York
10	El año en que votó por última vez / Su domicilio era (informe el número de casa, la calle y la ciudad) / En el condado/estado / Bajo el nombre (si es diferente de su nombre actual)		
11	**Elija un partido**--Marque únicamente una casilla ☐ Partido Demócrata ☐ Partido Republicano ☐ Partido Conservador ☐ Partido de las Familias Trabajadoras ☐ Partido de la Independencia ☐ Partido Verde ☐ Otros (completar) _____ ☐ No deseo afiliarme a ningún partido	12	**DECLARACIÓN JURADA:** Juro o declaro que • Soy ciudadano de los Estados Unidos. • Habré residido en el condado, ciudad o aldea por un mínimo de 30 días antes de las elecciones. • Reúno todos los requisitos para registrarme como votante en el Estado de Nueva York. • La firma o marca a continuación es de mi puño y letra. • La información que he ofrecido es verdadera. Entiendo que de no serlo, se me puede condenar y multar por hasta $5,000 y/o encarcelar por un máximo de cuatro años. → _____ (Firma o marca en tinta) (Fecha)

(Optativo) Inscríbase para donar sus órganos o tejidos.

Apellido_____
Nombre_____
Inicial del segundo nombre_____ Sufijo_____
Domicilio_____
Apt N.°_____ Código postal_____
Ciudad _____
Fecha de nacimiento_____ Sexo ☐ M ☐ F
Color de ojos_____ Estatura ___ pies ___ pulg

Con su firma a continuación, usted certifica que:

- Tiene 18 años o más;
- Presta su consentimiento para donar todos sus órganos y tejidos para trasplantes, investigación o ambos;
- Autoriza a la Junta Electoral a entregar su nombre e información identificatoria al DOH para inscribirse en el Registr;
- y autoriza al DOH a permitir el acceso a esta información a organizaciones de obtención de órganos reguladas por el gobierno federal,a bancos de tejidos y ojos con licencia del Estado de Nueva York y hospitales en caso de que usted fallezca

DONATE LIFE New York State

_____
Firma Fecha

ALBANY CO DSS
100 FIRST ST
40 HOWARD ST
ALBANY, NY 12202

NOTICE OF RECERTIFICATION FOR
MEDICAL ASSISTANCE.

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA
NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:	DATE:	CASE NUMBER:
U0102C4984	June 20, 2013	TST307SMW

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
Z61	TEST	FONT	DEFAULT MA	518-474-9440

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	518-473-1000
OR Agency Conference	518-473-1000
Fair Hearing information and assistance	518-473-1000
Record Access	518-473-1000
Child/Teen Health Plan	518-473-1000

CASE NAME / AND ADDRESS

Z61/TEST/FONT

HAYNER, MATTHEW
307 WEST ST,
ALBANY, NY 12345

MEDICAL ASSISTANCE

MEDICAID, FAMILY HEALTH PLUS, FAMILY PLANNING BENEFIT PROGRAM RENEWAL FORM

- It is time to renew your health insurance benefits.
- You must answer **all** the questions and return this form and any required documentation to the following address by **Tuesday, September 24, 2013.**

  ABC OFFICE NAME FOR TESTING, ABC FIRST LINE ADDRESS FOR TESTING, ABC SECOND LINE ADDRESS FOR TESTING, ABC CITY TESTIN NY 10009

- If you do not complete and return this form, you will lose your health insurance. If we are paying your Medicare premium or other health insurance premium, we will also stop making these payments.
- You must return this form even if you have told us you moved to another county.
- This form is not complete until you sign and date it.
- Please read the Terms, Rights, and Responsibilities.

CONTINUED ON THE NEXT PAGE ...

****
* Important Instructions-Please Read this Page *
****

- To determine your eligibility, the amount of income you report will be compared to available computer matches. In some cases, the data from the computer match may change your coverage from Medicaid to Family Health Plus.
- **You do not need to send proof of income at this time unless the renewal form says you must.**
- **However, since the amount you report may not match the amount found in the computer matches, you may wish to submit proof of your income to be sure that you receive the correct coverage.**
- You may be asked to provide proof of your income at a later date. If needed, you will be contacted and told what to send in. The enclosed "Documentation Checklist" shows you the things you can use as proof of these items.

You may call the social services office for help with this form. There are also community organizations and health plans that can help you. You can **call 1-877-934-7587** or **1-800-698-4543** to find a health plan or community organization in your area that provides assistance. If you go to one of these organizations for help, bring this letter with you. You must still return the form and documentation to the address above by the date shown. You may wish to keep a copy of this form for your records.

MAKE SURE YOU ANSWER EVERY QUESTION AND SIGN THE FORM. RETURN ALL PAGES AND ANY REQUIRED DOCUMENTATION BY MAIL OR IN PERSON TO THE SOCIAL SERVICES OFFICE. YOU DO NOT NEED TO COME IN FOR AN INTERVIEW.

CONTINUED ON THE NEXT PAGE ...

CASE NUMBER: TST307SMW CASE NAME: HAYNER, MATTHEW

RENEWAL FOR MEDICAID - FAMILY HEALTH PLUS -FAMILY PLANNING BENEFIT PROGRAM

1. You last reported you live at:
   307 WEST ST
   ALBANY, NY 12345

   Is this still where you live?

   [__] Yes
   [__] No. I live at:

   House# Street Apt. #

   City State Zip

   Send proof of your new address.

   [__] Check here if homeless.

   If you do not receive mail where you live,
   please write your mailing address below:

   House # Street Apt. # PO Box#

   City State Zip

   My telephone number is: _____
   [_] Home [_] Cell [_] Work [_] Other

   Another phone number where I can be reached is: _____
   [_] Home [_] Cell [_] Work [_] Other

2. You are renewing health care coverage for the following persons. **(Make any corrections to name or date of birth below.)** If a Social Security Number (SSN) is listed as "not on file", write it in the space below. If this person does not have a SSN leave this space blank. If the following persons are found to be not otherwise eligible for Medicaid or Family Health Plus, please check the box in the last column if they are interested in receiving coverage from the Family Planning Benefit Program (FPBP).

Name	Date of Birth	SSN (If you have one)	Still living with you?	FPBP
MARK HAYNER	6/15/1996	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
HELEN MOYER	8/15/1973	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MARTY MOYER	3/14/1970	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MARK MOYER	5/12/1997	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MOLLY MOYER	4/18/1993	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MADISON MOYER	9/15/2003	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		

CONTINUED ON THE NEXT PAGE ...

3. Who else lives with you? Write the full legal name(s) below and the relationship to the person listed first in question 2. (For example, spouse, parent/step-parent, child and their date of birth and gender.)

   o If anyone listed below wants to apply for health insurance, write their social security number below.

Name	Relationship	Date of Birth	Gender (M/F)	SSN (If you have one)	Does this person want health insurance?
_____	_____	_____	___	_____	___Yes ___No
_____	_____	_____	___	_____	___Yes ___No
_____	_____	_____	___	_____	___Yes ___No
_____	_____	_____	___	_____	___Yes ___No

   o Identity and U. S. citizenship or satisfactory immigration status must be documented. If anyone listed above who is applying for health insurance is declaring to be a U. S. citizen or national and provides his or her SSN or proof that an SSN was applied for, Medicaid will verify his or her SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required.

   o Anyone listed above who is applying for health insurance and is not a U.S. citizen must **send proof** of identity and immigration status.

   o Proof of income is also required

   o Include anyone applying for health insurance when you answer the rest of the questions on this form.

   Note: Only certain family members can apply using this form. We will contact you if we need a different form.

4. Is anyone listed in questions 2 or 3, pregnant?
   [__] No.
   [__] Yes. Who? _____ Expected due date: _____

   If yes, you **must send proof** of due date. See documentation checklist.

CONTINUED ON THE NEXT PAGE ...

5. NEW OR CHANGED HEALTH INSURANCE SINCE YOU LAST APPLIED OR RENEWED:

a. Has anyone who had health insurance coverage **lost** the coverage?
[__] No.

[__] Yes. Who? Insurance company name: Date Coverage Ended:

_____ _____ _____

b. Has anyone **started** being covered by health insurance (including Medicare or long-term care insurance) other than Medicaid/Family Health Plus? We may be able to pay the cost of your health insurance premiums if it is cost effective.
[__] No.

[__] Yes. Name of Insured Premium amount: Paid How Often:

_____ $_____ _____

You must send a copy of the front and back of the insurance card and/or Medicare card (red, white and blue card) for each person and a copy of the insurance policy.

c. If you are not insured through your job now, does your job offer health insurance? We may be able to pay the cost of your health insurance premiums if it is cost effective.
[__] No.

[__] Yes.

If yes, list employer name, address, and telephone number below:

_____
_____
_____
_____

6. ILLNESS, INJURY OR DISABILITY

a. Since you last applied/renewed, has anyone become blind, or disabled, or does anyone now have a chronic illness or special health care need? Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.

[__] No [__] Yes If yes, who?

_____

Explain: _____

_____

b. If you are blind or disabled do you pay special expenses (non-medical) in order to work?
[__] No [__] Yes **(You must send in receipts for these expenses.)**

c. Does anyone who is renewing or applying have a pending lawsuit due to an injury?
[__] No [__] Yes

If yes, who? _____

d. Does anyone renewing or applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else, (that could be covered by insurance)?
[__] No [__] Yes

If yes, who? _____

CONTINUED ON THE NEXT PAGE ...

7. If there is a parent or spouse living outside of the home, please answer the following questions.

A. Since you last applied/renewed, has the spouse or parent of someone renewing moved out of the home?

[__] No (Go to Question B.)

[__] Yes. Give the following information, if known.
Name: Parent_____Spouse _____
Date of Birth _____ Social Security Number _____
Address _____
Parent/Spouse of _____

Note: Families who are renewing for their children and pregnant women are NOT required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor, or a spouse living outside the home to be eligible for health insurance, unless there is a good cause.

[__] Check here if claiming good cause. I have a good reason you should not contact this parent/spouse (fear from a threat of physical or emotional harm). This is called "good cause". If you checked this box, you will be contacted to explain your reason and to provide proof.

B. Since you last applied/renewed, do you have any information that you have not previously given us to help us find a spouse or parent who does not live in the home (e.g., home address or work place)?
[__] No.
[__] Yes. **Give the following information, if known.**
Name: Parent_____Spouse _____
Home Address _____
Work Address _____
Parent/Spouse of _____

Name: Parent_____Spouse _____
Home Address _____
Work Address _____
Parent/Spouse of _____

CONTINUED ON THE NEXT PAGE ...

8. a. Write the types of income (money) and the amount received by everyone listed in Questions 2 and 3. See the documentation checklist for examples of income. **Write the amount before any taxes or other deductions; include tips/commissions. Send pay stubs or other proof.**

If you or anyone renewing or applying is self-employed, check here: [_]

Name	Type of Income/Source	Name of Employer (if income is from employment)	How Much (before taxes /deductions include tips/ commissions)	How Often Weekly/ 2 weeks/ Monthly
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____

Check the box if the statement applies to you:
[_] I do not get paychecks or pay stubs.
[_] I get paid in cash.

b. Do you or any adult in Question 2 or 3 have no income?
[_] No [_] Yes Who? _____

If there is no income listed above, please explain how you are living:
(For example: living with friend or relative.)

_____

c. Have you or anyone who is applying changed jobs or stopped working in the last three months?
[_] No [_] Yes If yes, who? _____
If yes, last job was: Date: _____/___/___
Name of Employer:_____

d. Are you or anyone who is renewing or applying a student, in a vocational, undergraduate, or graduate program?
[_] No [_] Yes
If yes: [_] Full Time [_] Part Time [_] Undergraduate [_] Graduate
Student's name: _____

e. Do you or anyone who is renewing or applying pay for health insurance premiums, Medicare premiums, court ordered support, or child/adult care expenses?
[_] No [_] Yes If yes, fill out below and send proof of each expense.

Type of expense	Name of person paying the expense	How much is being paid	How often is the expense paid (Ex. Weekly, monthly)
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____

The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

Are you currently enrolled in the Medicaid Buy-In program for Working People with Disabilities, or applying for MBI-WPD?
[_] No [_] Yes
If YES, you must submit proof of your employment. See the enclosed Documentation Checklist for the documents you can use to prove you are employed.

If you are enrolled in the MBI-WPD program but are no longer working, please state the reason and the date you last worked.

CONTINUED ON THE NEXT PAGE ...

Reason no longer working:

_____

Date last worked: _____

9. Has your share of the monthly housing payment (such as rent or mortgage, including property taxes) changed since you last applied/renewed for your healthcare coverage?

[_] No
[_] Yes. My new share of the monthly housing payment is $_____

If you pay for water separately, how much do you pay? $_____ **Send proof** of water bill.

Do you receive free housing from your employer? [_] Yes [_] No

10. **Proof of identity, United States citizenship or satisfactory immigration status is a requirement for Medicaid eligibility.**

If you are declaring to be a U. S. citizen, but you have not provided proof of U. S. citizenship, provide your SSN or proof that an SSN was applied for, and Medicaid will verify your SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required. Proof of identity and citizenship requires original documents or copies certified by the issuing agency.

a. Has anyone renewing not provided proof of U.S. citizenship? Who? SSN (If you have one)

_____ _____
_____ _____
_____ _____

If you are an immigrant, but have not provided proof of your identity and immigration status, or if your immigration status has changed you must send us proof. Send proof from the federal immigration agency showing your current immigration status.

b. Has the immigration status of anyone renewing changed? Who? SSN (If you have one)

_____ _____
_____ _____
_____ _____

CONTINUED ON THE NEXT PAGE ...

11. RESOURCES

List all resources (resources include money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, or property that someone owns. Do not list your home).

If you do not have any resources, please write "NONE" under "Resource Type."

What are your current resources?

Resource Type	Value	Owner	Bank/Company Name
	$		
	$		
	$		
	$		
	$		
	$		

Do you want to continue to receive Medicaid coverage for long-term care services, such as home care or personal care services? ____ Yes ____ No

If yes, you need to send proof of your current resources.

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities on the following pages. I certify under penalty of perjury that everything on this application is the truth as best I know.

SIGNATURE of Applicant or Representative _____ DATE _____

SIGNATURE of Other Applying Adult _____ DATE _____

OFFICE USE ONLY

Worker Signature	Supervisor Signature	Case Disposition

CONTINUED ON THE NEXT PAGE ...

CONTINUED ON THE NEXT PAGE ...

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The New York Medicaid program must tell you how we use, share, and protect your health information. The New York Medicaid program includes regular Medicaid, Medicaid Managed Care, and Family Health Plus. The program is administered by the New York State Department of Health and the Local Department of Social Services.

A copy of the Notice may be obtained at your local Department of Social Services. It is also available at:

http://www.health.state.ny.us/health_care/medicaid/publications/docs/inf/06inf-03att1.pdf

CONTINUED ON THE NEXT PAGE ...

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CHILD TEEN HEALTH PROGRAM

How can I get help finding a health care provider for my child for regular checkups?

