



**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-23
<b>To:</b>	Local District Commissioners
<b>Issuing Division/Office:</b>	Division of Employment and Transitional Supports
<b>Date:</b>	November 9, 2005
<b>Subject:</b>	9/05 Revisions of LDSS-4682, LDSS-4682 NYC, LDSS-4799, LDSS-4799 NYC, LDSS-4827 and LDSS-4827 NYC
<b>Suggested Distribution:</b>	Temporary Assistance 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 Temporary Assistance Bureau - (518) 474-9344 HEAP Bureau- (518) 473-0332 Metro Region - (212) 961-8207 Medicaid Local District Liaison - Upstate: (518) 474-8887 NYC: (212) 417-4500 WMS Questions: (518) 474-8749
<b>Attachments:</b>	Attachments: LDSS-4682: "Notification of Overpayment of Public Assistance to a Former Recipient and Demand For Repayment" (Rev.9/05), LDSS-4682 NYC: "Notification of Overpayment of Public Assistance to a Former Recipient and Demand For Repayment" (Rev.9/05) (NYC), LDSS-4799: "Intentional Program Violation (IPV) Disqualification Notice For the Food Stamp Benefits (FS) Program" (Rev.9/05), LDSS-4799 NYC: "Intentional Program Violation (IPV) Disqualification Notice For the Food Stamp Benefits (FS) Program" (Rev.9/05) (NYC), LDSS-4827: "Intentional Program Violation (IPV) Disqualification Notice for the Public Assistance Program" (Rev.9/05) LDSS-4827 NYC: "Intentional Program Violation Disqualification (IPV) Notice for the Public Assistance Program" (Rev.9/05) (NYC)
<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.
04 ADM-10 00 ADM-04 00 ADM-06 04 INF-26 03 INF-32		352.31 (d) (5) Part 358		TASB CHAPTER 22	GIS 03 TA/DC021

## Section 2

### I. Purpose:

The purpose of this release is to inform local districts that the following notices have been revised. (Copies attached)

- **LDSS-4682:** "Notification of Overpayment of Public Assistance to a Former Recipient and Demand For Repayment" (Rev.9/05) (Camera Ready Only),
- **LDSS-4682 NYC:** "Notification of Overpayment of Public Assistance to a Former Recipient and Demand For Repayment" (Rev.9/05) (NYC) (Camera Ready Only),
- **LDSS-4799:** "Intentional Program Violation (IPV) Disqualification Notice For the Food Stamp Benefits (FS) Program" (Rev.9/05) (Camera Ready Only),
- **LDSS-4799 NYC:** "Intentional Program Violation (IPV) Disqualification Notice For the Food Stamp Benefits (FS) Program" (Rev.9/05) (NYC) (Camera Ready Only),
- **LDSS-4827:** "Intentional Program Violation (IPV) Disqualification Notice for the Public Assistance Program" (Rev.9/05), (Camera Ready Only)
- **LDSS-4827 NYC:** "Intentional Program Violation (IPV) Disqualification Notice for the Public Assistance Program" (Rev.9/05) (NYC), (Camera Ready Only).

### II. Background:

As a result of a Stipulation of Settlement in the **Matter of Rivera v. Bane**, dated February 18, 2005 and "so ordered" on February 22, 2005, the requirement for NYC/HRA to provide the hearing packet and specifically identified documents within three days of a request ended. Therefore, the 2nd paragraphs in the "Access to Your File and Copies of Documents" sections on the NYC versions have been modified to reflect one statewide timeframe. Even though this change only affects the NYC versions of the notices, we have updated the Upstate versions for consistency purposes.

### III. Revisions:

**LDSS-4682:** "Notification of Overpayment of Public Assistance to a Former Recipient and Demand For Repayment" (Rev.9/05) (Camera Ready Only)

#### Front

The revision date has been changed to 9/05.

**Reverse**

**A.** The revision date has been changed to 9/05.

**B.** The second sentence at the top of the page was changed to:

If we made a mistake, we will correct it.

**LDSS-4682 NYC:** "Notification of Overpayment of Public Assistance to a Former Recipient and Demand For Repayment" (Rev.9/05) (NYC) (Camera Ready Only)

**Front**

The revision date has been changed to 9/05.

**Reverse**

**A.** The revision date has been changed to 9/05.

**B.** The second sentence at the top of the page was changed to:

If we made a mistake, we will correct it.

