Request for a Second-Level Desk Review of Pass-through Payment or Cumulative Excess Support Payment

Read the attached information and instructions before completing this form.

You can request a second-level desk review if you disagree with the First-Level Desk Review Determination. **Complete all sections of this form** and return to the New York State Office of Temporary and Disability Assistance within 20 business days of the date of the first-level determination.

Section A - Your Information

Name: _____ **SSN or ITIN:** _____

Current Mailing Address: _____

Telephone Number: _____

New York Case Identifier(s) *(Child Support Account Number[s]):* _____ _____ _____
(If more than one, please list all.)

Section B - Findings in Dispute and Attachments You Must Provide

I disagree with the First-Level Desk Review Determination because : *(attach additional sheets if necessary)*

You must attach a copy of the First-Level Desk Review Determination letter and any additional, but previously unavailable, documentation to support your reason for disagreeing with the first-level desk review determination.

☐ I have attached a copy of the First-Level Desk Review Determination and it is dated **within 20 business days** of this request.

☐ I have attached additional documentation that was previously unavailable to support my reason for disagreeing with the First-Level Desk Review Determination.

Section C - Request for Second-Level Review, Signature, and Date

I am hereby disputing the **First-Level Desk Review Determination** issued by _____ County,

dated _____, regarding my claim that the child support collections were not distributed and disbursed correctly and, as a result, I did not receive a pass-through or cumulative excess support payment(s) in an amount that I believe I was entitled to receive. Therefore, I request that the New York State Office of Temporary and Disability Assistance conduct a second-level desk review of pass-through payment or cumulative excess support payment.

This form was completed and submitted by:

_____ _____ _____
Signature Print Name Date

Return completed form to:

New York State Office of Temporary and Disability Assistance
Attn: Division of Child Support Services
Bureau of Program Operations and Contract Administration, Second-Level Desk Review
40 North Pearl Street, 13-C
Albany, NY 12243-0001