There is a Medicaid program for children from birth to age 21 called the Child/Teen Health Program (C/THP) which provides check-ups and follow-up care if problems are found. Children from birth to age 21 who have Medicaid, Medicaid Managed Care, and 19 and 20 year old young adults who have Family Health Plus, can take advantage of this benefit.

Children and young adults should see a doctor for regularly scheduled check-ups even if they are healthy. The C/THP recommends that children have 10 check-ups before the age of 3 and a check-up once a year after that. The C/THP helps establish a "medical home." A "medical home" is a situation in which each patient has an ongoing relationship with a physician who is responsible for the patient's health care needs and, when needed, arranges for care with other qualified physicians.

Depending on a child's age, the C/THP check-up includes:

- Health history
- Asthma assessment, diagnosis and treatment
- Dental screening
- Hearing and vision testing
- Complete physical exam
- Blood tests (such as sickle cell anemia)
- Immunizations
- Developmental/behavioral assessment
- Blood lead level lab test - Children who are 1 or 2 years old and children between 3 and 6 years old who have not had a blood lead level lab test will receive one.

Advice and answers to your health questions

There are no Medicaid co-pays for this benefit. The benefit also includes necessary services that might not normally be provided by the child's regular doctor or clinic. The medical provider will arrange for follow-up treatment for problems found during the check-up.

If you are enrolled in a managed care plan, the plan includes the C/THP. Speak to your plan representative about these services.

If you are not enrolled in a managed care plan and you live in upstate New York, call your local department of social services to help you find doctors, dentists, prenatal care, family planning, and other providers that accept Medicaid and help with transportation, if necessary.

If you live in NYC, call 1-888-692-8662 for help finding doctors, dentists, prenatal care, family planning, other providers that accept Medicaid and help with transportation, if necessary.

THE SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS and CHILDREN (WIC)

Are you pregnant? A new mother? Have a baby or young children?
WIC can help you help your family. WIC provides healthy foods, nutrition and health education, breastfeeding support and referrals to health and social services to New York families at no cost.

For the location of the nearest WIC clinic, call 1-800-522-5006.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid or Family Health Plus.

I understand that I must provide the information needed to prove my eligibility for each program. I agree to immediately report any changes to the information on this form. If I am unable to get the information, I will tell the local department of social services. The local department of social services may be able to help in getting the information.

I understand that workers from the programs for which family members or I are renewing may check the information given by me on this form. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

I understand that Medicaid and Family Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.

I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.

I understand that if my child is on Medicaid, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program.

I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS I certify under penalty of perjury, by signing my name on this form, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. The term "satisfactory immigration status" means an immigration status that does not make the person ineligible for benefits. **Important Information:** The **federal immigration agency** has said that enrollment in Medicaid/Family Health Plus CANNOT affect a person's ability to get a permanent resident card (green card), become a citizen, sponsor a family member or travel in and out of the country (unless Medicaid is being used to pay for long term care services in a nursing home or mental health facility). **The State will not report any information on this application to the federal immigration agency.**

SOCIAL SECURITY NUMBER SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient.

RELEASE OF MEDICAL INFORMATION I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid and Family Health Plus programs; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

MEDICAID MANAGED CARE If I am adding a family member to a Medicaid case and I live in a county that requires Medicaid recipients to join a health plan, I understand that this family member will be enrolled in the same health plan as my family, unless he or she is exempt or excluded.

RELEASE OF EDUCATIONAL RECORDS I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

EARLY INTERVENTION PROGRAM If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local department of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

I consent to sharing this information with any school-based health center that provides services to the applicant(s).

DOCUMENTATION CHECKLIST

This is a list of documents that the Medicaid Program accepts. Please review the enclosed "MEDICAID, FAMILY HEALTH PLUS AND/OR FAMILY PLANNING BENEFIT PROGRAM RENEWAL FORM" to determine what documents you need to provide in order to continue your health care coverage.

PROOF OF INCOME Anyone new applying for health insurance must send proof of current income. However, any recipient may choose to send proof of current income if they want to.

Earned Income from Employer	Current paycheck/stubs (4 four consecutive weeks) **or** letter from employer
Self-Employment Income	Current signed income tax return and all schedules **or** record of earnings and expenses
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant **or** check stub
Unemployment Benefits	Award letter/certificate, monthly benefit statement, correspondence from the NYS Department of Labor, printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us), **or** copy of Direct Payment Card with printout
Private Pensions/Annuities	Statement from pension/annuity
Social Security	Award letter/certificate, annual benefit statement, **or** correspondence from Social Security Administration
Employment Based Sick Pay/Disability Income	Award letter/certificate, benefit check stub, **or** correspondence from source of income
Child Support/Alimony	Letter from person providing support, letter from court, child support/alimony check stub, copy of NY Eppicard with printout, copy of child support account information from www.newyorkchildsupport.com, **or** copy of bank statement showing direct deposit
Worker's Compensation	Award letter **or** check stub
Veteran's Benefits	Award letter, benefit check stub, **or** correspondence from Veterans Administration
Military Pay	Award letter **or** check stub
Interest/Dividends/Royalties	Current statement from bank, credit union, or financial institution, letter from broker, letter from agent, **or** 1099 or tax return (if no other documentation is available)
Support from other Family Members	Signed statement or letter from family member
Income from a trust	Trust document

PROOF OF EMPLOYMENT (Medicaid recipients currently enrolled in the Medicaid Buy-In program must provide documentation of employment.)

- Current paycheck/stub; **or**
- Detailed written statement from employer; **or**
- W-2 form; **or**
- Income tax return.

CHILD CARE / DEPENDENT CARE EXPENSES Anyone new applying for health insurance must send proof of this expense, if applicable.)

- Written statement from day care center or other child/adult care provider; **or**
- Canceled checks or reciepts that show your payments.

HEALTH INSURANCE PREMIUMS (Provide, if applicable.)

Letter from employer Premium statement Pay stub

PRIVATE OR EMPLOYER BASED HEALTH INSURANCE (Provide only if new or changed since you last applied/renewed)

- Insurance policy; **or**
- Premium statement; **or**
- Insurance Card; **or**
- Terminati on letter; **or**
- Medicare Card (Red, white and blue card).

PREGNANCY (Provide, if applicable.)

- Statement from medical professional (such as a doctor or nurse practitioner) with the expected date of delivery; **or**
- Presumptive Eligibility Screening Worksheet completed by a qualified provider that tells us the expected date of delivery; **or**
- WIC Medical Referral Form that tells us the expected date of delivery.

If you do not have proof of your pregnancy when you return this renewal form, please get it as soon as possible and send it to your worker.

SPECIAL WORK EXPENSES FOR BLIND/DISABLED

If you are blind or disabled and must pay special non-medical expenses in order to work, (for example, you need special equipment or transportation), send in receipts that show what the expenses are and who provides them.

CITIZENSHIP/IDENTITY

NOTE: Anyone new applying for health insurance must prove identity, but does not have to send proof of citizenship or immigration status if he/she is:

- Pregnant; **or**
- An undocumented immigrant applying for Medicaid coverage because of an emergency medical condition. (See Medical Assistance section of Book 2, LOCAL DEPARTMENT OF SOCIAL SERVICES-4148B for more information on citizenship or immigration status).

Documents which Establish both Citizenship and Identity: Identity and U. S. citizenship or satisfactory immigration status must be documented if anyone new is applying for health insurance. If you are applying for health insurance and are declaring to be a U. S. citizen or national, if you provide your SSN or proof that an SSN was applied for, Medicaid will verify your SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required. All documents must be originals or copies certified by the issuing agency. For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, American Samoa, Swain's Island and, if born on or after certain dates, Puerto Rico, Guam, the U. S. Virgin Islands and the Northern Mariana Islands. **(If you provide one of the following, no other document is required for proof of citizenship/identity.)**

- U.S. passport book/card; **or**
- Certificate of Naturalization (N-550 or N-570); **or**
- Certificate of U.S. Citizenship (N-560 or N-561); **or**
- NYS Enhanced Driver's License (EDL); **or**
- Native American Tribal Document, Certificate of Degree of Indian blood or other Native American/Alaska native tribal document with photo.

Documents which Establish Citizenship but also require one identity document

- U.S. Birth Certificate
- Certification of birth issued by Department of State (FS-545 or DS-1350); **or**
- Report of Birth Abroad (FS-240); **or**
- U.S. Citizen ID Card (I-197 or I-179); **or**
- Religious/school records; **or**
- Military record of service showing U.S. place of birth; **or**
- Final adoption decree; **or**
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

Documents which Establish Identity

- State driver's license or ID card with photo; **or**
- ID card issued by a Federal, State, or local government agency; **or**
- U.S. Military card or draft record or U.S. Coast Guard Merchant Mariner Card; **or**
- School ID card with a photo; **or**
- Verified school, nursery or daycare records (for children under 16); **or**
- Clinic, doctor or hospital records (for children under 16).

Current Immigrant Status must be provided for any new person applying or any person renewing whose status has changed in the past 12 months or you must prove that you are in a satisfactory immigration status.

Immigration Status/Identity

- I-551 Permanent Resident Card ("Green Card"); **or**
- I-766 Employment Authorization Card.

Immigration Status, but require an additional identity document

- I-94 Arrival/Departure Record; **or**
- USCIS Form I-797 Notice of Action; **or**
- Evidence of Continuous U.S. residence prior to January 1, 1972.

These lists are not all inclusive. If you do not have one of these documents, please contact your local department of social services for information on other documents that can be used.

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

New York State Board of Elections, 40 Steuben Street,
Albany, New York 12207-2109
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the **DMV number (driver's license number or non-driver ID number)**, or the **last four digits of your social security number**, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to *Verifying your identity* above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. To vote in a primary election, you must be enrolled in one of these listed parties — Except the Independence Party, which permits non-enrolled voters to participate in certain primary elections.

NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ **YES** (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)
☐ NO because I choose not to register OR
☐ I am already registered at my current address OR
☐ I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____ ___/___/___
(Signature) (Date)

_____
(Please Print Name)

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料：如果你有興趣索取本中文資料表格，請電 1 - 800 - 367-8683

한국어: 한국어 양식을 원하시면 1-800-367-8683 으로 전화하십시오.

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (01/2011)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1	Are you a U. S. citizen? Yes ☐ No ☐ If you answered NO, do not complete this form.	2	Will you be 18 years old on or before election day? Yes ☐ No ☐ If you answered NO, do not complete this form unless you will be 18 by the end of the year.	**For Board use only!**
3	Last Name / First Name / Middle Initial / Suffix			
4	Address where you live (do not give P.O. address) / Apt. No. / City/Town/Village / Zip Code / County			
5	Address where you get your mail (if different from above) / P.O. Box, star route, etc. / Post Office / Zip Code			
6	Date of Birth	7	Sex (circle) M F	8 Home Tel. Number (optional)
10	The last year you voted / Your Address was (give house number, street and city) / In county/state / Under the Name (if different from your name now)	9	ID Number—Check the applicable box and provide your number: ☐ New York DMV number __ __ __ __ __ __ __ __ __ If you do not have a New York DMV number, please provide: ☐ Last four digits of your Social Security Number __ __ __ __ ☐ I do not have a New York Driver's license number	
11	**Choose a party** -- Check one box only ☐ Democratic Party ☐ Republican Party ☐ Conservative Party ☐ Working Families Party ☐ Independence Party ☐ Green Party ☐ Other (write in) _____ ☐ I do not wish to enroll in a party	12	**AFFIDAVIT:** I swear or affirm that • I am a citizen of the United States. • I will have lived in the county, city or village for at least 30 days before the election. • I will meet all requirements to register to vote in New York State. • This is my signature or mark on the line below. • The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years. → _____ (Signature or Mark in Ink) (Date)	

(Optional) Register to donate your organs and tissues

Last Name_____
First Name_____
Middle Initial_____ Suffix_____
Address_____
Apt Number_____ Zip Code_____
City_____
Birth Date_____ Sex ☐ M ☐ F
Eye Color_____ Height___ Ft.___In.

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.

_____
Sign Date

XL148F (06/11)

MELROSE FS CENTER F40
260 E. 161 STREET
BRONX, NY 10451

NOTICE OF DECISION ON YOUR
SUPPLEMENTAL NUTRITION ASSISTANCE.

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS EN ESPANOL, POR FAVOR PONGASE EN CONTACTO CON SU TRABAJADOR(A).

PROGRAM CODE = F40

NOTICE NUMBER:	DATE:	CASE NUMBER:
N0200H1518	May 5, 2014	010039392F

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
F40				

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	718-664-1670
OR Agency Conference	718-664-1670
Fair Hearing information and assistance	718-555-5555
Record Access	718-555-5555
Child/Teen Health Plan	718-555-5555

CASE NAME / AND ADDRESS

JAD ANNA
40 BOND ST,
BROOKLYN, NY 11201

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

NYS is in the process of changing your EBT. This change or conversion to a new EBT system will require NYS to turn-off the current EBT system sometime during the Fall of 2014 for about 24 hours, starting at 11pm on a Friday night. This means you must plan your cash and food purchases before the EBT system is turned off. Please be advised that more information will be released prior to the conversion weekend on OTDA website @ www.otda.ny.gov, www.mybenefits.ny.gov the EBT helpline the EBT helpline number @ 1-888-328-6399 and OTDA hotline number @ 1-800-342-3009.

SUPPLEMENTAL NUTRITION ASSISTANCE

Your April 10, 2014 application for SNAP benefits is **APPROVED (pending verification)** from April 10, 2014 to March 31, 2015.

For the month of April, 2014 you will get $242.00 in SNAP benefits. This is because we must figure your first month's benefit from the date you applied to the end of the month.

Beginning May, 2014 you will get $347.00 in SNAP benefits each month.

The following individuals are approved (pending verification) for SNAP benefits:

ANNA JAD
PAUL JAD

YOU MUST SUBMIT DOCUMENTATION
So you could get SNAP benefits right away, we calculated your benefit without all the necessary proof.
Listed here is the proof you still need to provide:

- who the following are:

  ANNA JAD
  PAUL JAD

CONTINUED ON THE NEXT PAGE ...

You need to provide only ONE kind of proof for EACH person mentioned above. Some examples of proof are:

Driver's license
Photo ID
Birth certificate
U.S. Passport

- OTHER:
  See the Documentation Requirements (Form W-113K)

WHAT HAPPENS IF YOU DO NOT SUBMIT THE REQUESTED DOCUMENTATION?
You will NOT be able to receive SNAP benefits after April, 2014 or in the future unless you provide this proof. It will be used to determine the SNAP benefits for which you are eligible.

Based on the verification you provide, we may be required to change the SNAP benefits you receive. You will NOT receive notification of any changes to your benefits based on the proof you still need to provide.

If your first month's SNAP benefit is more than $0, it will become available on May 2, 2014.

Each month after that, your SNAP benefits will become available on the 4 day of the month.

If you do not use your SNAP benefits account for a period of 365 consecutive days, any SNAP benefits remaining in the account that is at least 365 days old will be expunged (removed) from the account. Expunged SNAP benefits cannot be reissued.