**C.** The second paragraph in the "Access to Your File and Copies of Documents" was changed to read:

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

**LDSS-4799:** "Intentional Program Violation (IPV) Disqualification Notice For the Food Stamp Benefits (FS) Program" (Rev.9/05) (Camera Ready Only)

**Front**

The revision date has been changed to 9/05.

**Reverse**

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If we made a mistake, we will correct it.

**LDSS-4799 NYC:** "Intentional Program Violation (IPV) Disqualification Notice For the Food Stamp Benefits (FS) Program" (Rev.9/05) (NYC) (Camera Ready Only)

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A. The revision date has been changed to 9/05.

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If we made a mistake, we will correct it.

C. The second paragraph in the “Access to Your File and Copies of Documents” was changed to read:

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

**LDSS-4827: “Intentional Program Violation (IPV) Disqualification Notice For The Public Assistance Program” (Rev.9/05) (Camera Ready Only)**

**Front**

A. The revision date has been changed to 9/05.

B. A new “VI. Effect on Your Medical Assistance Benefits” section was added that reads as follows:

**VI. Effect On Your Medical Assistance Benefits**

- ☐ You do not receive Medical Assistance.
- ☐ Your Medical Assistance will continue unchanged.
- ☐ Your Medical Assistance is discontinued for the same reason your Public Assistance is discontinued.
- ☐ Your Medical Assistance will continue pending a separate Medical Assistance eligibility determination.

This decision is based on Section 366(1) (a) of the Social Services Law.

**Reverse**

A. The revision date has been changed to 9/05.

B. The second sentence at the top of the page was changed to:

If we made a mistake, we will correct it.

**LDSS-4827 NYC: “Intentional Program Violation (IPV) Disqualification Notice For The Public Assistance Program” (Rev.9/05) (NYC) (Camera Ready Only)**

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A. The revision date has been changed to 9/05.

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## **VI. Effect On Your Medical Assistance Benefits**

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- ☐ Your Medical Assistance is discontinued for the same reason your Public Assistance is discontinued.
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This decision is based on Section 366(1) (a) of the Social Services Law.

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C. The second paragraph in the “Access to Your File and Copies of Documents” was changed to read:

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.

## **IV. Forms Ordering Information**

- The revised 9/05 versions of the LDSS-4682, LDSS-4682 NYC, LDSS-4799, LDSS-4799 NYC, LDSS-4827 and LDSS-4827 NYC (Camera Ready Copies) can be requested at any time. The Spanish Camera Ready Copies of these forms (LDSS-4682-SP, LDSS-4682-SP NYC, LDSS-4799-SP, LDSS-4799-SP NYC, LDSS-4827-SP and LDSS-4827-SP NYC) have also been revised. Upon receipt of any revised Camera Ready Copies, all previous versions of the forms should be destroyed.
- Any future written requests for Camera Ready Copies of the 9/05 versions of the LDSS-4682, LDSS-4682 NYC, LDSS-4799, LDSS-4799 NYC, LDSS-4827 and LDSS-4827 NYC or the Spanish versions, should be submitted on OTDA-876 “Request For Forms or Publications”, and should be sent to:

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

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

- Camera Ready Copies of the documents may also be ordered through Outlook. To order a Camera Ready Copy you must obtain an OTDA-876 electronically by going to the OTDA

Intranet Website at <http://otda.state.ny.net/> then to Division of Program Support & Quality Improvement page, then to PSQI E-Forms page (this page contains the electronic OTDA-876).

- For those who do not have Outlook but who have Internet access for sending and receiving email, the Internet email address is: [gg7359@dfa.state.ny.us](mailto:gg7359@dfa.state.ny.us). For a complete list of available forms, please refer to OTDA Intranet site: [http://otda.state.ny.net/ldss\\_eforms/default.htm](http://otda.state.ny.net/ldss_eforms/default.htm).

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

NOTIFICATION OF OVERPAYMENT OF PUBLIC ASSISTANCE  
TO A FORMER RECIPIENT AND DEMAND FOR REPAYMENT

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

SECTION I – PUBLIC ASSISTANCE

This is to tell you about an overpayment that occurred when your Public Assistance case was active. The time period during which the overpayment occurred was from \_\_\_\_\_ to \_\_\_\_\_.

The amount of the overpayment is: \_\_\_\_\_.

The reason(s) for the overpayment is: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

THE LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 352.31(d)(5).

