

NOTICE OF INTENT TO CHANGE BENEFITS - PART A

PUBLIC ASSISTANCE GRANT AND/OR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS FOR NONCOMPLIANCE WITH WORK REQUIREMENTS (TIMELY AND ADEQUATE) AND NOTICE OF EFFECT ON MEDICAID BENEFITS

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

This **NOTICE** is to tell you that this agency intends to **CHANGE** your household's benefits as explained below and on PART B.
See PART B for SUPPLEMENTAL NUTRITION ASSISTANCE (SNAP) INFORMATION.

ATTENTION: 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 FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION (ON THE BACK OF THIS NOTICE) TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

PUBLIC ASSISTANCE

- REDUCE your public assistance grant from \$ _____ to \$ _____ effective _____ until _____ (the sanctioned person) complies with work requirements assigned by this agency or documents an exemption from public assistance work requirements. _____ (the sanctioned person) should contact the worker noted above when he/she is willing to comply with public assistance work requirements. The worker will explain what he/she needs to do in order to comply with public assistance work requirements.
- REDUCE your public assistance grant effective _____ from \$ _____ to \$ _____ for _____ days and until _____ (the sanctioned person) complies with work requirements to which he/she gets assigned or documents an exemption from public assistance work requirements. _____ (the sanctioned person) should contact the worker noted above when he/she is willing to comply with public assistance work requirements. The worker will explain what he/she needs to do in order to comply with public assistance work requirements.
- DISCONTINUE your public assistance grant effective _____ for _____ days and until the sanctioned person complies with public assistance work requirements as assigned by this agency. You have the right to reapply for public assistance at anytime, but we strongly recommend that you reapply on or before _____ to ensure timely processing of the new application. At that time, the sanctioned person must comply with assigned public assistance work requirements or document an exemption from public assistance work requirements to meet this eligibility requirement for assistance. You may reapply after this date but, if so, there may be delays in your getting full assistance.

Response to Conciliation (worker should select only one response below):

- The sanctioned individual did not respond within the required number of days identified in the conciliation letter that the sanctioned individual was sent or given.
- The sanctioned individual agreed to come to a meeting on or before _____ to discuss why he/she did not comply with the public assistance work requirement(s), but he/she did not show up.
- The sanctioned individual answered our conciliation letter and discussed with us his/her reason(s) for not completing the public assistance work requirement(s) noted below. We have decided that the sanctioned individual did not have a good reason for not complying with the public assistance work requirement(s) and that his/her actions were willful.

The REASON for this action is that after a review of your case, including any reasons _____ may have given us for not complying, it has been determined that beginning on _____ (date) _____ (the sanctioned person) willfully and without good cause failed or refused to: _____

The length of the sanction period provided above depends on whether or not your public assistance household includes a dependent child and the number of times an individual has been sanctioned in the past for failure to comply with public assistance work requirements. We have determined that your public assistance household _____ a dependent child. We have also determined that this is the _____ time(s) _____ (the sanctioned person) has been sanctioned for non-compliance with public assistance work requirements.

If you disagree with any determination as described in this letter, you have the right to request a conference and/or a review at a fair hearing. For additional information on how to ask for a conference and/or a fair hearing, please see the section of the letter titled "Conference and Fair Hearing Section".

The REGULATION that allows us to do this is 18 NYCRR 385.12.

MEDICAL ASSISTANCE

Your Medical Assistance coverage will continue unchanged.

The REGULATION that allows us to do this is 18 NYCRR 360-2.6.

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.

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

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

BENEFIT AREA	TIME LIMIT
Public Assistance	60 days
SNAP Benefits	90 days

KEEPING YOUR BENEFITS THE SAME: If you request a fair hearing before the effective date stated in this notice and our action affects your Public Assistance or SNAP Benefits, you will continue to receive your benefits unchanged until the fair hearing decision is issued.

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

I do not want to keep my benefits the same until the fair hearing decision is issued:

- Public Assistance SNAP Benefits

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.ny.gov/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, write or fax 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.