If you have also applied for public assistance and are approved, your SNAP benefits might be reduced or discontinued. If your SNAP benefits change or your household is determined ineligible for SNAP benefits due to this proof, you will not be notified.

This decision is based on Regulation 18 NYCRR 387.8, 387.14, 387.15 and CFR 273.2(j)(1)(IV).

How we figured your SNAP Benefits:

Check the information below and let us know if something is wrong. If there is a mistake, it could mean that this decision we made about your benefit is not correct.

- You will get $347.00 for the month of June, 2014.
- There are 2 people in your SNAP household.
- You pay $850.00 for housing.
- According to our records, your type of housing is known as Unfurnished Apartment Or Room.
- Your heat is included in your rent. Either you have incurred air conditioning costs or we anticipate that you will receive a HEAP payment during this heating season for your current living situation. (You may need to apply for HEAP separately.) We allow the standard of $753.00.
- There is no one 60 or older or disabled in your SNAP household.
- You have no allowable medical expenses.
- You have no individuals in your household that are enrolled in a Medicare approved Prescription Drug Discount Card program.
- No one in your household pays legally-obligated child support.
- We allow expenses for child care or dependent care while you are employed or seeking employment through job search, or are in training. You do not pay for child care or dependent care.
- No one has income.

SERVICES AND OTHER INFORMATION

Your NYS Common Benefit Identification Card:

CONTINUED ON THE NEXT PAGE ...

If you are a new recipient, a New York State Common Benefit Identification card will be mailed to you, or you have been provided with an opportunity to pick up a card. If you received benefits in the past and were sent a card, a new card will not automatically be mailed to you. If possible, you should use the same card you received before. Please keep your card in a safe place and let us know immediately if your card does not work, is lost or stolen. Keep this card even if you stop receiving benefits. The same card will be used again if you become eligible again in the future.

Your Personal Identification Number (PIN):

If you are a new recipient of either SNAP Benefits or cash assistance, a PIN will be mailed to you. If you have received such benefits since 2001 and had a PIN, you can continue to use that PIN. You will use your new PIN along with your NYS Common Benefit Identification Card to get your benefits. Never keep your PIN and your card in the same place. Never write your PIN on your card.

IMPORTANT REMINDER

Protect Your Electronic Benefit Transfer (EBT) Benefits from Thieves.

If someone calls you do not ever give out personal information, such as your social security number, EBT card number, or EBT personal identification number (PIN). Even if the caller claims to be a local agency worker, a State, a Federal or an EBT official, do not give them your personal information. If your EBT card is lost, stolen or damaged you must first call EBT Customer Service at 1-888-328-6399 to stop the card so it may no longer be used. Then contact your local assistance center for a replacement card.

Remember - if someone has personal information about you and has your EBT card (or knows your card number) they can steal all of your EBT benefits.

Free Nutrition Information

All SNAP recipients are eligible for **Eat Smart New York (ESNY)** - Free nutrition education classes which teach you how to shop smart and stretch your food dollars. For more information and to find out if ESNY is available in your county, call 1-800-342-3009 or go online at:
http://www.otda.state.ny.us/main/programs/nutrition/.

CONTINUED ON THE NEXT PAGE ...

CONTINUED ON THE NEXT PAGE ...

CONFERENCE AND FAIR HEARING SECTION

DO YOU THINK WE ARE WRONG?

If you think our decision was wrong, you can request a review of our decision. If we made a mistake, we will correct it. You can do both of the following:

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

CONFERENCE (Informal meeting with us)

If you think our decision was wrong or if you do not understand our decision, or need additional information about the reason for our decision, please call us to arrange a meeting. To do this, call the conference telephone number listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you have asked for a fair hearing.

STATE FAIR HEARING

Deadline for Requesting a Fair Hearing

If you want the State to review our decision about your SNAP benefits, you must ask for a fair hearing by **August 3, 2014**. This is the deadline even if you asked for a meeting (conference) with us.

How to Request a Fair Hearing

You can ask for a fair hearing in writing, by telephone, by fax, electronically or in person.

WRITE: Complete the "tear-off" Request for a Fair Hearing at the bottom of this page and send it to the address on the bottom of the next page.

OR CALL: (800) 342-3334

When you call, please tell the worker the number of this notice which is N0200H1518.

OR FAX: Send a copy of this notice to fax no. **(518) 473-6735.**

OR ONLINE: Complete the online request form at: **http://www.otda.ny.gov/oah/forms.asp**

OR WALK-IN: Bring a copy of this notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, NY.

If you cannot reach the State electronically, by phone or fax, please write to request a fair hearing before the deadline for requesting a fair hearing.

What to Expect at a Fair Hearing

The State will send you a notice which 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 or 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.

(Read the next page for more of your Rights)

REQUEST FOR A FAIR HEARING

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.)

_____

_____

_____

Name : **JAD ANNA**
Address : **40 BOND ST,**
BROOKLYN, NY 11201

District/Office No: **66/F40**
Notice No. : **N0200H1518**
Case Number: **010039392F**
Telephone :

ONLY USE THIS TEAR-OFF TO REQUEST A HEARING ABOUT THIS NOTICE.

CONTINUED ON THE NEXT PAGE ...

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 which explain why we are wrong.

To help you explain at the hearing why you think our decision is 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 obtain a lawyer at no cost to you by contacting:

BROOKLYN LEGAL SERVICES CORPORATION, 105 COURT STREET, BROOKLYN, NY 11201
Telephone: (718) 237-5500
LEGAL AID SOCIETY, 166 MONTAGUE ST, BROOKLYN, NY 11201
Telephone: (718) 722-3100

For the names of other lawyers check your Yellow Pages under "LAWYERS".

ACCESS TO YOUR FILES AND COPIES OF DOCUMENTS

To help you get ready for the hearing, you have a right to look at your case files. If you call, write or fax 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 us, we will send you free copies of 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 your 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.

Send this "Request for a Fair Hearing" to:

The Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, New York 12201

Helping Hands for People in Need

Check your eligibility for a wide range of economic supports at *www.myBenefits.ny.gov*. The resources below are available to help you make ends meet. If you have additional questions about the information below, you may call the NYS toll free hotline number: 1-800-342-3009.

Nutrition Assistance* – *to help feed your family and stretch your food budget. Visit www.myBenefits.ny.gov.

- ***Education*** - Food Stamp recipients are eligible for **free** nutrition education to help you make sound nutritional choices.
- **School Breakfast and Lunch -** free or reduced price meals are available to school children from low-income households.
- **Women, Infants and Children (WIC)** - healthy food for low-income pregnant, post partum or breastfeeding women, as well as infants and children up to age 5, call **1-800-522-5006.**

Tax Credits – to supplement your wages and help provide for your children. *Visit www.myBenefits.ny.gov.*

- **The Federal and State Earned Income Tax Credits (EITC) –** Low-income taxpayers may qualify for both a Federal and State EITC. New York City residents may qualify for an additional City credit.
- **Federal Child Tax Credit and Additional Child Tax Credits** – Low-income taxpayers with dependent children under age 17 may qualify for this federal tax benefit. The **Empire State Child Tax Credit** is a refundable credit for full-year New York residents with children ages 4-16. Call **1-800-829-1040.**
- **The Federal Child and Dependent Care Credit** is a tax benefit offered by the federal government. The **New York State Child and Dependent Care Credit** helps even more low-income families because, unlike the federal credit, it is refundable. New York City residents may qualify for an additional refundable City credit. Call **(518) 457-5181.**
- **Volunteer Income Tax Assistance (VITA)** is a program that provides free income tax preparation services for income eligible taxpayers. VITA sites are located in every county in the State and a list of their locations may be found on the myBenefits website.

Home Energy Assistance Program (HEAP) - ***Visit www.myBenefits.ny.gov.***
HEAP assists eligible households in meeting their home energy needs including assistance with furnace repair and/or replacement and home weatherization. To apply, contact your local department of social services or your county office for the aging.

Health Insurance Programs – to help families that cannot afford medical care. *Visit www.myBenefits.ny.gov.*

- **Medicaid** is available for low-income individuals and families who meet income limits, requirements, and, if applicable, citizenship or immigration status. Call **1-800-541-2831 or in NYC call 1-718-557-1399 or 1-877-472-8411.**
- **Child Health Plus (CHP)** for children under 19 years old whose family income is too high to qualify for Medicaid. Call **1-800-698-4543.**
- **Family Health Plus (FHP)** for uninsured, low-income adults ages 19 through 64, with or without children, who are not eligible for Medicaid and have no other health insurance. Call **1-877-934-7587.**

Job Placement Services – Visit ***www.myBenefits.ny.gov* and click on *Resources for Working Families.***

- **Food Stamp Employment and Training** provides work preparation and support services for Food Stamp recipients. Contact your local department of social services.
- **Workforce New York One-Stop System** provides job services through a network of local One-Stop centers and affiliate sites.

Social Security Disability Insurance and Supplemental Security Income (SSI) - Only individuals who have a disability and meet certain medical criteria may qualify for benefits under either program. Call **1–800–772–1213 or visit *www.socialsecurity.gov***

Child Support Program assists custodial parents in establishing paternity, obtaining, modifying and enforcing financial and medical support obligations. Visit www.childsupport.ny.gov or call **1-800-846-0773.**

Child Care Subsidies can enable parents or caretakers to work, engage in work-related activities or attend high school or equivalent training. Contact your local department of social services or visit ***www.ocfs.ny.us*** and click on "Child Care".

Domestic Violence – If you or someone you know is being abused and would like more information on what can be done to keep you, your family or neighbors safe, call **1-800-942-6906**.

LDSS-3151 (Rev. 8/12)

NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) CHANGE REPORT FORM

(Please Print Clearly)

CASE NUMBER

010039392F

YOU MUST REPORT ANY CHANGES IN YOUR CIRCUMSTANCES ACCORDING TO THE RULES LISTED BELOW.

DATE:

TO:

ADDRESS: JAD ANNA
40 BOND ST,
BROOKLYN, NY 11201

COMPLETE THIS FORM AND MAIL TO:

LOCAL DISTRICT NAME, ADDRESS AND TELEPHONE NUMBER:

MELROSE FS CENTER F40
260 E. 161 STREET
BRONX, NY 10451

718-664-1670

YOUR RESPONSIBILITY TO REPORT CHANGES

Please read the questions and rules carefully. If you fail to report any changes that you are required to report under the rules, we may have to establish a claim for overpayment of Supplemental Nutrition Assistance program (SNAP) benefits and collect the amount of the overpayment from you.

The changes that you MUST report are explained below. You may still voluntarily report any change about your SNAP household and, if this change will increase your benefit level and you verify this change, we will increase your benefit.

ARE YOU A "SIMPLIFIED REPORTER" (6 MONTH) OR A "CHANGE REPORTER"? YOU MAY ANSWER THESE QUESTIONS TO FIND OUT WHETHER YOU ARE A "SIMPLIFIED REPORTER" OR A "CHANGE REPORTER".

1. Do you receive transitional SNAP benefits (TBA)?	☐ **YES – Go To "TBA" on page 3 of this form** (Skip questions 2 through 8)	☐ **NO –** Go To Question #2, below
2. Do you receive New York State Nutrition Improvement Project (NYSNIP) benefits?	☐ **YES – Go To "NYSNIP" on page 3 of this form** (Skip questions 3 through 8)	☐ **NO –** Go To Question #3, below
3. Are you certified for SNAP benefits for three months or less at a time?	☐ **YES –Go To "Change Reporting" on page 2 of this form** (Skip questions 4 through 8)	☐ **NO –** Go To Question #4, below
4. Does anyone in your household have earned income that is being counted in your SNAP benefit amount?	☐ **YES –Go To "Simplified Reporting" on page 2 of this form** (Skip questions 5 through 8)	☐ **NO –** Go To Question #5, below
5. Are all of the adults (18 or older) in your household either permanently disabled or 60 or older?	☐ **YES –Go To "Change Reporting" on page 2 of this form** (Skip questions 6 through 8)	☐ **NO –** Go To Question #6, below
6. Does your household receive $0 income (including $0 Temporary Assistance)	☐ **YES –Go To "Change Reporting" on page 2 of this form**(Skip questions 7 and 8)	☐ **NO –** Go To Question #7, below
7. Are you without shelter (undomiciled) or a migrant/seasonal farmworker?	☐ **YES – Go To "Change Reporting" on page 2 of this form** (Skip question 8)	☐ **NO –** Go To #8, below
8. You answered "NO" to all 7 questions above	☐ **Go To "Simplified Reporting" on the top of page 2 of this form**	

SIMPLIFIED REPORTING RULES: As a SNAP household under the "Simplified Reporting" rules, you are only required to report changes at the time of your next recertification, except for the following three situations:

1. **If your household's gross monthly income exceeds 130% of the poverty level, you MUST report this monthly amount to your social services district by telephone, in writing, or in person within 10 days after the end of the calendar month in which you exceed the 130% level.** Gross income is the amount of income before taxes and other deductions are taken out, not the amount you receive when you cash your check. We must use the gross income in figuring your eligibility for SNAP benefits. Your worker will explain what 130% of the poverty level means for a family of your size. Any other kind of income that you receive besides earnings must be added to your gross earned income to know if you are over 130% of the poverty level. Examples of other sources of income that count include child support you receive, Unemployment Insurance, Temporary Assistance (TA) payments, Workers Compensation, Social Security Benefits, Supplemental Security Income (SSI) and private disability payments.

   If you fail to report that your gross income is above 130% of the poverty level in any calendar month, all benefits received after that month may be considered an overpayment. This is true even if your gross income falls below the 130% poverty level in a future month.

2. **If your household's certification period is longer than 6 months:** At a six-month checkpoint into your certification period, you will receive a report form that you **MUST** return within ten days after you receive the form. If your household has any of the changes listed below, you **MUST** report them on the report form that is sent to you at the six-month checkpoint.

   List of Changes you must report at the six-month checkpoint:

   - Changes in any **source of income** for anyone in your household
   - Changes in your household's total **earned income** when it goes up or down by more than $100 a month
   - Changes in your household's total **unearned income from a public source** such as Social Security Benefits or Unemployment Insurance Benefits when it goes up or down by more than $50 a month
   - Changes in your household's total **unearned income from a private source** such as Child Support Payments or Private Disability Insurance when it goes up or down by more than $100 a month
   - Changes in the amount of court ordered **child support you pay** to a child outside of your SNAP household
   - Changes in **who lives with you**
   - **If you move**, your new address and your new rent or mortgage costs, heat costs and utility costs
   - **A new or different car**, or other vehicle
   - Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2000 (more than $3250 if anyone in your household is disabled or 60 years old or older)
   - Any changes in your household that would result in a penalty as described on page 6 of this form

3. **If anyone in your SNAP household is an Able-Bodied Adult Without Dependents** ("ABAWD"), you **MUST** tell us if their work hours go below 80 hours a month within 10 days after the end of that month.

