

**NOTICE OF ACTION ON YOUR APPLICATION/BENEFIT
FOR THE CHILD ASSISTANCE PROGRAM, STATUS OF MEDICAL ASSISTANCE,
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS AND SERVICES**

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|--|------------|--|---------------------|---------------|
| NOTICE DATE: | | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE | | |
| CASE NUMBER | CIN NUMBER | | | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | | | |
| <div style="border: 1px solid black; width: 100%; height: 100%; margin: 5px;"></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. |

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

SNAP BENEFITS NOT PICKED UP WITHIN 365 DAYS CANNOT BE REPLACED.

1. **INCREASE** your SNAP Benefits from \$_____ to \$_____ effective _____.
2. **CONTINUE** your SNAP Benefits unchanged at \$_____.
 You will continue to get the benefit above until _____. This is because you are eligible for Transitional SNAP Benefits. You are not required to report any changes until the end of this transition period. If you have changes during your transition period that may increase your benefits, you must contact your worker to file an early recertification application in order to receive any increase. Early recertifications that result in a benefit increase will end your transition period, otherwise, your transitional period and benefit will continue as described above.
3. **REDUCE** your SNAP Benefits from \$_____ to \$_____ effective _____.
4. **DISCONTINUE** your SNAP Benefits as of _____.
5. **OVERPAYMENT INFORMATION**
 We are establishing a SNAP overpayment because you or your household got more in SNAP Benefits than you should have. See the Demand Letter (and also, if your case is closing, the Repayment Agreement) for more information on this overpayment.
 You currently have a SNAP overpayment. If your case is closing, see the Demand Letter and Repayment Agreement for more information on the amount you owe and how you will repay this overpayment.
 The benefit above reflects a _____% reduction (recoupment) of \$_____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19.
6. You failed to meet recertification requirements for the Child Assistance Program but can still be recertified for SNAP Benefits. You will receive your monthly SNAP Benefit of \$_____ for ONLY one additional month. To have your SNAP Benefits continued, you must reapply. We will send you a separate notice telling you how to continue your SNAP Benefits.
7. If this box is checked, during your eligibility period you will get the following amounts, that are different than your regular monthly benefit, for the time periods listed below:

8. **OTHER:** _____

The reason for this action is: _____

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

Responsibility To Report Changes – See enclosed LDSS-3151: “SNAP Change Report Form” for information on when to report changes.

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

| | | |
|-------|----------|--------------|
| NAME: | ADDRESS: | CASE NUMBER: |
|-------|----------|--------------|

CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

If you think our decision is 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.

The Office of Temporary and Disability Assistance (OTDA) policy issuances and manuals are posted on the OTDA website at otda.ny.gov/legal. These issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. In addition, upon request to your local social services district, specific OTDA policy issuances and manuals will also be available to assist you or your representative.

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 |
|---|------------|
| Child Assistance Program, Medical Assistance, Social Services | 60 days |
| SNAP Benefits | 90 days |

KEEPING YOUR BENEFITS THE SAME: We will not change your Public Assistance, SNAP Benefits, Medical Assistance and Social Services benefits if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any Public Assistance and SNAP Benefits you got, but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

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:

- Child Assistance Program Medical Assistance SNAP Benefits Social Services

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 Part A and Part B 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.)

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 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.