



**George E. Pataki**  
Governor

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

**Robert Doar**  
Commissioner

## Informational Letter

### Section 1

<b>Transmittal:</b>	05-INF-11
<b>To:</b>	Local District Commissioners
<b>Issuing Division/Office:</b>	Division of Employment and Transitional Supports
<b>Date:</b>	June 14, 2005
<b>Subject:</b>	5/05 Revision of Mandatory Client Notice, "Repayment of Interim Assistance" (LDSS-2425)
<b>Suggested Distribution:</b>	Temporary Assistance Staff Finance/Accounting Staff Food Stamp Benefits Staff Medicaid Directors CAP Coordinators Employment Coordinators WMS Coordinators Staff Development Coordinators
<b>Contact Person(s):</b>	Forms Questions: Bob Gullie 1-800-343-8859 Extension 6-1095 Program Questions: Food Stamp Bureau - (518) 473-1469 Cash Assistance - (518) 474-9344 HEAP - (518) 473-0332 Metro Region - (212) 961-8207 WMS Questions: (518) 474-8749
<b>Attachments:</b>	Attachment 1: Filing References Attachment 2: LDSS-2425: Repayment of Interim Assistance Notice (Rev.5/05)
<b>Attachment Available On – Line:</b>	<input checked="" type="checkbox"/>

### Filing References

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

### Section 2

## I. Purpose

To notify local districts that the mandatory client notice, LDSS-2425: "Repayment of Interim Assistance Notice" has been revised.

## II. Background

The Repayment of Interim Assistance Notice was developed for the specific purpose of notifying recipients that the local department of social services has either received a retroactive SSI payment or a partial payment of an initial SSI claim from the Social Security Administration (SSA) for the period for which the recipient received Safety Net Assistance and/or any other payments furnished with State and local funds for the recipient's basic needs. This notice also includes the calculation of interim assistance due to the district and possibly a balance due to the recipient.

## III. Revisions to the Notice

The following are the 5/05 revisions that have been made to this notice:

### A. Front:

1. The revision date has been changed to 5/05.
2. The language in the first paragraph – fifth line, was changed from "eligible for SSI benefits" to "payment of SSI benefits".
3. The language in the second paragraph - fourth line, was changed from "eligible for SSI benefits" to "payment of SSI benefits".

### B. Reverse:

Revision date has been changed to 5/05

## III. Forms Ordering Information

We expect that the above referenced LDSS-2425 (Rev.5/05) will be printed and delivered to the Albany warehouse by the end of September 2005.

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

When the revised notices are received by local districts, they **must immediately destroy** previous versions and replace them with the newly revised form.

Additionally, for local district staff, an electronic PDF version of the above referenced notice can be accessed on the OTDA Intranet website at [http://otda.state.nyenet/otda/ldss\\_eforms/default.htm](http://otda.state.nyenet/otda/ldss_eforms/default.htm) .

The Spanish version of this notice, LDSS-2425-SP (Rev.5/05), will not be printed, but will be available for local districts as a camera ready master copy for reproduction. Local districts will also be able to download this form from the NYS OTDA intranet site at [http://otda.state.nyenet/otda/ldss\\_eforms/default.htm](http://otda.state.nyenet/otda/ldss_eforms/default.htm).

Any future requests for printed copies of the revised LDSS-2425 (Rev.5/05) or a Spanish camera-ready master copy (LDSS-2425-SP) should be submitted on OTDA-876 (Rev.6/98): "Request for Forms or Publications" form, and should be sent to:

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

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

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

**ATTACHMENT 1**

**Filing References**

<b>Previous ADMs/INFs</b>	<b>Releases Cancelled</b>	<b>Dept. Regs.</b>	<b>Soc. Serv. Law &amp; Other Legal Ref.</b>	<b>Manual Ref.</b>	<b>Misc. Ref</b>
89 ADM – 21		350.5,351.22	SSL 22		
89 ADM - 8		351.23	SSL 366-a		
89 ADM – 6		352.31(d)			
88 ADM – 4		355,358-3.3,			
87 ADM – 4		359,360-2.4,			
86 ADM – 7		2.5,2.6,6.4			
85 ADM - 45		7.5			
85 ADM – 17		369.6			
82 ADM – 55		387.19			
80 ADM – 90		387.20			
93 INF – 45		505.14(b)(5)			
92 INF – 46		(v),(viii),			
92 INF – 34		(x)			
90 INF – 57		385.3			
89 INF – 53		385.14			
88 INF – 83					
88 INF-28					