CHANGE REPORTING RULES:

As a SNAP household under the "Change Reporting" rules, you **MUST** report the following changes within 10 days after the end of the month in which the change happened:

- Changes in any **source of income** for anyone in your household
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month
- Changes in your household's total **unearned income from a public source** such as Social Security Benefits or Unemployment Insurance Benefits when it goes up or down by more than $50 a month
- Changes in your household's total **unearned income from a private source** such as Child Support Payments or Private Disability Insurance when it goes up or down by more than $100 a month
- Changes in the amount of court ordered **child support you pay** to a child outside of your SNAP household
- Changes in **who lives with you**
- **If you move**, your new address and your new rent or mortgage costs, heat costs and utility costs
- **A new or different car**, or other vehicle
- Increases in your household's **cash, stocks, bonds, money in the bank or savings institution** if the total cash and savings of all household members now amounts to more than $2000 for a household **without** an elderly or permanently disabled household member **or** $3250 for a household **with** an elderly or permanently disabled household member
- If anyone in your SNAP household is an **Able-Bodied Adult Without Dependents** ("ABAWD"), you must tell us if their work hours go below 80 hours a month within 10 days after the end of that month
- Any changes in your household that would result in a penalty as described on page 6 of this form

TBA CHANGE REPORTING for household in receipt of transitional benefits:

- Transitional SNAP benefits can continue for up to five months after your Temporary Assistance case closes.
- You are not required to report changes during the transition period. If you have changes that may increase your benefits you can contact your worker to file an early recertification application at any time during your transitional period to receive the increase. The increase cannot be done until a signed recertification application is filed, and the entire recertification process is completed.
- You must recertify near the end of your transitional period to see if you can continue to receive SNAP benefits after your transitional period ends. We will send you a notice reminding you of this recertification requirement. If you do not recertify, we will not send you any other notice and must close your SNAP case.

NYSNIP CHANGE REPORTING for participants in NYSNIP:

- You will receive a contact letter 24 months after you begin participation in NYSNIP that you must complete and return.
- You are not required to report changes during your certification period other than the 24-month contact letter. You may voluntarily report increases in your medical expenses, rent or utility costs, or decreases in your income. If you report and verify these changes, you may be eligible for more SNAP benefits. You are not required to, but should report your new address if you move, so that you continue to receive any notices we send to you.

Medical Expenses: You are not required to report changes in your medical expenses during your certification period. However, you may voluntarily report changes in your medical expenses for household members that are:

- 60 years old or older
- disabled spouses or children of a deceased veteran
- getting Supplemental Security Income (SSI)
- getting Social Security Disability payments
- getting veterans' disability benefits
- getting government disability retirement benefits
- getting Railroad Retirement disability benefits
- getting disability-based medical assistance

If you report and verify an increase in your medical expenses, you may be eligible for more SNAP benefits. Changes in medical expenses must be reported at your next recertification.

Temporary Assistance (TA) Reporting Rules: The rules listed above apply only to SNAP. If you also receive TA, you are still required to report changes for TA within 10 days of the change, on periodic report mailers, TA Eligibility Questionnaires and at recertification.

When to use this form:

This form may be used to report any required or voluntary changes. You can also use this form to report changes in the cost of caring for children or disabled adults, or changes in shelter costs even if you haven't moved. If these expenses go up you may be eligible for more SNAP benefits.

If proof of the changes you are reporting is available, please include it with this form. This will help make sure that you get the correct amount of SNAP benefits. **Reported changes must be verified before we can increase your benefits.**

This form should be mailed or brought to the agency listed above. If for some reason you can't mail or bring in this form, you can report the changes by calling us at the telephone number listed on Page 1 of this form.

If you no longer want to receive SNAP benefits, sign here to withdraw from participation in SNAP. Your SNAP benefits will stop. You have the right to contest this withdrawal if you feel that you were given incorrect or incomplete information about your eligibility for SNAP benefits by requesting a Fair Hearing within 90 days. You may re-apply for SNAP benefits at any time after your withdrawal.

X_____

IF YOU WITHHOLD INFORMATION ABOUT CHANGES IN YOUR HOUSEHOLD THAT YOU ARE REQUIRED TO REPORT, YOU WILL OWE US THE VALUE OF ANY EXTRA SNAP BENEFITS YOU RECEIVE AS A RESULT. IF YOU INTENTIONALLY WITHHOLD INFORMATION WHEN YOU ARE REQUIRED TO REPORT IT, YOU MAY ALSO BE DISQUALIFIED FROM SNAP AND COULD BE SUBJECT TO CRIMINAL PROSECUTION (SEE ATTACHED "SNAP PENALTY WARNING" ON PAGE 6 OF THIS FORM).

CHANGE REPORT FORM PAGE 4 LDSS-3151 (Rev. 8/12)

Use the Form Below to Report Changes

CHANGE IN INCOME OR SOURCE OF INCOME - If you are a Simplified Reporter, your reporting rules are explained beginning on Page 2 of this form. If you are a Change Reporter, your reporting rules are also explained on Page 2.

NAME OF PERSON RECEIVING INCOME	SOURCE OF INCOME	NEW AMOUNT	HOW OFTEN RECEIVED
1.		$	
2.		$	
3.		$	

CHANGE IN HOUSEHOLD - List below all new members to your household including newborn children. Also list members who have moved in or out or have died.

NAME	AGE	RELATIONSHIP	CHANGE (CHECK ONE)	DATE	INCOME AMOUNT	SOURCE
1.			☐ Came Into Household ☐ Left Household		$	
2.			☐ Came Into Household ☐ Left Household		$	
3.			☐ Came Into Household ☐ Left Household		$	
4.			☐ Came Into household ☐ Left Household		$	

CHANGE OF ADDRESS

NEW MAILING ADDRESS	CITY	STATE	ZIP CODE

IF YOU DON'T HAVE A STREET ADDRESS, GIVE DIRECTIONS TO YOUR HOME (if you are homeless, leave blank)	TELEPHONE NUMBER WHERE YOU CAN BE REACHED ( ) Area Code

CHANGE IN HOUSING COSTS - If you have moved, you must list your new costs below. Even if you have not moved, you can use this section to tell us that your rent, mortgage payment or other costs have changed.

Are you a roomer or boarder? ☐ YES ☐ NO If Yes, are meals ☐ INCLUDED ☐ NOT INCLUDED

RENT	YES	NO	IF YES, GIVE MONTHLY AMOUNT	CHANGE (CHECK ONE)
Do you pay **rent?**	☐	☐	$	☐ Same ☐ More ☐ Less
Do you pay for the following **separate** from your **rent?**	YES	NO		
• Heat and/or air conditioning	☐	☐		
• Utilities (electricity, cooking gas, etc.)	☐	☐		
• Telephone	☐	☐		
MORTGAGE PAYMENT	YES	NO	IF YES, GIVE MONTHLY AMOUNT	CHANGE (CHECK ONE)
Do you have a **mortgage** payment?	☐	☐	$	☐ Same ☐ More ☐ Less
Do you pay for the following **separate** from your **mortgage:**	YES	NO	IF YES, GIVE MONTHLY AMOUNT	CHANGE (CHECK ONE)
• Property taxes	☐	☐	$	☐ Same ☐ More ☐ Less
• House Insurance	☐	☐	$	☐ Same ☐ More ☐ Less
• Heat and/or air conditioning	☐	☐		
• Utilities (electricity, cooking gas, etc.)	☐	☐		
• Telephone	☐	☐		

Are you living in section 8 or other subsidized housing? ☐ YES ☐ NO	Are you living in public housing? ☐ YES ☐ NO

CHANGE IN NUMBER OF CARS OR VEHICLES - Has anyone in your household purchased, sold or traded a car, truck, boat, camper, motorcycle or other vehicle since the last time you told us about vehicles?

MAKE	MODEL	YEAR	IF SOLD, AMOUNT RECEIVED
1.			$
2.			$
3.			$

CHANGE IN SAVINGS - List the **total** amount of money that the members of your household now have. Include cash, savings accounts, checking accounts, stocks, bonds or other investments. You must tell us if your household savings have **increased** to more than $2,000 (more than $3,250 if anyone in your household is 60 years old or older or been determined to be disabled). $

CHANGE IN CHILD CARE, DEPENDENT CARE COSTS OR THE AMOUNT OF CHILD SUPPORT PAID - Have your child care or dependent care costs changed? If so, you may be eligible for more SNAP benefits.

CHANGE (CHECK ONE)	FOR WHOM?	WHOM DO YOU PAY?	NEW AMOUNT	HOW OFTEN DO YOU PAY?
1. ☐ NO LONGER HAVE COST ☐ HAVE COST			$	
2. ☐ NO LONGER HAVE COST ☐ HAVE COST			$	
3. ☐ NO LONGER HAVE COST ☐ HAVE COST			$	

CHANGE IN MEDICAL COSTS (Doctors, Dentists, Hospitals, Prescriptions, etc.) – You are only required to report changes in your medical expenses at recertification. However, you may voluntarily report changes in your medical expenses at any time for household members who are:

- 60 years old or older
- disabled spouse or children of a deceased veteran
- getting Supplemental Security Income (SSI)
- getting Social Security Disability payments
- getting veterans' disability benefits
- getting government disability retirement benefits
- getting Railroad Retirement disability benefits
- getting disability-based medical assistance

If you report and verify an increase in your medical expenses, you may be eligible for more SNAP benefits.

NAME	TYPE OF COST	AMOUNT	HOW OFTEN IS EACH PAYMENT DUE?
		$	
		$	
		$	
		$	

DO YOU EXPECT THE CHANGES YOU HAVE REPORTED TO CONTINUE NEXT MONTH? ☐ YES ☐ NO

If "**NO**"explain:

CHECK HERE IF YOU HAVE NO CHANGES TO REPORT ABOUT YOUR SNAP HOUSEHOLD ☐ NO CHANGES

BE SURE TO READ AND SIGN PAGE 6 ➔

CHANGE OF BENEFITS

We will use your answers on this form to see if your household's benefits will change. Before we change your benefits, we will send you a notice explaining what will happen. If you don't agree with our decision, you have the right to a fair hearing to challenge our decision.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) PENALTY WARNING

Any information you provide in connection with your application for SNAP benefits will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied SNAP. You may be subject to criminal prosecution for knowingly providing incorrect information.

You will **never** be able to get SNAP again if you are:

- Found guilty in a court of law for the second time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for SNAP: **or**
- Found guilty in a court of law of selling or obtaining firearms, ammunition or explosives in exchange for SNAP; **or**
- Found guilty in a court of law of trafficking in SNAP worth $500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP, authorization cards or access devices; **or**
- Found guilty in a court of law of committing a third Intentional Program Violation (IPV).

You will not be able to get SNAP for two years if you are found guilty in a court of law for the first time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for SNAP.

If you have committed your:

- First IPV, you will not be able to get SNAP for one year.
- Second IPV, you will not be able to get SNAP for two years.

A court could also bar you from receiving SNAP benefits for an additional 18 months.

If you make a false statement about who you are or where you live in order to get multiple SNAP, you will not be able to get SNAP for ten years (or **permanently** if this is the third IPV).

You may be found guilty of an Intentional Program Violation if you:

- Make a false or misleading statement, or misrepresent, conceal or withhold facts; **or**
- Commit any act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of SNAP benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

You could also be fined up to $250,000, sent to jail for up to 20 years, or both.

CERTIFICATION

I understand the penalty for hiding or giving false information. I also understand I will owe the value of any extra SNAP benefits I receive because I don't fully report changes in my household. I agree to prove any changes reported if necessary. The answers on this form are correct and complete to the best of my knowledge. I understand that my signature authorizes federal, state and local officials to contact other persons or organizations to verify the information I have provided.

SIGNATURE	DATE
X	

Electronic Benefit Transfer (EBT)
How to Use Your Benefit Card to Get Supplemental Nutrition Asistance Program (SNAP) and/or Cash Benefits

YOUR BENEFIT CARD

- Keep your card in your card sleeve and in a safe place when you are not using it.
- Sign the back of your card.
- Do not write on or scratch the black stripe on the back of your card.
- Do not put your card near magnets. If your card is damaged or bent, it will need to be replaced by your local assistance center.
- If your card is lost, stolen or damaged, you must first call EBT Customer Service at **1-888-328-6399.**
- The Quest® mark is displayed on the back of your card.

YOUR PIN—KEEP YOUR PIN A SECRET

PIN stands for Personal Identification Number.

- Your PIN is your electronic signature.
- It contains four (4) numbers.
- Your benefit card will not work without your PIN.
- If you forget your PIN or want to change your PIN at any time, call **1-888-328-6399**. You will be asked to provide certain information for security purposes. You may also change your PIN at most Social Services Offices, Job Centers and SNAP Centers.
- If you enter your PIN incorrectly four times in a row, your account will be locked out until the next day even if you select a new PIN.
- **Never write your PIN on your card or on the card sleeve.**
- Never let anyone, even a store cashier, see you enter your PIN at a machine.
- **Never give your PIN to anyone. If a person has your card and knows your PIN, all of your benefits can be used.**
- If someone else uses your card and PIN, your BENEFITS WILL NOT BE REPLACED.
- If you need a friend or close relative to have access to your EBT benefits, contact your local agency about naming an Authorized Representative on your case.

HOW TO USE YOUR CARD AT THE STORE

1. Before you shop, check your last receipt to find out how much money is in your account, or call toll free **1-888-328-6399** or on the Internet www.ebtaccount.jpmorgan.com.
2. Most food stores accept the EBT Card. Look for the Quest® sign on the door or window of the store.
3. Many stores that do not display the Quest® sign will accept the card. If you do not see the sign, ask a clerk before shopping.
4. At check-out, your card is swiped through the machine by you or the store cashier.
5. Follow the directions on the machine to enter your PIN. Only you should enter your PIN.
6. Tell the cashier how much money to enter, or enter the amount yourself.
7. Always check your receipt to make sure that the amount on the EBT purchase is the same as the grocery receipt.
8. If you are required to **"key"** enter your card that fails to **"swipe"** a purchase transaction because the card is damaged, you **must** contact EBT Customer Service **(1-888-328-6399)** and request a new card from your Case Manager.

CHECKING YOUR SNAP and/or CASH ACCOUNT BALANCES

Check your balance **before** you shop or withdraw cash!

You can do **FREE** balance inquiries:

- At food stores to check your food account.
- At ATMs to check your cash account where EBT cards are accepted.
- By calling Customer Service toll free at **1-888-328-6399**.
- On the internet at www.ebtaccount.jpmorgan.com

SNAP PURCHASE

- Use your SNAP benefit account to purchase food. You cannot get cash back from your SNAP account.
- Remember, you can only buy allowable food items with your SNAP benefits.
- All SNAP benefit transactions are free. There is no limit to the number of times you can use your card for SNAP benefit transactions.

CASH PURCHASE

- Any item may be purchased using your cash benefit account where EBT cards are accepted.