SECTION II – METHOD OF PAYMENT

You must repay the entire amount of the overpayment all at once, or in installments. Please return this agreement to let us know about the repayment method that you choose by \_\_\_\_\_.

Make sure you sign and date this agreement below, before you return it.

1. ☐ EBT Cash Account – Please take:
- ☐ Everything in my EBT Cash Account, up to the amount of my overpayment(s).
- ☐ \$ \_\_\_\_\_ from my EBT Cash Account, up to the amount of my overpayment(s).

I understand that if there is not enough in my EBT Cash Account to pay all my overpayment(s),  
I must also check another box below for other ways to repay.

If you choose to pay in installments, please check the installment method you wish to use:

2. ☐ All at once
3. ☐ Part now, the rest in monthly payments
4. ☐ Monthly payments

I agree to repay by this method.

Your Address (if different than above): \_\_\_\_\_

Your Phone Number or Where We Can Reach You ( \_\_\_\_\_ ) \_\_\_\_\_.

Signature\_\_\_\_\_ Date \_\_\_\_\_

- We will contact you to discuss the repayment method you have chosen and give you a written statement showing how much you will be repaying (and how long your payments will continue should you choose to repay through monthly payments).

If you do not appeal this decision or if you fail to respond to this notice to repay or you do not repay this debt either all at once, or by monthly payments, the social services district may refer the debt for collection in a number of ways including, but not limited to, automated collection from your tax refund.

IF YOU NEED HELP IN COMPLETING THIS AGREEMENT, PLEASE CALL US AT THE TELEPHONE NUMBER ABOVE.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION.

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

Accounting Use Only – Cash Repayment 02

Date Entered on Admin. Screen \_\_\_\_/\_\_\_\_/\_\_\_\_ Transaction Amount \$ \_\_\_\_\_.\_\_\_\_\_

Entered by: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME:	ADDRESS:	FORMER 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. If we made a mistake, we will correct it.

You can do both 1 and 2:

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

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

If you ask for a conference, you are still entitled to a fair hearing. **Even if you ask for a conference, you still have only 60 days from the date of this notice to request a fair hearing. HOWEVER, IF YOU WANT TO PREVENT COLLECTION OF THIS DEBT UNTIL YOU HAVE HAD A FAIR HEARING, YOU MUST REQUEST A FAIR HEARING WITHIN TEN DAYS FROM THE DATE OF THIS NOTICE. Read below for fair hearing information.**

2. **STATE FAIR HEARING** – You have 60 days from the date of this notice to ask for a fair hearing:

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

**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 of each notice for yourself.

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

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

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

**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>.

**TO PREVENT POSSIBLE COLLECTION ACTIVITIES UNTIL AFTER A FAIR HEARING HAS BEEN HELD: You must call for a fair hearing within ten days of the date of this notice.** You may request a fair hearing up to 60 days from the date of this notice but if you make your request later than ten days after the date of this notice, you may not be able to delay collection until the fair hearing decision is issued.

**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.



NOTIFICATION OF OVERPAYMENT OF PUBLIC ASSISTANCE  
TO A FORMER RECIPIENT AND DEMAND FOR REPAYMENT (NYC)

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

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The amount of the overpayment is: \_\_\_\_\_.

The reason(s) for the overpayment is: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

THE LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 352.31(d)(5). (DELETED LINE THAT WAS HERE)

SECTION II – METHOD OF PAYMENT

You must repay the entire amount of the overpayment all at once, or in installments. Please return this agreement to let us know about the repayment method that you choose by\_\_\_\_\_.

Make sure you sign and date this agreement below, before you return it.

1. ☐ EBT Cash Account – Please take:
- ☐ Everything in my EBT Cash Account, up to the amount of my overpayment(s).
- ☐ \$ \_\_\_\_\_ from my EBT Cash Account, up to the amount of my overpayment(s).

I understand that if there is not enough in my EBT Cash Account to pay all my overpayment(s),  
I must also check another box below for other ways to repay.

If you choose to pay in installments, please check the installment method you wish to use:

2. ☐ All at once
3. ☐ Part now, the rest in monthly payments
4. ☐ Monthly payments

I agree to repay by this method.

Your Address (if different than above): \_\_\_\_\_

Your Phone Number **or** Where We Can Reach You ( \_\_\_\_\_ ) \_\_\_\_\_.