### REPAYMENT OF INTERIM ASSISTANCE NOTICE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS				
<div style="border: 1px solid black; width: 100%; height: 100%; display: flex; justify-content: space-between; align-items: center;"> <span style="font-size: 2em;">[</span> <span style="font-size: 2em;">]</span> </div>		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ <hr style="border-top: 1px dashed black;"/> <b>OR</b> Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

Dear Sir/Madam:

- In accordance with your authorization, the Commissioner of the Social Security Administration has sent your retroactive Supplemental Security Income (SSI) payment to this Department. This payment includes benefits for a period during which you received Safety Net Assistance and other payments furnished to you with State and local funds for your basic needs. We have deducted the amount of Safety Net Assistance and other payments furnished to you with State and local funds for your basic needs beginning with the date you became eligible for payment of SSI benefits (or were reinstated after a period of suspension or termination) and ending in the month we received your initial SSI payment or the following month if your Safety Net Assistance and other payments furnished to you with State and local funds for your basic needs payments could not be stopped soon enough.
- The Commissioner of the SSA has sent this Office a portion of your initial SSI payment to repay benefits paid to you by this office. The repayment of benefits is for a period during which you received Safety Net Assistance and other payment furnished to you with State and local funds for your basic needs. The repayment period begins with the date you became eligible for payment of SSI benefits (or were reinstated after a period of suspension or termination) and ends in the month we received your repayment from SSA, or the following month if your Safety Net Assistance and other payments furnished to you could not be stopped soon enough. The SSA has deducted the amount of this payment from your initial SSI payment and sent it directly to this Office. The SSA will distribute to you any balance from your initial SSI payment you are due.

The REGULATION that allows us to do this is 18 NYCRR Part 353.

The amount of public assistance received during this period is shown below.

Safety Net Assistance and Other Payments furnished for basic needs calculation

MONTH	20	20	20	20	20	<b>TOTAL Interim Assistance</b>	
January							\$
February							
March							
April							
May							
June							
July							
August							
September							
October							
November							
December							
<b>TOTAL</b>	\$	\$	\$	\$	\$		

Our Calculations show that:

- There is no balance due you from this agency       There is a balance due you from this agency of \$ \_\_\_\_\_

Remarks:

I certify that the above is a true statement of receipts and disbursements under our agreement with the Commissioner of the Social Security Administration for the purpose of furnishing interim assistance to individuals as established in Section 1631(g) of the Social Security Act ( 42 U.S. Code 1383[g] )

\_\_\_\_\_  
Worker's Signature

\_\_\_\_\_  
Title

Amount of SSI Check	\$	Date of Initial SSI Eligibility	
Less: Amount of Safety Net Assistance benefits and other payments for basic needs.	\$	Date of SSI Check	
Refund Due	\$	Date SSI Check Received By Department of Social Services	
<b>TOTAL AMOUNT RECOVERED BY AGENCY</b>	<b>\$</b>	Date Reimbursement Check Sent To You	

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION  
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

Enclosure

DISTRIBUTION: White – CLIENT/FAIR HEARING COPY

Yellow – CLIENT COPY

Pink – AGENCY COPY

NAME:	ADDRESS:	CASE NUMBER:
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**CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?**

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

1. Ask for a meeting (conference) with one of our supervisors;
  2. Ask for a State fair hearing with a State hearing officer.
1. **CONFERENCE** (Informal meeting with us) If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.
  2. **STATE FAIR HEARING** – You have 60 days from the date of this notice to ask for a fair hearing:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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