CASH WITHDRAWAL

- Some stores will allow you to receive cash back above the cost of your purchase.
- Some stores will allow cash withdrawal without a purchase.
- You must follow the store's policy regarding the allowable amount for cash back or withdrawals.
- If you use both a SNAP benefit account and a cash benefit account at the same time your card will be swiped through the machine twice and you must enter your PIN twice.

HOW TO USE YOUR BENEFIT CARD AT AN AUTOMATED TELLER MACHINE (ATM)

Choose an ATM in a place where you feel safe.

Always follow directions on the ATM.

Put your card in the machine.

- Enter your PIN.
- Never let anyone see you enter your PIN.
- Press Withdrawal.
- Press Checking.
- Enter the dollar amount you want.
- Take your cash, card, and receipt so you will know how much you have left in your account.
- Check the receipt to make sure it is the same as the amount you got.

- You will have two (2) free ATM withdrawals each month at ATMs which do not surcharge.
- After the first 2 free, each extra ATM withdrawal will cost you a 50¢ fee even at ATMs that do not surcharge.
- This fee will be automatically taken out of your cash benefit account. You will not receive any other notification that this fee is being charged.

WARNING: SOME LOCATIONS CHARGE $1.00 OR MORE FOR CASH WITHDRAWALS. LOOK FOR A MESSAGE ON THE ATM TO TELL YOU ABOUT THE SURCHARGE BEFORE YOU WITHDRAW ANY CASH.

YOU CAN CALL **1-800-289-6739** FREE FOR ATM LOCATIONS IN YOUR AREA THAT **DO NOT** SURCHARGE FOR CASH WITHDRAWALS.

IDENTITY THEFT – PROTECT YOUR EBT BENEFITS

If someone calls you, don't give them personal information such as your social security number, EBT card number, or EBT PIN. Even if the caller claims to be a local agency worker, a State, a Federal or an EBT official, do not give them your personal information.

If you suspect or know:

- That your card or card number has been stolen;
- That someone not authorized by you has gained access to your PIN; or
- That someone has gained information about your identity that may result in your benefits being stolen.

Then follow these three (3) steps:

1. You **must** contact EBT Customer Service (**1-888-328-6399**) or on the Internet at www.ebtaccount.jpmorgan.com to report your EBT card stolen. EBT Customer Service will deactivate your card so that no one else can use it. Only by first contacting EBT Customer Service to deactivate your EBT card can you protect yourself against potential benefit theft.
2. Contact your local agency worker to report the problem and to request what is called EBT ARU PIN Restriction. You, as the cardholder, will need to sign a permission form at your local agency or assistance center in order for this procedure to be used. This is a procedure that your local agency can use to make it impossible to change your PIN over the phone through the EBT Customer Service helpline or through the internet Cardholder Account website. Once this procedure is done, any PIN changes would have to be done by you, with your card in hand, at the local agency or assistance center.
3. Request that your worker issue you a new EBT card. It is recommended that you select a new PIN for your new card at the agency or assistance center.

CARDHOLDER ACCOUNT WEBSITE

You can now get information about your account(s) on the Internet by going to www.ebtaccount.jpmorgan.com . Once you sign in with your card number and PIN, you will be able to do the following:

- Get your account summary (account balances)
- Get your account(s) activity (transaction) details
- Get an online account statement
- Change your PIN (unless you have a PIN restriction in place)
- Communicate directly with EBT Customer Service; and
- Report your card damaged, lost or stolen.

The website also allows you to create your own account ID and password after you have logged in for the first time. You should use your most recent active card number to sign in. Authorized representatives can also use this website to access account information by using their own EBT card and PIN.

EXPUNGED BENEFITS

An expunged benefit is a benefit that is **removed** from a cash or SNAP account. In the cash benefit program, if you do not use your account for a period of 90 consecutive days, any cash benefit remaining in the account that is at least 90 days old will be expunged (removed) from the account. You may ask your worker to reissue any expunged cash benefit for which you are eligible. In the SNAP benefit program, if you do not use your SNAP account for a period of 365 consecutive days, any SNAP benefit remaining in the account that is at least 365 days old will be expunged (removed) from the account. Expunged SNAP benefits cannot be reissued.

EBT TRANSACTION ERRORS

Occasionally an EBT **system** error occurs during a cash or SNAP transaction resulting in a mistake being made in the account balance. Some examples of EBT system transaction errors:

- If you made a SNAP purchase, and the SNAP account was incorrectly charged twice for the same purchase; or
- If an ATM only gave you $20 when you requested $40, but your cash account was still charged the $40.

If you think a **system** (not clerical or human) error has reduced your account incorrectly, you may file a claim for an account adjustment by contacting EBT Customer Service. You have 90 days from the date of the suspected transaction error to file your claim.

- SNAP account claims are usually resolved within 15 days.
- Cash account claims may take up to 30 days to resolve.
- EBT Customer Service will provide you with a claim number that you can use to check the status of your claim.

While you are waiting for your claim to be resolved, your local agency or assistance center cannot replace the amount you are disputing. If you have an emergency or immediate need you may contact your local agency or assistance center regarding that need.

WHEN TO CONTACT CUSTOMER SERVICE

Call Toll Free **1-888-328-6399**
or
On the Internet **www.ebtaccount.jpmorgan.com**
24 hours/7 days a week

Your call will be answered by an automated system. You will be guided through menu options to help direct your call

Call if:

- You need your SNAP or cash account balance.
- You have questions or problems with your SNAP or cash account information.
- Your card is lost, stolen or damaged.
- You suspect that a transaction error occurred and you would like to file a claim.
- You need information about using your benefit card or PIN.

People with disabilities may use the following numbers for assistance:

TTY Users: 1-800-662-1220
Non TTY Users: 1-800-421-1220
VCO Users: 1-877-826-6977

IT'S THE LAW

Misuse or abuse of your card will result in investigation by State and/or Federal authorities. Documented violations will result in sanctions including:

- Disqualification from program
- Recovery through recoupment/restitution
- Referral for criminal prosecution

It is a crime to defraud the system or to misuse your card.

ALBANY PA DISTRICT DEFAULT
1234 ANYSTREET
ALBANY, NY 12034-1234

NOTICE OF RECERTIFICATION FOR
PUBLIC ASSISTANCE AND
SUPPLEMENTAL NUTRITION ASSISTANCE.

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS
EN ESPANOL, POR FAVOR PONGASE EN CONTACTO
CON SU TRABAJADOR(A).

NOTICE NUMBER:	DATE:	CASE NUMBER:
U0102L7889	May 7, 2014	MAW17RCTRK

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
40N	WMS	MAW	TESTING ALBA PROGRAM PA	800-111-2222

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	518-123-1234
OR Agency Conference	518-123-1234
Fair Hearing information and assistance	518-123-1234
Record Access	518-123-1234
Child/Teen Health Plan	518-123-1234

CASE NAME / AND ADDRESS

40N/WMS/MAW

MAW17RCTRK MS
40 NORTH PEARL
ALBANY, NY 12243

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

NYS is in the process of changing your EBT. This change or conversion to a new EBT system will require NYS to turn-off the current EBT system sometime during the Fall of 2014 for about 24 hours, starting at 11pm on a Friday night. This means you must plan your cash and food purchases before the EBT system is turned off. Please be advised that more information will be released prior to the conversion weekend on OTDA website @ www.otda.ny.gov, www.mybenefits.ny.gov the EBT helpline the EBT helpline number @ 1-888-328-6399 and OTDA hotline number @ 1-800-342-3009.

PUBLIC ASSISTANCE AND SUPPLEMENTAL NUTRITION ASSISTANCE

This letter is to tell you that you must have a face-to-face recertification interview to help us figure out if you can still get public assistance and SNAP benefits.

Your interview is on Monday, June 2, 2014 at 2:00 p.m.

Your interview will be conducted at: ALBANY COUNTY
DEPT OF SOCIAL SERVICES
123 OFA STREET
ALBANY NY 12345

We have enclosed a recertification form which you must fill out and bring to your interview.

You will need to explain about the people in your home. You will need to prove that the people who get assistance live in your home. You will need to show proof of expenses (such as rent, utilities, child care), proof of any income you get, proof of any assets you have and proof of any changes in your living situation such as change in household size. If you need any help getting any proof, please let your worker know as soon as possible.

WHAT HAPPENS IF I DO NOT COME TO THE INTERVIEW?

CONTINUED ON THE NEXT PAGE ...

Public Assistance

If you do not come to your interview, we will think that you do not want public assistance. We will then close your public assistance case. We will send you a notice telling you the closing date.

If you cannot come to the interview, please call the above telephone number before the interview date so we can set up another interview.

Medical Assistance

A face-to-face interview is not required to continue your Medical Assistance. However, you must report any changes in address, income, resources or household size to this Department.

SNAP benefits

You will not get SNAP benefits after **July 31, 2014** unless you reapply. If you cannot come to the interview, you must set up a new interview date by calling the above telephone number.

You have the right to request that the SNAP in-office interview be waived in hardship situations. Hardship generally includes, but is not limited to, illness, transportation difficulties, care of a household member, residency in a rural area, prolonged severe weather or work or training hours that prevent you from coming in during regular office hours.

If you, a member of your household, or your authorized representative do not turn in your recertification form, come for an interview and give any required documentation, you will not get SNAP benefits unless you apply again and are eligible.

If any proof is still needed after your interview, you will be told what you need to give us and you will have at least ten days to give it.

You can mail or bring in the recertification form before your interview. If you do this by July 15th and you are still eligible, you will get SNAP benefits without a break. You should fill out as much of the recertification form as you can. It must be accepted if it has at least your name, your address (if you have one) and your signature. In addition, if you turn in a recertification form by the 15th of the month, we must interview you by the end of that month in order for you to get SNAP benefits without a break. If you do not apply again or do not get interviewed, your SNAP benefits will stop without us sending you another notice.

SNAP Rights

- You have the right to ask for an application for SNAP benefits. This office must accept the application as long as it is signed and has a readable name (and address if you have one).
- You have the right to apply for SNAP benefits in person, by mail or through an authorized representative. An interview may be required.
- If all members of your household are now getting Supplemental Security Income (SSI) or plan to apply for SSI, you may apply for SNAP benefits at the Social Security Office instead of turning in your recertification form at the SNAP office. If you choose to do this, the Social Security Office must also get your application by July 15th. They will interview you and send your application and supporting documents to the SNAP office to see if you can still get SNAP benefits.

This decision is based on Regulation 18 NYCRR 387.17.

You have the right to appeal the decision on SNAP benefits. Be sure to read the back of this notice on how to appeal.

What Happens To My Child Care If My PA Case Closes?

If you are no longer PA eligible or your PA case is closing, you need to let your worker know if you need Child Care Assistance to continue. Your worker will determine if you are eligible to continue to receive Child Care Assistance.

Below are two of the Child Care Assistance Programs for which you may be eligible. Your worker can explain both of these to you. If you are not eligible for either

CONTINUED ON THE NEXT PAGE ...

of these two programs, ask your worker if you are eligible for any other child care assistance.

Guarantee of Child Care in Lieu of (Instead of) Public Assistance

This program helps working families who are financially eligible to receive PA and need child care to work, but choose to receive child care assistance instead of PA. If you are eligible for PA, but choose not to continue receiving PA, then you may be eligible for Child Care In Lieu of PA. If you are earning at least minimum wage, you must be earning at least the following amount of money (or if you are self-employed, your gross receipts less allowable deductions must be at least the following amount). If you are a single parent, you must have earnings/receipts of at least $127/week or $550/month. If you are a two-parent family, you must have gross earnings/receipts of at least $181/week or $784/month.

If you are in a job where minimum wage is not required and you are not making minimum wage, you must work at least a minimum number of hours per week. If you are a single parent, the minimum hours must be at least 17.5 hours per week. If you are a two-parent family, the minimum combined number of hours is 25 per week.

If you are a two-parent family with one parent who is employed and earning the minimum wage or more per hour or, are self employed that parent must earn at least $127 per week or $550 per month and the other parent is in a job where minimum wage is not required that part must work at least 7.5 hours per week.

This program does not have a time limit. Families may receive Child Care In Lieu of PA for as long as they remain eligible. You will be required to pay part of the cost of child care. This is called your family share. The amount you will pay depends on your income and the size of your family.

Transitional Child Care (TCC)

This program helps working families who are no longer financially eligible to receive PA and need child care in order to work. If your family is receiving PA, but your PA case is closing due to an increase in earned income or child support, or you have voluntarily closed your PA case and you are no longer financially eligible for PA, you may be eligible for TCC. If your family is receiving Child Care in Lieu of PA you may also be eligible for TCC when you become financially ineligible for PA. To be eligible for TCC, families must have been receiving PA (or Child Care in Lieu of PA), for 3 of the past 6 months prior to your PA case closing. Families may be eligible for assistance through TCC for up to 12 months after the family becomes ineligible for PA.

*** IMPORTANT:** Please have your landlord complete the enclosed Shelter Verification form (DSS 3668). Return the completed form by mail or to your worker when you appear for your interview.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The New York Medicaid program must tell you how we use, share, and protect your health information. The New York Medicaid program includes regular Medicaid, Medicaid Managed Care, and Family Health Plus. The program is administered by the New York State Department of Health and the Local Department of Social Services.

A copy of the Notice may be obtained at your local Department of Social Services. It is also available at:

http://www.health.state.ny.us/health_care/medicaid/publications/docs/inf/06inf-03att1.pdf

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CONFERENCE AND FAIR HEARING SECTION

DO YOU THINK WE ARE WRONG?

If you think our decision was wrong, you can request a review of our decision. If we made a mistake, we will correct it. You can do both of the following:

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

CONFERENCE (Informal meeting with us)

If you think our decision was wrong or if you do not understand our decision, or need additional information about the reason for our decision, please call us to arrange a meeting. To do this, call the conference telephone number listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you have asked for a fair hearing.

STATE FAIR HEARING

Deadline for Requesting a Fair Hearing

If you want the State to review our decision about your SNAP benefits, you must ask for a fair hearing by **August 5, 2014**. This is the deadline even if you asked for a meeting (conference) with us.

How to Request a Fair Hearing

You can ask for a fair hearing in writing, by fax or by telephone or electronically.

WRITE: Complete the "tear-off" Request for a Fair Hearing at the bottom of this page and send it to the address on the bottom of the next page.

OR CALL: (800) 342-3334.

When you call, please tell the worker the number of this notice which is U0102L7889.

OR FAX: Send a copy of this notice to fax number **(518) 473-6735**

OR ONLINE: Complete the online request form at: **http://www.otda.ny.gov/oah/forms.asp**

If you cannot reach the State electronically, by phone or fax, please write to request a fair hearing before the deadline for requesting a fair hearing.

What to Expect at a Fair Hearing

The State will send you a notice which 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 or 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 which explain why we are wrong.

(Read the next page for more of your Rights)

REQUEST FOR A FAIR HEARING

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.)