Signature\_\_\_\_\_ Date \_\_\_\_\_

- We will contact you to discuss the repayment method you have chosen and give you a written statement showing how much you will be repaying (and how long your payments will continue should you choose to repay through monthly payments).

If you do not appeal this decision or if you fail to respond to this notice to repay or you do not repay this debt either all at once, or by monthly payments, the social services district may refer the debt for collection in a number of ways including, but not limited to, automated collection from your tax refund.

IF YOU NEED HELP IN COMPLETING THIS AGREEMENT, PLEASE CALL US AT THE TELEPHONE NUMBER ABOVE.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION.

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

Accounting Use Only – Cash Repayment 02

Date Entered on Admin. Screen \_\_\_\_/\_\_\_\_/\_\_\_\_ Transaction Amount \$ \_\_\_\_,\_\_\_\_.\_\_\_\_

Entered by: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME:	ADDRESS:	FORMER 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. If we made a mistake, we will correct it. You can do both 1 and 2:

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

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

If you ask for a conference, you are still entitled to a fair hearing. **Even if you ask for a conference, you still have only 60 days from the date of this notice to request a fair hearing. HOWEVER, IF YOU WANT TO PREVENT COLLECTION OF THIS DEBT UNTIL YOU HAVE HAD A FAIR HEARING, YOU MUST REQUEST A FAIR HEARING WITHIN TEN DAYS FROM THE DATE OF THIS NOTICE. Read below for fair hearing information.**

2. **STATE FAIR HEARING** – You have 60 days from the date of this notice to ask for a fair hearing:

If you do not agree that you owe this overpayment you MUST call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency’s decision that you owe the debt was wrong.

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

**Mail:** Send a copy of 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**.

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

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

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

**TO PREVENT POSSIBLE COLLECTION ACTIVITIES UNTIL AFTER A FAIR HEARING HAS BEEN HELD:** You must call for a fair hearing within ten days of the date of this notice. You may request a fair hearing up to 60 days from the date of this notice but if you make your request later than ten days after the date of this notice, you may not be able to delay collection until the fair hearing decision is issued.

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

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

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

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

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

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

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

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

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

INTENTIONAL PROGRAM VIOLATION (IPV)  
DISQUALIFICATION NOTICE FOR THE FOOD STAMP BENEFITS (FS) PROGRAM

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN/RID NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP		
		-----  <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.

This is to inform you and members of your family or household that you, \_\_\_\_\_, are disqualified from receiving FS, as explained below:

**I. Reason For Disqualification** - The reason for the disqualification is that you:

☐ Were determined to have committed a FS-IPV by an administrative disqualification hearing held on \_\_\_\_\_, which resulted in a decision dated \_\_\_\_\_.

☐ Waived rights to an administrative disqualification hearing by signing a waiver on \_\_\_\_\_.

☐ Were found guilty of a crime or offense by a court of law on \_\_\_\_\_ for committing a FS-IPV.

☐ Signed a disqualification consent agreement on \_\_\_\_\_.

The regulation that allows us to disqualify you is 18 NYCRR 359.9.

**II. Period of Disqualification** - You, the recipient named in this notice, are disqualified from receiving FS for the period(s) checked:

☐ For 12 months, because this is your first FS-IPV, and it is not a drug or firearms or explosives-related offense.

☐ For 24 months, because this is your:

☐ second FS-IPV that is not a drug or firearms or explosives-related offense

☐ first FS-IPV and it is based on a court finding of trafficking in controlled substances in exchange for FS.

☐ For 120 months, because you were found guilty about making a false statement about who you are or where you live in order to get multiple FS.

☐ **Permanently**, because this is your:

☐ third FS-IPV that is not a drug or firearms or explosives-related offense

☐ second FS-IPV and it is based on a court finding of trafficking in controlled substances in exchange for FS

☐ first FS-IPV and it is based on a court finding of trading in firearms, ammunition, or explosives in exchange for FS.

☐ first FS-IPV and it is based on a court finding of trafficking in FS worth \$500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of FS, authorization cards or access devices.

☐ For \_\_\_\_\_ months because this is the penalty ordered by the court. This is your \_\_\_\_\_ FS-IPV.

☐ This is your \_\_\_\_\_ FS-IPV. Normally, this means you cannot get FS for \_\_\_\_\_ months, but because we did not notify you in time:

☐ you will be disqualified for \_\_\_\_\_ months, beginning \_\_\_\_\_.