_____

_____

_____

Name : **MAW17RCTRK MS**
Address : **40 NORTH PEARL**
ALBANY, NY 12243

District No: **01**
Notice No. : **U0102L7889**
Case Number: **MAW17RCTRK**
Telephone : **518-123-4567**

ONLY USE THIS TEAR-OFF TO REQUEST A HEARING ABOUT THIS NOTICE.

CONTINUED ON THE NEXT PAGE ...

To help you explain at the hearing why you think our decision is 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 obtain a lawyer at no cost to you by contacting:

ADV NO 14, 14 JHGD, WKJDH, NY 12453
Telephone: (518) 999-0014
ADV NO 13, 13 LKDFSJ, WQLKDJ, NY 12563
Telephone: (518) 999-0013
ADV NO 12, 12 ANY AVE, ASSDJKBASDJK, NY 12345
Telephone: (518) 999-0012
ADV NO 1, 123 ANY ST, ALBANY Y, NY 12345
Telephone: (518) 111-1111
ALBANY LEGAL AID, 528 CENTRAL AVE, ALBANY, NY 12208
Telephone: (518) 462-5501
TEST ADVOCATE CONTACT DATA 12838, XXXX, YYYY, ZZZZ, NY 12838
Telephone: (518) 777-8888
W, T, Q, NY 12210
Telephone: (518) 234-0456
ONTARIO COMM ACTION, 124 ONTARIO ST, 234 CENTRAL AV, ALBANY, NY 12208
Telephone: (518) 004-0009
TEST ADVOCATE, 1234 ANYSTREET, ALBANY, NY 12022
Telephone: (518) 747-9440
LEGAL AID SOCIETY OF NORTHEASTERN NY, 55 COLUMBIA STREET, ALBANY, NY 12207
Telephone: (518) 462-6765

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 which 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 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 us at the Record Access telephone number listed at the top of page 1 of this notice or write us at the address printed at the top of page 1 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 telephone numbers listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

Send this "Request for a Fair Hearing" to:

The Office of Administrative Hearings
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, New York 12201

CONTINUED ON THE NEXT PAGE ...

WHAT IF I NO LONGER WANT OR NEED ASSISTANCE?

If you do not want or need public assistance, SNAP benefits, medical assistance and/or child care assistance, please tell us.

If you want any of these benefits to stop, check the box(es) below next to the benefit(s) and tell us the reason. It is important for you to tell us why you want your case closed because, depending on the reason, you may be able to get medical assistance for up to a year. You may also be able to get help with your child care. Sign, date and send back this form to the Social Services district at the address shown on page 1 of this notice, if you no longer want or need assistance.

CHECK BELOW IF YOU DO NOT WANT OR NEED ANY OF THE FOLLOWING BENEFITS:

[ ] I do not want or need **PUBLIC ASSISTANCE.** If you check this box but still want SNAP benefits, you must submit a recertification application in the way explained in the SNAP section of this notice. Your medical assistance will continue unless you also check below. If you check this box and still want/need Child Care Assistance, you must contact your worker so that your eligibility for Child Care Assistance can be determined.

[ ] I do not want or need **SNAP benefits.**

[ ] I do not want or need **MEDICAL ASSISTANCE.**

[ ] I do not want or need **CHILD CARE ASSISTANCE.**

List Reason: _____

_____

_____

SIGNATURE: _____

DATE SIGNED: _____ **CASE NUMBER:** MAW17RCTRK

LDSS-3668 (Rev. 2/10) **SHELTER VERFICATION**

Local District Name and Address:	Case Number:	Worker ID:
	Case Name and Address:	

Dear Sir/Madam:

We are currently reviewing the assistance case of the above named person. In order to complete our evaluation of this case, we need information regarding household composition and shelter expenses. This form is for verification purposes only, and does not imply any obligation on the part of this Agency.

Please complete this questionnaire beginning with Section A below. Thank you for your cooperation.

SECTION A: SHELTER DESCRIPTION

	Type of Dwelling (Check One)	
Address:_____	☐ Hotel/Motel	☐ Room in Private Home
City:_____	☐ Apartment (# ___)	☐ Commercial Rooming House Are Meals Included? ☐Yes ☐No
Zip Code:_____	☐ House ☐ Trailer	
County:_____	No. of Bedrooms: ____	Is any part of the room rent used for heat or utilities? ☐Yes ☐No

SECTION B: HOUSEHOLD COMPOSITION

Number of people living in this rental unit: _____

Names	How long has this person lived here?	Names	How long has this person lived here?

Does anyone listed above have a telephone? ☐Yes ☐No Number: _____	Is anyone listed above employed? ☐ Yes ☐ No Name: _____ Employer:_____
Does anyone listed above perform any services for you for which he/she receives a lower rent? ☐ Yes ☐ No If yes, explain: _____	Do you have any employment opportunities for a member of this household? ☐ Yes ☐ No If yes, explain: _____

LDSS-3668 (Rev. 2/10) **SHELTER VERFICATION**

SECTION C: SHELTER EXPENSES

Rental Amount: $_____ Due: ☐ Weekly ☐ Monthly ☐ Every 2 weeks ☐ Twice a month	Is rent paid up to date? ☐Yes ☐No Last month that rent was paid in full: ____
Name of person(s) paying rent: _____ Name of Tenant of Record: _____ (If different from person paying the rent)	Is rent subsidized? (e.g. HUD) ☐Yes ☐No If yes, amount subsidized: _____ Subsidizing agency: _____

Check the following which are included in the rent:

☐ Heat ☐ Electricity ☐ Hot Water ☐ Air Conditioning ☐ Furniture ☐ Garbage Collection

☐ Stove ☐ Refrigerator ☐ Water/Sewer ☐ Cooking Fuel ☐ Meals ☐ Heating Equipment

If heat is **not included** in rent, check the primary type of fuel used for heating :

☐ Natural Gas ☐ Kerosene ☐ Propane ☐ Coal ☐ Wood ☐ Electricity ☐ Oil

Does the furnace/stove heat:

☐ Only this apartment ☐ Entire House ☐ Other (Specify): _____

Does the tenant pay to you an amount, separate from the rent, for heat?

☐ Yes ☐ No If yes, list monthly amount:_____

If no, does the tenant pay the vendor directly for heat? ☐ Yes ☐ No

Does the tenant pay to you an amount, separate from the rent, for water?

☐ Yes ☐ No If yes, list monthly amount: _____

Does the tenant pay to you an amount, separate from the rent, for other non-heating utilities?

☐ Yes ☐ No If yes, list monthly amount: _____

If tenant pays for non-heating utilities, are there separate meters for the tenant's apartment?

☐ Yes ☐ No

To your knowledge, does anyone that lives outside of the household pay all or part of the rent and/or utilities?

☐ Yes ☐ No If yes, please explain: _____

SECTION D: LANDLORD INFORMATION

Does Landlord live in the same apartment/ rental unit as tenant? ☐ Yes ☐ No	Date Tenant moved in / will move in:
Relationship to Tenant:	Landlord's Name:
Landlord's Address:	Landlord's Telephone Number:
Landlord's Signature:	Landlord's E-mail Address:
Date:	Owner's Name (If different than landlord):
Owner's Address:	Owner's Telephone Number: Owner's E-mail Address:

Domestic Violence Information for all Temporary Assistance Applicants

This information is intended to help you determine if you are a victim of domestic violence and to consider ways to help keep yourself and your family safe and self-supporting.

Are you in danger of your partner or ex-partner doing any of the following:

- Physically hurting you – for example, pushing, grabbing, slapping, hitting, choking, or kicking?
- Forcing you to have sex when you don't want to or to do sexual things you don't want to do?
- Threatening to hurt you, your children or someone close to you?
- Constantly putting you down or telling you that you are worthless?
- Stalking, checking up on you or following you?
- Making you afraid?

What kinds of help are available?

Temporary Assistance: You must meet certain requirements to be eligible for temporary assistance. If you are a victim of domestic violence and believe meeting those program requirements may put you or your children at risk of harm or make it more difficult to escape the abuse you may request a temporary delay (waiver) of certain requirements. For example: meeting all or some employment, child support enforcement or drug and alcohol assessment and treatment requirements may be temporarily delayed. You may complete the Domestic Violence Screening Form and request to see a Domestic Violence Liaison to determine your eligibility for a temporary waiver.

Services: You can call a 24 hour domestic violence hotline for information about emergency shelter, support groups, counseling and your legal rights.

In NYC call: 1-800-621-4673

In any other area of NY State call: 1-800-942-6906

ALL Spanish speaking callers may call: 1-800-942-6908

Local Domestic Violence Hotline Number

NOTICE ATTACHMENTS

DSS-3174	(Rev. 5/05)	...RECERTIFICATION for PUBLIC ASSISTANCE - MEDICAL ASSISTANCE - FOOD STAMPS.
PUB-1313	(Rev. 5/05)	...HOW TO COMPLETE THE SOCIAL SERVICES RECERT FORM.

New York State
Office of Temporary and
Disability Assistance

MASS NOTICE OF INTENT TO CHANGE SNAP
OCTOBER 2014

Case Number:
Loc. Off./Unit/Worker:

General Telephone No. for
Questions or Help:

Dear SNAP Recipient:

You are receiving this notice because you receive Supplemental Nutrition Assistance Program (SNAP) benefits as a participant in the New York State Nutrition Improvement Project (NYSNIP), **and**

- you either do not incur a separate bill or charge for heating or air conditioning costs, **and** you have not received Home Energy Assistance Program (HEAP) benefits of more than $20 during the month this letter is dated or during the immediately preceding twelve (12) months, **or**
- you have not provided any information to your local social services district about your shelter costs or utility costs since your current SNAP case opened.

If you do not incur a separate bill or charge for heating or air conditioning costs, **and** you have not received a HEAP benefit of more than $20 during the month this letter is dated or during the immediately preceding twelve (12) months, then **due to a change in federal law** (Section 4006 of the Agricultural Act of 2014), you are no longer eligible to have the Heating/Air Conditioning Standard Utility Allowance (HCSUA) used in your SNAP benefit calculation. As a result, **beginning October 1, 2014, your SNAP benefits will decrease.**

If your monthly shelter costs (rent, mortgage, etc.) are more than $242, your only income is SSI, and your monthly SNAP benefit was $189, then beginning October 1, 2014 your monthly SNAP benefit will be $31.

If your monthly shelter costs (rent, mortgage, etc.) are more than $242, you receive other income (such as Social Security Disability income or have earnings) in addition to SSI, and your monthly SNAP benefit was $189, then beginning October 1, 2014 your monthly SNAP benefit will be $22.

If your monthly shelter costs are $242 or less, beginning October 1, 2014, your monthly SNAP benefit will be $16.

Also, if you are a SNAP recipient participating in NYSNIP and you have not provided any information to your local social services district about your shelter costs or utility costs since your current SNAP case opened, then beginning October 1, 2014, your monthly SNAP benefit will be $16.

If you do incur a separate bill or charge for heating costs, air conditioning costs, electricity, cooking gas or other utility cost from a utility or from your landlord, or if you or someone you live with has received a HEAP payment of more than $20 during the month this letter is dated or during the immediately preceding twelve (12) months, you might be eligible to have the Heating/Air Conditioning SUA or Utility SUA used in your SNAP benefit calculation and may be eligible for more SNAP benefits. If so, please contact your local social services district office at the number on this letter.

If you think we made a mistake in figuring your October SNAP benefits due to the above noted changes, you may ask for a state fair hearing, *within 90 days of when your October 2014 SNAP benefits become available*. You can ask for a fair hearing by writing to: Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany New York 12201; Faxing (518) 473-6735; on-line by requesting a form at: http://www.otda.ny.gov/oah/forms.asp; or by calling toll free: 1-800-342-3334.

LEGAL ASSISTANCE: If you think that you need a lawyer to assist 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.

PREAVISO DE CAMBIOS EN SUBSIDIO SNAP
OCTUBRE 2014

Estimado(a) beneficiario(a) de SNAP:

Le enviamos este aviso porque usted recibe el subsidio del Programa de Asistencia Nutricional Suplementaria (SNAP) como participante en el proyecto titulado Proyecto de Mejora Nutricional del Estado de Nueva York (NYSNIP), y usted, ya sea:

- No tiene facturas o cargos por separado de calefacción o aire acondicionado, **y** no ha recibido un Subsidio de Energía para el Hogar (HEAP) por un monto mayor de $20 en el mes de la fecha de esta carta o los últimos 12 meses, **o bien**;
- Usted no ha suministrado datos a su departamento local de servicios sociales del distrito pertinente gastos de alojamiento o servicios públicos desde que su caso actual de SNAP se abrió recientemente.

Si no tiene facturas o cargos por separado de calefacción o aire acondicionado, y no ha recibido un Subsidio de Energía para el Hogar (HEAP) por un monto mayor de $20 en el mes de la fecha de esta carta o en los últimos doce (12) meses, a consecuencia de una **modificación en la reglamentación federal** (Sección 4006 de la Ley sobre Agricultura de 2014), usted ya no es apto(a) para que se tome en consideración el Subsidio Estándar de Servicios Públicos (HCSUA) en el cálculo de su subsidio SNAP. Como consecuencia, **a partir del 1º de octubre de 2014, su subsidio SNAP disminuirá**.

Si sus gastos mensuales por alojamiento (alquiler, hipoteca, etc.) sobrepasan los $242, su único ingreso es SSI, y su subsidio mensual SNAP era de $189; comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $31.

Si sus gastos mensuales por alojamiento (alquiler, hipoteca, etc.) sobrepasan los $242, recibe otro ingreso (tal como Seguro Social por Incapacidad o percibe ingresos) además de SSI, y su subsidio mensual SNAP fue de $189; comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $22.

Si sus gastos mensuales por alojamiento son de $242 o menos, comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $16.

Además, si usted es un beneficiario de subsidio SNAP que participa en el programa NYSNIP, y no ha suministrado ningún dato a su departamento local de servicios sociales del distrito pertinente a los gastos de alojamiento o servicios públicos desde que su caso actual de SNAP se abrió recientemente; comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $16.

Si tiene una factura o cargos por separado de calefacción, aire acondicionado, electricidad, gas para cocinar u otro cobro por servicio público proveniente de una compañía de servicios públicos o arrendador; o si usted o una de las personas que viven con usted ha recibido un pago de subsidio HEAP por un monto mayor de $20 en el mes de la fecha de esta carta o en los últimos doce (12) meses, se podrá utilizar la asignación de Subsidio Estándar de Servicios Públicos (SUA) para calefacción / aire acondicionado o asignación SUA para servicios públicos en el cálculo de su subsidio SNAP y podrá recibir un aumento de subsidio SNAP. De ser así, comuníquese con la oficina local de servicios sociales del distrito al número indicado en esta carta.

Si cree que hemos cometido un error al calcular el monto del subsidio SNAP para el mes de octubre según los cambios antes mencionados, puede solicitar una audiencia imparcial dentro de 90 días contados a partir de la fecha en octubre cuando el subsidio SNAP es acreditado a su cuenta. Puede solicitar una audiencia imparcial mandando una carta a: *Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany New York 12201*; por fax al: (518) 473-6735; o en línea solicitando un formulario en: http://www.otda.ny.gov/oah/forms.asp; o llamando gratis al: 1-800-342-3334

ASISTENCIA LEGAL: si cree que necesita representación legal en la resolución de este problema, puede obtener los servicios de un abogado, sin costo alguno, comunicándose con la Sociedad de Ayuda Legal (Legal Aid Society) u otra asociación de defensa legal de su localidad.