☐ you will not be disqualified.

☐ Other: \_\_\_\_\_

**III. Dates of Disqualification** - Your disqualification period will begin \_\_\_\_\_ and will end \_\_\_\_\_.

**IV. Revised FS Amount**

☐ Your household's monthly amount of FS will be reduced from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ for your disqualification period. In figuring the amount of FS your household will get, we do not count the disqualified person in the household, but we must count the disqualified person's income. You will **not** automatically be added back into the FS case when your disqualification period ends. To prevent a delay in getting FS again, you must contact us at the number above no later than 30 days before your disqualification period ends.

☐ Your FS will be discontinued, effective \_\_\_\_\_. Your FS case will **not** automatically be reopened when your disqualification period ends. To prevent a delay in getting FS again, you must reapply for FS no later than 30 days before your disqualification period ends.

**V. Amount of Overpayment and Overpayment Period** - Your household got \$\_\_\_\_\_ more in FS than it should have during \_\_\_\_\_ to \_\_\_\_\_.

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges. This decision is based on 31 CFR 285.

If you do not access your FS within 270 days, they will be expunged (taken back). If you have a FS overpayment, your expunged FS will be put towards your overpayment. If you apply for FS again, and have not repaid the amount you owe, your FS will be reduced if you begin to get FS again. You will be notified, at that time, of the amount of reduced FS you will get.

INTENTIONAL PROGRAM VIOLATION (IPV)  
DISQUALIFICATION NOTICE FOR THE FOOD STAMP BENEFITS (FS) PROGRAM

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. If we made a mistake, we will correct it.  
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 or any members of your family or household may request a fair hearing ONLY to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined. (2) the amount of the FS allotment to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration.

You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

You have **90** days from the date of this notice to ask for a fair hearing.

If this notice is telling you that you got too much in Food Stamp Benefits and that you must pay them back and you do not agree, you **must** call for a fair hearing within 90 days of the date of this notice. If you do not call for a fair hearing within 90 days of the date of this notice, you cannot claim in the future that the agency’s decision that you owe the debt was wrong.

**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 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.

INTENTIONAL PROGRAM VIOLATION (IPV)  
DISQUALIFICATION NOTICE FOR THE FOOD STAMP BENEFITS (FS) PROGRAM (NYC)

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

This is to inform you and members of your family or household that you, \_\_\_\_\_, are disqualified from receiving FS, as explained below:

**I. Reason For Disqualification** - The reason for the disqualification is that you:

☐ Were determined to have committed a FS-IPV by an administrative disqualification hearing held on \_\_\_\_\_, which resulted in a decision dated \_\_\_\_\_.

☐ Waived rights to an administrative disqualification hearing by signing a waiver on \_\_\_\_\_.

☐ Were found guilty of a crime or offense by a court of law on \_\_\_\_\_ for committing a FS-IPV.

☐ Signed a disqualification consent agreement on \_\_\_\_\_.

The regulation that allows us to disqualify you is 18 NYCRR 359.9.

**II. Period of Disqualification** - You, the recipient named in this notice, are disqualified from receiving FS for the period(s) checked:

☐ For 12 months, because this is your first FS-IPV, and it is not a drug or firearms or explosives-related offense.

☐ For 24 months, because this is your:

☐ second FS-IPV that is not a drug or firearms or explosives-related offense

☐ first FS-IPV and it is based on a court finding of trafficking in controlled substances in exchange for FS.

☐ For 120 months, because you were found guilty about making a false statement about who you are or where you live in order to get multiple FS.

☐ **Permanently**, because this is your:

☐ third FS-IPV that is not a drug or firearms or explosives-related offense

☐ second FS-IPV and it is based on a court finding of trafficking in controlled substances in exchange for FS

☐ first FS-IPV and it is based on a court finding of trading in firearms, ammunition, or explosives in exchange for FS.

☐ first FS-IPV and it is based on a court finding of trafficking in FS worth \$500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of FS, authorization cards or access devices.

☐ For \_\_\_\_\_ months because this is the penalty ordered by the court. This is your \_\_\_\_\_ FS-IPV.

☐ This is your \_\_\_\_\_ FS-IPV. Normally, this means you cannot get FS for \_\_\_\_\_ months, but because we did not notify you in time:

☐ you will be disqualified for \_\_\_\_\_ months, beginning \_\_\_\_\_.

☐ you will not be disqualified.