CENTER F-15
233 SCHERMERHORN ST., 2ND FLOOR
BROOKLYN, NEW YORK 11201

New York State
Office of Temporary and
Disability Assistance

MASS NOTICE OF INTENT TO CHANGE SNAP
OCTOBER 2014/NYC

Case Number:
Loc. Off./Unit/Worker:

General Telephone No. for
Questions or Help: 718-722-4009

Dear SNAP Recipient:

You are receiving this notice because you receive Supplemental Nutrition Assistance Program (SNAP) benefits as a participant in the New York State Nutrition Improvement Project (NYSNIP), **and**

- you either do not incur a separate bill or charge for heating or air conditioning costs, **and** you have not received Home Energy Assistance Program (HEAP) benefits of more than $20 during the month this letter is dated or during the immediately preceding twelve (12) months, **or**
- you have not provided any information to your local social services district about your shelter costs or utility costs since your current SNAP case opened.

If you do not incur a separate bill or charge for heating or air conditioning costs, **and** you have not received a HEAP benefit of more than $20 during the month this letter is dated or during the immediately preceding twelve (12) months, then **due to a change in federal law** (Section 4006 of the Agricultural Act of 2014), you are no longer eligible to have the Heating/Air Conditioning Standard Utility Allowance (HCSUA) used in your SNAP benefit calculation. As a result, **beginning October 1, 2014, your SNAP benefits will decrease.**

If your monthly shelter costs (rent, mortgage, etc.) are more than $242, your only income is SSI, and your monthly SNAP benefit was $189, then beginning October 1, 2014 your monthly SNAP benefit will be $31.

If your monthly shelter costs (rent, mortgage, etc.) are more than $242, you receive other income (such as Social Security Disability income or have earnings) in addition to SSI, and your monthly SNAP benefit was $189, then beginning October 1, 2014 your monthly SNAP benefit will be $22.

If your monthly shelter costs are $242 or less, beginning October 1, 2014, your monthly SNAP benefit will be $16.

Also, if you are a SNAP recipient participating in NYSNIP and you have not provided any information to your local social services district about your shelter costs or utility costs since your current SNAP case opened, then beginning October 1, 2014, your monthly SNAP benefit will be $16.

If you do incur a separate bill or charge for heating costs, air conditioning costs, electricity, cooking gas or other utility cost from a utility or from your landlord, or if you or someone you live with has received a HEAP payment of more than $20 during the month this letter is dated or during the immediately preceding twelve (12) months, you might be eligible to have the Heating/Air Conditioning SUA or Utility SUA used in your SNAP benefit calculation and may be eligible for more SNAP benefits. If so, please contact the New York City Human Resources Administration office at the number on this letter.

If you think we made a mistake in figuring your October SNAP benefits due to the above noted changes, you may ask for a state fair hearing, *within 90 days of when your October 2014 SNAP benefits become available*. You can ask for a fair hearing by writing to: Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany New York 12201; Faxing (518) 473-6735; on-line by requesting a form at: http://www.otda.ny.gov/oah/forms.asp; or by calling toll free: 1-800-342-3334.

LEGAL ASSISTANCE: If you think that you need a lawyer to assist 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.

PREAVISO GENERAL SOBRE CAMBIOS EN SUBSIDIO SNAP
OCTUBRE 2014 / NYC

Estimado(a) beneficiario(a) de SNAP:

Le enviamos este aviso porque usted recibe el subsidio del Programa de Asistencia Nutricional Suplementaria (SNAP) como participante en el proyecto titulado Proyecto de Mejora Nutricional del Estado de Nueva York (NYSNIP), **y** usted, ya sea:

- No tiene facturas o cargos por separado de calefacción o aire acondicionado, **y** no ha recibido un Subsidio de Energía para el Hogar (HEAP) por un monto mayor de $20 en el mes de la fecha de esta carta o los últimos doce (12) meses, **o bien**;
- Usted no ha suministrado datos a la oficina local de servicios sociales del distrito pertinente gastos de alojamiento o servicios públicos desde que su caso actual de SNAP se abrió recientemente.

Si no tiene facturas o cargos por separado de calefacción o aire acondicionado, **y** no ha recibido un Subsidio de Energía para el Hogar (HEAP) por un monto mayor de $20 en el mes de la fecha de esta carta o en los últimos doce (12) meses, a consecuencia de una **modificación** en la **reglamentación federal** (Sección 4006 de la Ley sobre Agricultura de 2014), usted ya no es apto(a) para que se tome en consideración el Subsidio Estándar de Servicios Públicos (HCSUA) en el cálculo de su subsidio SNAP. Como consecuencia, **a partir del 1º de octubre de 2014, su subsidio SNAP disminuirá**.

Si sus gastos mensuales por alojamiento (alquiler, hipoteca, etc.) sobrepasan los $242, su único ingreso es SSI, y su subsidio mensual SNAP era de $189; comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $31.

Si sus gastos mensuales por alojamiento (alquiler, hipoteca, etc.) sobrepasan los $242, recibe otro ingreso (tal como Seguro Social por Incapacidad o percibe ingresos) además de SSI, y su subsidio mensual SNAP fue de $189; comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $22.

Si sus gastos mensuales por alojamiento son de $242 o menos, comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $16.

Además, si usted es un beneficiario de subsidio SNAP que participa en el programa NYSNIP, y no ha suministrado ningún dato a su departamento local de servicios sociales del distrito pertinente a los gastos de alojamiento o servicios públicos desde que su caso actual de SNAP se abrió recientemente; comenzando el 1º de octubre de 2014, su subsidio mensual SNAP será de $16.

Si tiene una factura o cargos por separado de calefacción, aire acondicionado, electricidad, gas para cocinar u otro cobro por servicio público proveniente de una compañía de servicios públicos o arrendador; o si usted o una de las personas que viven con usted ha recibido un pago de subsidio HEAP por un monto mayor de $20 en el mes de la fecha de esta carta o en los últimos doce (12) meses, se podrá utilizar la asignación SUA para calefacción / aire acondicionado o asignación SUA para servicios públicos, en el cálculo de su subsidio SNAP y podrá recibir un aumento de subsidio SNAP. De ser así, comuníquese con la oficina de Recursos Humanos de la Ciudad de Nueva York (*New York City Human Resources Administration*) al número indicado en esta carta.

Si cree que hemos cometido un error en el cálculo del monto del subsidio SNAP para el mes de octubre según los cambios antes mencionados, puede solicitar una audiencia imparcial estatal dentro de *90 días contados a partir de la fecha en octubre cuando el subsidio SNAP es acreditado a su cuenta*. Puede solicitar una audiencia imparcial mandando una carta a: *Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany New York 12201*; por fax al: (518) 473-6735; o en línea solicitando un formulario en: http://www.otda.ny.gov/oah/forms.asp; o llamando gratis al: 1-800-342-3334

ASISTENCIA LEGAL: si cree que necesita representación legal en la resolución de este problema, puede obtener los servicios de un abogado, sin costo alguno, comunicándose con la Sociedad de Ayuda Legal (*Legal Aid Society*) u otra asociación de defensa legal de su localidad.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 13, 2012
[redacted]
AGENCY: Washington
FH #: 6182056Z

In the Matter of the Appeal of

[redacted]

from a determination by the Washington County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on December 3, 2012, in Washington County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination by the managed-care company to deny the Appellant's dentist's request for prior authorization for partial denture to replace missing teeth correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant has been in receipt of Family Health Plus through [redacted].

2. On July 30, 2012, the Appellant's dentist requested prior authorization from [redacted]. for partial denture to replace missing teeth.

3. By Notice dated July 31, 2012, the managed-care company determined to deny the dentist's request for prior authorization for a partial denture to replace missing teeth on the grounds that the Appellant was not missing enough teeth. That determination stated that to qualify for this service, one must have less than four upper back teeth that touch four of the lower back teeth when biting down.

4. On August 13, 2012, the Appellant requested this fair hearing.

APPLICABLE LAW

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the managed care program for both Medicaid and Family Health Plus.

Pursuant to Chapter 4 of the Operational Protocol, Family Health Plus provides a comprehensive prepaid benefit package consisting of primary, preventive, specialist and inpatient health care services. Unlike the Partnership Plan which governs Medicaid Managed Care, there are no partial capitation plans, fee-for-service wraparounds, stop-loss limits or extended benefits. A detailed list of the scope of benefits provided in the Family Health Plus Prepaid Benefits Package is listed in Appendix K of the Medicaid Managed Care/Family Health plus Contract.

Family Health Plus organizations are subject to the provisions of Section 364-j of the Social Services Law. Section 364-j.4(j) provides that such organizations are responsible for providing or arranging for medical Assistance services and assisting participants in the prudent selection of such services. Section 364-j.4 (k) requires such organizations to establish appropriate utilization and referral requirements for medical service providers. Section 364-j.4.(o) requires such organizations to provide or arrange, directly or indirectly, including by referral, for the full range of covered services.

Section 506.2(a) of 18 NYCRR provides that dental care in the Medical Assistance program shall include only preventive, prophylactic and other routine dental care, services and supplies, and dental prosthetic and orthodontic appliances required to alleviate a serious health condition including one which affects employability.

Section 506.3(b) of the Regulations requires prior approval for all dental prosthetic appliances which shall be furnished only if required to alleviate a serious health condition including one which affects employability.

With regard to the replacement of dentures, the New York State Medicaid Program Provider Manual for Dental Procedure Codes Section VI provides, in pertinent part, as follows:

> Complete or partial dentures will not routinely be replaced when they have been provided by the Medicaid program and become unserviceable or are lost within four years, except when they become unserviceable through extensive physiological change. If the recipient can provide documentation that reasonable care has been exercised in the maintenance of the prosthetic appliance, and it did not become unserviceable or lost through negligence, a replacement may be considered. Prior approval requests for such replacements will not be reviewed without supporting documentation. A verbal statement by the recipient that is then included by the provider on the prior approval request would generally not be considered sufficient.

With regard to dentures, the New York State Medicaid Program Provider Manual for Dental Procedure Codes Section VI provides, in pertinent part, as follows:

> Complete and/or partial dentures will be approved only when existing prostheses are not serviceable or cannot be relined or rebased.
>
> If a recipient's health would be adversely affected by the absence of a prosthetic replacement, and the recipient could successfully wear a prosthetic replacement, such a replacement will be considered. In the event that the recipient has a record of not successfully wearing prosthetic replacements in the past, or has gone an extended period of time (three years or longer) without wearing a prosthetic replacement, the prognosis is poor. Mitigating factors surrounding these circumstances should be included with the prior approval request.
>
> Partial dentures will be approved only when they are required to alleviate a serious health condition including one that affects employability. Eight natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) are generally considered adequate for functional purposes. One missing maxillary anterior tooth or two missing mandibular anterior teeth may be considered a problem that warrants a prosthetic replacement.

DISCUSSION

By Notice dated July 31, 2012, the managed-care company determined to deny the dentist's request for prior authorization for a partial denture to replace missing teeth on the grounds that the Appellant was not missing enough teeth. That determination was correct.

The managed-care company contended that the request was properly denied because there was no evidence of any serious health condition which maxillary dentures would alleviate and because the request did not show the Appellant to be missing sufficient teeth for Medicaid to consider her masticatory function to be severely impaired. The company said that the company's review of the request and x-rays showed 6 pairs of posterior teeth in occlusion: 1 and 32, 2 and

31, 29 and 4, 28 and 5, 21 and 12, and 13 and 20. The company said that, since the Medicaid standard states that 4 upper and 4 lower posterior teeth in functional contact with each other is considered adequate for chewing purposes, the dental director determined that the Appellant did not meet the Medicaid criteria for lower partial dentures.

The Appellant said she used to have a partial denture that had been paid for by Medicaid. She said she lost that partial during a move.

The Appellant said that, when she chews apples, her gums hurt. She said it is hard to eat crunchy foods, such as cereal and nuts. She said her front teeth are chipping and becoming "raggedy." She said she chews on her left side.

Under Medicaid, partial dentures will be approved only when they are required to alleviate a serious health condition. Eight natural or prosthetic teeth in occlusion (four maxillary and four mandibular teeth in functional contact with each other) are generally considered adequate for functional purposes. One missing maxillary anterior tooth or two missing mandibular anterior teeth may be considered a problem that warrants a prosthetic replacement.

On this record, there is insufficient evidence to establish that the Appellant meets the Medicaid criteria for approval of a partial denture.

As to the Appellant's claim that the request should be approved because she is merely requesting the replacement of a partial denture previously provided through Medicaid, there is no evidence that the Appellant meets the Medicaid criteria for replacement, particularly since, in this case, there is evidence that the prosthetic appliance may have been lost through negligence during a move. Even if there were no negligence, the Provider Manual merely states that a replacement may be considered. In this case, the matter has been considered, with a denial on the grounds discussed above, a lack of evidence that the request met established criteria.

DECISION

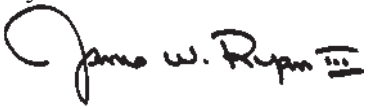
The determination by the Managed Care Agency to deny the Appellant's dentists' request for prior authorization for partial denture to replace missing teeth was correct.

FH# 6182056Z

DATED: Albany, New York
01/03/2013

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee

OAH-4482/30B (Rev. 6/10)

From: New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201 - 1930

TRANSMITTAL OF FAIR HEARING DECISION
TO SOCIAL SERVICES AGENCY

Fair Hearing #: 6209274M
Hearing Date: 12/05/12
Decision Date: 01/03/13
Case #: [redacted]
Category/Subcategory: [redacted]

Primary Agency: ALBANY
Appellant: [redacted]

Representative:

Other Agencies:

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*************************************
*                                   *
* ENCLOSED IS THE DECISION RENDERED *
*      IN THE ABOVE FAIR HEARING    *
*                                   *
*************************************
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If this decision reverses or does not affirm the action intended to be taken by your Agency and directs your Agency to take certain other action, you must do so and so notify the Appellant forthwith (as quickly as possible). The Appellant has been advised to contact the state's Compliance Unit if compliance is not effected within ten (10) days after receipt of this decision.

In accordance with the provisions of Title 18 NYCRR, if this decision indicates that the social services official has misapplied provisions of the law, State regulation, or such official's own state-approved policy, the social services official is required to review other cases with similar facts for conformity with the principles and findings in the decision.