☐ Other: \_\_\_\_\_

**III. Dates of Disqualification** - Your disqualification period will begin \_\_\_\_\_ and will end \_\_\_\_\_.

**IV. Revised FS Amount**

☐ Your household's monthly amount of FS will be reduced from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ for your disqualification period. In figuring the amount of FS your household will get, we do not count the disqualified person in the household, but we must count the disqualified person's income. You will **not** automatically be added back into the FS case when your disqualification period ends. To prevent a delay in getting FS again, you must contact us at the number above no later than 30 days before your disqualification period ends.

☐ Your FS will be discontinued, effective \_\_\_\_\_. Your FS case will **not** automatically be reopened when your disqualification period ends. To prevent a delay in getting FS again, you must reapply for FS no later than 30 days before your disqualification period ends.

**V. Amount of Overpayment and Overpayment Period** - Your household got \$ \_\_\_\_\_ more in FS than it should have during \_\_\_\_\_ to \_\_\_\_\_.

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges. This decision is based on 31 CFR 285.

If you do not access your FS within 270 days, they will be expunged (taken back). If you have a FS overpayment, your expunged FS will be put towards your overpayment. If you apply for FS again, and have not repaid the amount you owe, your FS will be reduced if you begin to get FS again. You will be notified, at that time, of the amount of reduced FS you will get.

INTENTIONAL PROGRAM VIOLATION (IPV)  
DISQUALIFICATION NOTICE FOR THE FOOD STAMP BENEFITS (FS) PROGRAM (NYC)

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. If we made a mistake, we will correct it.  
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 or any members of your family or household may request a fair hearing ONLY to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined. (2) the amount of the FS allotment to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration.

You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

You have **90** days from the date of this notice to ask for a fair hearing.

If this notice is telling you that you got too much in Food Stamp Benefits and that you must pay them back and you do not agree, you **must** call for a fair hearing within 90 days of the date of this notice. If you do not call for a fair hearing within 90 days of the date of this notice, you cannot claim in the future that the agency’s decision that you owe the debt was wrong.

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

**Mail:** Send a copy of the entire notice 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 back of this notice to: **(518) 473-6735**.

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

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

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

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

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

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

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

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

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

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

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

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

INTENTIONAL PROGRAM VIOLATION  
DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

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

This is to inform you and members of your family, household or other assistance unit that you, \_\_\_\_\_ , are disqualified from receiving the benefits for the time stated in Section II.

I. Reason For Disqualification

The reason for the disqualification is that you:

- ☐ were determined to have committed an Intentional Program Violation. This was determined by an administrative disqualification hearing held on \_\_\_\_\_ , which resulted in a decision dated \_\_\_\_\_ .
- ☐ waived rights to an administrative disqualification hearing by signing a Waiver on \_\_\_\_\_ .
- ☐ were found guilty of a crime or offense by a court of law on \_\_\_\_\_ for committing an Intentional Program Violation.
- ☐ signed a disqualification consent agreement on \_\_\_\_\_ and this agreement:

☐ did not need to be confirmed by a court.

☐ was confirmed by a court on \_\_\_\_\_ .

The regulation which allows us to disqualify you is 18 NYCRR 359.9.

II. Disqualification Period(s)

You, the recipient named in this notice, are disqualified from receiving Public Assistance for the period(s) checked:

- ☐ for 6 months because this is the first time that you committed a Public Assistance-IPV and you wrongfully received an amount less than \$1,000.
- ☐ for 12 months because this is the second time that you committed a Public Assistance-IPV, or you wrongfully received between \$1,000 and \$3,900.
- ☐ for 18 months because this is the third time that you committed a Public Assistance-IPV, or you wrongfully received over \$3,900.
- ☐ for 5 years because you have committed three or more previous Public Assistance-IPV's.
- ☐ for \_\_\_\_\_ months because this is the penalty ordered by the court. This is the \_\_\_\_\_ time that you committed a Public Assistance-IPV.

**NOTE:** Your eligibility for other assistance programs, such as Medical Assistance, Child Care Assistance, Emergency Assistance or other Social Services Assistance or Services, may be affected if you must be eligible for Public Assistance in order to receive the particular assistance or for services.

III. When does the disqualification begin and end?

- ☐ Your disqualification will begin \_\_\_\_\_ and will end \_\_\_\_\_ .

Your case will **not** automatically be reopened when the disqualification period ends. To prevent a delay in getting Public Assistance again, you must contact your Social Services District no later than 30 days before the disqualification period ends if you want to reapply for Public Assistance.
- ☐ You are not receiving benefits under Public Assistance. You will be subject to the above disqualification penalties if you apply for and are found eligible for assistance or benefits for these programs in the future.

IV. Revised Benefit Levels and Recoupment/Repayment Information

How much Public Assistance will the remaining members of your Public Assistance unit get?

- ☐ Your Public Assistance will be discontinued as noted in Section II.
- ☐ Your household's Public Assistance will be reduced from \$ \_\_\_\_\_ to \$ \_\_\_\_\_. The reduction will begin as noted in Section II. (We do not count the disqualified person in the Public Assistance household, but we must count that person's income.)

Public Assistance Repayment

The amount of the Public Assistance overpayment made to your household is \$ \_\_\_\_\_ .

- ☐ The amount of the Public Assistance owed by your household is \$ \_\_\_\_\_. (This is different from \$ \_\_\_\_\_ because you have already repaid \$ \_\_\_\_\_ ) .
- ☐ A recoupment at the rate of \_\_\_\_\_ percent (%) is being taken against the grant of the remaining household members. If you believe that this reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase general incidentals, or to pay for extraordinary medical needs that are not covered by Medical Assistance. Your worker will let you know what kind of evidence you will need to support your hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction of between 5 and 10 percent (%).

☐ The recoupment is for the recovery of the overpayment that resulted from the IPV.

☐ The recoupment is to repay a previous overpayment. The overpayment that resulted from this IPV will be recouped when the previous overpayment(s) has been recouped.

The regulation which allows us to do this is 18 NYCRR 352.31(d).

- ☐ You are not currently receiving assistance, but you will be responsible to repay the overpayment.

The regulation which allow us to do this is 18 NYCRR 359.9(f).

V. Effect On Your Food Stamp Benefits

- ☐ You do not receive Food Stamp Benefits.
- ☐ Your Food Stamp Benefits will continue unchanged.
- ☐ You will receive a separate notice about your Food Stamp Benefits.

VI. Effect On Your Medical Assistance Benefits

- ☐ You do not receive Medical Assistance.
- ☐ Your Medical Assistance will continue unchanged.
- ☐ Your Medical Assistance is discontinued for the same reason your Public Assistance is discontinued.
- ☐ Your Medical Assistance will continue pending a separate Medical Assistance eligibility determination.

This decision is based on Section 366(1) (a) of the Social Services Law.



INTENTIONAL PROGRAM VIOLATION  
DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

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. If we made a mistake, we will correct it.  
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 or any members of your family or household may request a fair hearing ONLY to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined, (2) the amount of the Public Assistance benefits to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration

You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

You have **60** days from the date of this notice to ask for a fair hearing.

If this notice is telling you that you got too much in Public Assistance benefits and that you must pay them back and you do not agree, you must, call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt is wrong.

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

**Writing:** Send a copy of 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 of each notice for yourself.

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

**Phoning:** (800) 342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.) If you cannot reach the State by phone, please write to ask for a fair hearing before the deadline.

**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>.

**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.



INTENTIONAL PROGRAM VIOLATION  
DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

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

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.
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This is to inform you and members of your family, household or other assistance unit that you, \_\_\_\_\_, are disqualified from receiving the benefits for the time stated in Section II.

I. Reason For Disqualification

The reason for the disqualification is that you:

☐ were determined to have committed an Intentional Program Violation. This was determined by an administrative disqualification hearing held on \_\_\_\_\_, which resulted in a decision dated \_\_\_\_\_.

☐ waived rights to an administrative disqualification hearing by signing a Waiver on \_\_\_\_\_.

☐ were found guilty of a crime or offense by a court of law on \_\_\_\_\_ for committing an Intentional Program Violation.

☐ signed a disqualification consent agreement on \_\_\_\_\_ and this agreement:

☐ did not need to be confirmed by a court.

☐ was confirmed by a court on \_\_\_\_\_.

The regulation which allows us to disqualify you is 18 NYCRR 359.9.

II. Disqualification Period(s)

You, the recipient named in this notice, are disqualified from receiving Public Assistance for the period(s) checked:

☐ for 6 months because this is the first time that you committed a Public Assistance-IPV and you wrongfully received an amount less than \$1,000.