If you have questions about directions contained in this decision, please contact:

New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
Compliance Unit
P. O. Box 1930
Albany NY 12201 - 1930

The following agencies have been notified of the issuance of this fair hearing decision:

ALBANY CO DEPT OF SOCIAL SERVICES,BRENDHAN ALLARDICE
ALBANY CO DEPT OF SOCIAL SERVICES,KATHY TREMONT
ALBANY CO DEPT OF SOCIAL SERVICES,GINA CATALDO
ALBANY CO DEPT OF SOCIAL SERVICES,ATT: KATHY TREMONT
ALBANY CO DEPT OF SOCIAL SERVICES,ATT: LORRAINE RICHARDS

OAH-4482/30B (Rev. 6/10)

From: New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, NY 12201 - 1930

TRANSMITTAL OF FAIR HEARING DECISION
TO SOCIAL SERVICES AGENCY

Fair Hearing #: 6182056Z
Hearing Date: 12/03/12
Decision Date: 01/03/13
Case #: [redacted]
Category/Subcategory: [redacted]

Primary Agency: [redacted]
Appellant:

Representative:

Other Agencies: CATH

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*************************************
*                                   *
* ENCLOSED IS THE DECISION RENDERED *
*     IN THE ABOVE FAIR HEARING     *
*                                   *
*************************************
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If this decision reverses or does not affirm the action intended to be taken by your Agency and directs your Agency to take certain other action, you must do so and so notify the Appellant forthwith (as quickly as possible). The Appellant has been advised to contact the state's Compliance Unit if compliance is not effected within ten (10) days after receipt of this decision.

In accordance with the provisions of Title 18 NYCRR, if this decision indicates that the social services official has misapplied provisions of the law, State regulation, or such official's own state-approved policy, the social services official is required to review other cases with similar facts for conformity with the principles and findings in the decision.

If you have questions about directions contained in this decision, please contact:

New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
Compliance Unit
P. O. Box 1930
Albany NY 12201 - 1930

The following agencies have been notified of the issuance of this fair hearing decision:

WASHINGTON CO DSS-PAULA REID,
WASHINGTON CO DSS,JEANETTE MACQUESTEN
WASHINGTON CO DEPT OF SOC SERVICES,MS. TAMMY DELORME, COMMISSIONER
FRANK RINALDI,FIDELIS CARE
MARIA BOTHA-LOPEZ,FIDELIS CARE
MATT HEUSTON,FIDELIS CARE
EVELYN HUANG,FIDELIS CARE

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: October 9, 2012
[redacted]
AGENCY: Albany
FH #: 6209274M

In the Matter of the Appeal of

[redacted]

from a determination by the Albany County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on December 5, 2012, in Albany County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Kathy Tremont, Fair Hearing Representative

ISSUE

Was the Agency's determination to accept the Appellant's application for Medical Assistance for Appellant subject to a monthly spenddown of excess income of $453.00 on the grounds that the Appellant's household has income which exceeds the applicable Medical Assistance income standards correct?

Was the Agency determination that the Appellant's household was not eligible for Family Health Plus on the grounds that the Appellant has a health insurance plan correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 51, applied for Medical Assistance on September 21, 2012.

2. By notice dated October 2, 2012, the Agency informed the Appellant of its determination to accept the Appellant's application for Medical Assistance for Appellant subject to a monthly spenddown of excess income of $453.00 on the grounds that the Appellant's household has income which exceeds the applicable Medical Assistance income standards. The notice also advised the Appellant of the Agency's determination that the Appellant's household was not eligible for Family Health Plus on the grounds that the Appellant has a health insurance plan.

3. The Appellant's household's monthly income is as follows:

Household Member	**Source**	**Unearned Income**
Appellant	SSD	$1,275.00
	Gross Unearned Income	**$1,275.00**

4. The Appellant's monthly Medicaid budget is calculated as follows:

Gross Monthly Unearned income	$1,275.00	
Subtract		
$20 Disregard	- $20.00	
Health Insurance premium	- $0.00	
Net Monthly Unearned Income		**$1,255.00**
Gross Monthly Earned income	**$0.00**	
Total Net Income		**$1,255.00**
Medical Assistance Standard of Need		-$792.00
Available Monthly Excess Income		**$463.00**

5. On October 9, 2012, the Appellant requested this fair hearing.

APPLICABLE LAW

A person who is sixty-five years of age or older, blind or disabled who is not in receipt of Public Assistance and has income or resources which exceed the standards of the Federal Supplemental Security Income Program (SSI) but who otherwise is eligible for SSI may be eligible for Medical Assistance, provided that such person meets certain financial and other eligibility requirements under the Medical Assistance Program. Social Services Law Section 366.1(a)(5).

To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result - net income - is compared to the statutory "standard of need" set forth in Social Services Law Section 366.2(a)(7) and 18 NYCRR Subpart 360-4. If an applicant's or recipient's net income is less than

or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medical Assistance coverage is available.

The amount by which net income exceeds the standard of need is considered "excess income". If the applicant or recipient has any excess income, he/she must incur bills for medical care and services equal to or greater than that excess income to become eligible for Medical Assistance. In such instances Medical Assistance coverage may be available for the medical costs which are greater than the excess income. If a person has expenses for in-patient hospital care, the excess income for a period of six months shall be considered available for payment. For other medical care and services the excess income for the month or months in which care or services are given shall be considered available for payment of such care and services. 18 NYCRR 360-4.1, 360-4.8.

Administrative Directive 87 ADM-4 provides detailed instructions regarding the appropriate application of medical bills to offset excess income so that an individual can become eligible for Medical Assistance. This offsetting process is called "spenddown". Said Directive further provides that whenever a spenddown is indicated, the Agency is required to include a copy of the letter "Explanation of the Excess Income Program" along with the Notice to the recipient whenever an acceptance, intended change, denial, or discontinuance indicates a spenddown liability situation. Administrative Directive 87 ADM-4 provides that some over-the-counter drugs and medical supplies such as bandages and dressings may be applied to offset determined excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items may not be so applied.

Regulations at 18 NYCRR 360-4.6 provide for additional income disregards for applicants and recipients who are 65 years of age or older, certified blind or certified disabled. These disregards are to be applied in the following order:

- the first $20 per month of any unearned income. Only one $20 disregard is permitted per couple. A certified blind or certified disabled child living with parents is entitled to a separate $20 disregard from his/her total unearned income. If a person's unearned income is under $20, the balance will be deducted from earned income;

- the first $65 of earned income;

- health insurance premiums;

Local social services districts now provide a "Pay-In" program, established under provisions of Section 366(2)(b)(3) under which Medical Assistance recipients having excess income may simply remit the amount of the excess to the local district each month, and receive an uninterrupted authorization for full coverage for all costs (at the Medicaid rate) of all necessary medical services by participating providers.

Pursuant to section 369-ee of the Social Services Law, a person is eligible to receive health care services under the Family Health Plus Program if he or she:

(i) resides in New York state and is at least age nineteen, but under sixty-five years of age;

(ii) is not eligible for medical assistance solely due to income or resources or is eligible for medical assistance only through the application of excess income toward the costs of medical care and services;

(iii) does not have equivalent health care coverage under insurance or equivalent mechanisms;

****

(v)(A) in the case of a parent or stepparent of a child under the age of twenty-one who lives with such child, has gross family income equal to or less than the applicable percent of the federal income official poverty:

(I) January 1, 2001 – 120% and

(II) October 1, 2001 – 133% and

(III) October 1, 2002 – 150%; or

(B) in the case of an individual who is not a parent or stepparent living with his or her child under the age of twenty-one, has gross family income equal to or less than 100% of the federal income official poverty line for a family of the same size.

In order to be eligible for Family Health Plus, 19 and 20-year-olds living with their parents, must have gross family income equal to or less than the following federal income poverty lines for a family of the same size:

- effective January 1, 2001, 120 percent; and
- effective October 1, 2001, 133 percent; and
- effective October 1, 2002, is 150 percent.

01 OMM/ADM-6

In order to be eligible for Family Health Plus, 19 and 20 year-olds not residing with their parents, must have gross family income equal to or less than 100 percent of the federal income official poverty line for a family of the same size. 1 OMM/ADM-6

There are Additional requirements in order to be eligible for Family Health Plus relating to the existence of heath care coverage and insurance. Pursuant to GIS 09 MA/027, effective January 1, 2010, eligibility shall be determined without regard to resources..

Every person determined eligible for or receiving Family Health Plus coverage must enroll in a family health insurance plan.

100% of the Federal Poverty Line for a household of one is $931.00 per month in the year 2012.

DISCUSSION

The Appellant contests the adequacy of his Medical Assistance. The Agency's evidence indicates that the Appellant's monthly gross SSD benefit is $1,275.00. A budget was calculated and it was determined that the Appellant's net income (gross income less Medical Assistance deductions) is over the Medical Assistance income limit by $453.00. This amount is the Appellant's spenddown.

The Appellant said that he gets a net SSD benefit of $698.00. His gross benefit is reduced due to child support or alimony. The Appellant said that he cannot afford his spenddown requirement with all of his expenses. He stated that he will get Medicare in March, but he cannot wait because he has doctors to see.

Based on the testimony and evidence in the record, as the budget that is stated above indicates, the Agency's determination to accept the Appellant's application for Medical Assistance for Appellant subject to a monthly spenddown of excess income of $453.00 on the grounds that the Appellant's household has income which exceeds the applicable Medical Assistance income standard was correct. Child support and alimony payments deducted from Social Security benefits are not allowable for purposes of Medicaid eligibility.

With respect to the Agency's determination that the Appellant was not eligible for Family Health Plus, although the Agency stated the grounds as being that the Appellant has health insurance, the evidence indicates that the Appellant's gross income exceeds the Family Health Plus income limit. Therefore, the Appellant is not eligible for Family Health Plus.

DECISION

The Agency's determination to accept the Appellant's application for Medical Assistance for Appellant subject to a monthly spenddown of excess income of $453.00 on the grounds that the Appellant's household has income which exceeds the applicable Medical Assistance income standards was correct.

The Agency determination that the Appellant was not eligible for Family Health Plus was correct.

FH# 6209274M

DATED: Albany, New York
01/03/2013

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee

Andrew M. Cuomo
Governor

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

Kristin M. Proud
Commissioner

Dear Appellant/Representative:

This is in response to your recent request that the above-referenced fair hearing be rescheduled.

Please be advised we have rescheduled your hearing and will notify you shortly under separate cover of the new date and time.

Please be further advised, however, that this office will be unable to provide any further rescheduling of this hearing. Any requests for adjournments must be made in person directly at the hearing. The hearing officer will then determine if there is sufficient reason to grant an adjournment. Failure to appear will constitute a default of the fair hearing.

Sincerely,

Michael P. Allen
Director of Administration
Office of Administrative Hearings

"Providing temporary assistance for permanent change"

NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
40 NORTH PEARL STREET
ALBANY, NEW YORK 122443-0001

Andrew M. Cuomo
Governor

Kristin M. Proud
Commissioner

Dear Appellant:

This is in response to your recent request to our office to review the above-referenced fair hearing decision. We have reviewed the fair hearing file and decision and have concluded that inasmuch as the fair hearing decision affirmed the local agency's determination, your further recourse should be to apply for a judicial review of this decision.

Please be advised that a petition for judicial review must be made within four months of the decision in accordance with the provisions of Article 78 of the Civil Practice Law and Rules. The petition for judicial review must be filed directly with the Supreme Court in your county. **Please note that your fair hearing decision was issued on behalf of the state agency whose name appears directly above the signature on the last page. A request for judicial review must include the Commissioner of the Agency that issued the decision after fair hearing.** Your notification to this office does not constitute the commencement of a proceeding for judicial review.

May I suggest that this is a matter that should be handled by an attorney and that you consult one with reference to the procedure. It is possible that you may obtain the services of an attorney to handle such proceeding for judicial review by contacting your local bar association or Legal Aid Society.

Sincerely,

Michael P. Allen
Director of Administration
Office of Administrative Hearings

Andrew M. Cuomo
Governor

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

Kristin M. Proud
Commissioner

Dear Appellant:

We have received a report from the Agency regarding compliance with the above referenced fair hearing decision. A review of that report, the fair hearing decision and your original complaint confirms that the Agency has taken appropriate action to comply with the directives of the decision After Fair Hearing.

Therefore, we will regard this matter as satisfactorily resolved and your compliance inquiry has been closed.

Should you have any questions or would like to discuss this case further, please contact the Compliance Coordinator listed below:

Andrew M. Cuomo
Governor

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

Kristin M. Proud
Commissioner

Dear Representative:

This is to acknowledge receipt of your complaint of non-compliance regarding the above referenced fair hearing decision.

We will review this matter with the Agency to insure that appropriate action is taken. You will be contacted by this Office upon completion of compliance.

Should you have any questions or if you would like to discuss this case futher, you may contact the Compliance Coordinator listed below:

Andrew M. Cuomo
Governor

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

Kristin M. Proud
Commissioner

Dear Appellant/Representative:

Your request for an adjournment of the above-referenced fair hearing has been granted. You will be sent a Notice of Fair Hearing (form OAH-457) by mail when the hearing is rescheduled.

Sincerely,

Michael P. Allen
Director of Administration
Office of Administrative Hearings

Andrew M. Cuomo
Governor

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

Kristin M. Proud
Commissioner

Dear Sir/Madam:

You made a request for a fair hearing (or did so on behalf of the appellant, in which case, the language of this letter is directed to the appellant). In your request, you indicated that you are medically unable to attend a hearing at the regular location. This letter will explain your options:

Coming to the Hearing by Special Transportation

If you are unable to use transportation other than public transportation, you may be able to arrange for special transportation to the hearing site by contacting your local social services department/NYC agency. You should be prepared to provide the local social services department/NYC agency current medical verification that you are unable to travel by public transportation.

In NYC, Access-A-Ride is available in all five boroughs. Your local NYC agency can provide instructions for using this service. Taxi fare is reimbursed by the NYC Human Resources Administration (HRA) without prior approval by submitting current medical verification that you are unable to travel by public transportation and a receipt for the taxi. Although HRA will reimburse the total cost of the taxi to and from your verified residence, you will be responsible to pay the cost of the trip to the hearing site and at the hearing site ask HRA for the round-trip fare.

Appearing by a Representative

If you cannot come to a hearing yourself, you can send a representative. Your representative can be a friend or relative or a lawyer. **The representative must bring a current statement from your medical professional (physician, physician's assistant, nurse practitioner, etc.) that you are unable to travel to the hearing site by any available means, including public transportation, Access-A-Ride, or taxi service. This statement must be specific as to the diagnosis and how long you will be unable to travel. If the Appellant is (1) a resident of a Nursing Home or (2) in receipt of Sleep-in or Split-Shift Home Care, the representative does not need to provide a statement from your medical professional to the Hearing Officer.**

If your representative is not a lawyer, or an employee of a lawyer, your representative must ALSO bring the hearing officer a written letter, signed by you, saying that you want that person to represent you.

You should be aware that if you send a representative to your hearing, your own oral testimony will not be part of the fair hearing record. The hearing officer will decide the case based on the testimony and documents, including any written statements made by you, which are submitted by your representative, and any witnesses which your representative brings to the hearing.

LETTER 15
To: Homebound Appellants/Representatives of Homebound Appellants