☐ for 12 months because this is the second time that you committed a Public Assistance-IPV, or you wrongfully received between \$1,000 and \$3,900.

☐ for 18 months because this is the third time that you committed a Public Assistance-IPV, or you wrongfully received over \$3,900.

☐ for 5 years because you have committed three or more previous Public Assistance-IPV's.

☐ for \_\_\_\_\_ months because this is the penalty ordered by the court. This is the \_\_\_\_\_ time that you committed a Public Assistance-IPV.

**NOTE:** Your eligibility for other assistance programs, such as Medical Assistance, Child Care Assistance, Emergency Assistance or other Social Services Assistance or Services, may be affected if you must be eligible for Public Assistance in order to receive the particular assistance or for services.

III. When does the disqualification begin and end?

☐ Your disqualification will begin \_\_\_\_\_ and will end \_\_\_\_\_.

Your case will **not** automatically be reopened when the disqualification period ends. To prevent a delay in getting Public Assistance again, you must contact your Social Services District no later than 30 days before the disqualification period ends if you want to reapply for Public Assistance.

☐ You are not receiving benefits under Public Assistance. You will be subject to the above disqualification penalties if you apply for and are found eligible for assistance or benefits for these programs in the future.

IV. Revised Benefit Levels and Recoupment/Repayment Information

**How much Public Assistance will the remaining members of your Public Assistance unit get?**

☐ Your Public Assistance will be discontinued as noted in Section II.

☐ Your household's Public Assistance will be reduced from \$ \_\_\_\_\_ to \$ \_\_\_\_\_. The reduction will begin as noted in Section II. (We do not count the disqualified person in the Public Assistance household, but we must count that person's income.)

Public Assistance Repayment

The amount of the Public Assistance overpayment made to your household is \$ \_\_\_\_\_.

☐ The amount of the Public Assistance owed by your household is \$ \_\_\_\_\_. (This is different from \$ \_\_\_\_\_ because you have already repaid \$ \_\_\_\_\_).

☐ A recoupment at the rate of \_\_\_\_\_ percent (%) is being taken against the grant of the remaining household members. If you believe that this reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase general incidentals, or to pay for extraordinary medical needs that are not covered by Medical Assistance. Your worker will let you know what kind of evidence you will need to support your hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction of between 5 and 10 percent (%).

☐ The recoupment is for the recovery of the overpayment that resulted from the IPV.

☐ The recoupment is to repay a previous overpayment. The overpayment that resulted from this IPV will be recouped when the previous overpayment(s) has been recouped.

The regulation which allows us to do this is 18 NYCRR 352.31(d).

☐ You are not currently receiving assistance, but you will be responsible to repay the overpayment.

The regulation which allow us to do this is 18 NYCRR 359.9(f).

V. Effect On Your Food Stamp Benefits

☐ You do not receive Food Stamp Benefits.

☐ Your Food Stamp Benefits will continue unchanged.

☐ You will receive a separate notice about your Food Stamp Benefits.

VI. Effect On Your Medical Assistance Benefits

☐ You do not receive Medical Assistance.

☐ Your Medical Assistance will continue unchanged.

☐ Your Medical Assistance is discontinued for the same reason your Public Assistance is discontinued.

☐ Your Medical Assistance will continue pending a separate Medical Assistance eligibility determination.

This decision is based on Section 366(1) (a) of the Social Services Law.

INTENTIONAL PROGRAM VIOLATION  
DISQUALIFICATION NOTICE FOR THE PUBLIC ASSISTANCE PROGRAM

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. If we made a mistake, we will correct it.

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 or any members of your family or household may request a fair hearing **ONLY** to review (1) the amount of an overpayment or overissuance, but only if the amount was not determined when your disqualification was determined, (2) the amount of the Public Assistance benefits to be provided to the remaining members of your family or household during the disqualification period and (3) the failure to restore you to the household at the end of the disqualification period after you request such restoration

You or members of your family or household do not have a right to a fair hearing to review the fact that you have been disqualified.

You may contest this action in an appropriate court of law pursuant to Article 78 of the New York Civil Practice Law and Rules (CPLR).

You have **60** days from the date of this notice to ask for a fair hearing.

If this notice is telling you that you got too much in Public Assistance benefits and that you must pay them back and you do not agree, you must, call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency’s decision that you owe the debt is wrong.

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

**Mail:** Send a copy of 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.

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

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

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

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

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

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

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

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

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

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

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

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