

**GENERAL INFORMATION SYSTEM**  
**Center for Employment & Economic Supports**

December 23, 2014

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**TO:** Subscribers**SUGGESTED DISTRIBUTION:** NYC HRA Commissioner, Program and Operation  
Directors, Center Managers, WMS Coordinators, Staff  
Development Coordinators**FROM:** Phyllis D. Morris, Deputy Commissioner  
Center for Employment and Economic Supports**SUBJECT:** SSI COLA and NYSNIP Standard Benefit Amount Adjustments**EFFECTIVE DATE:** January 1, 2015**CONTACT PERSON:** SNAP Bureau at 1-800-343-8859, ext. 3-1469  
Upstate WMS at 1-800-343-8859, ext. 3-7991  
NYC WMS at 212-961-8185**Background**

Every year, the Social Security Administration (SSA) evaluates the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) data to determine if a cost of living adjustment (COLA) should be made to RSDI (regular Social Security and Social Security Disability benefits) and federal Supplemental Security Income (SSI) benefits to reflect an increase or decrease in the cost of living. The CPI-W increased by 1.7% from the end of the third quarter of 2013 to the end of the third quarter of 2014. Therefore, effective January 1, 2015, RSDI and SSI recipients will receive a 1.7% COLA increase. SSA and SSI benefits will be increased accordingly.

14 INF-12 announced the COLA increase to SSI benefits.

**Purpose**

The purpose of this GIS is to inform the local social services districts about the effect of the annual COLA on Supplemental Nutrition Assistance Program (SNAP) benefits, particularly on New York State Nutrition Improvement Project (NYSNIP) benefits; and to inform the local districts about the notices that were sent to affected households notifying them about the change in SNAP benefits.

**Program Implications**

As part of the 2015 January mass re-budgeting/authorization (MRB/A), NYSNIP benefit levels will be adjusted effective January 1, 2015. This adjustment to SNAP benefit amounts is required because of the SSI COLA.

Information regarding the WMS MRB/A of Temporary Assistance and SNAP benefit levels for New York City WMS was provided in WLM 2014-00400. **Information**

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regarding the SSI COLA and details on its effect on SNAP and SNAP case processing also is provided to New York City Human Resources Administration (HRA) workers in HRA Policy Directive PD #14-30-ELI.

The new NYSNIP SNAP benefit amounts (see attached table of NYSNIP Benefit Levels effective 01/01/15) are effective for any **NYSNIP SNAP Shelter Type** budgets with a **FROM Date** of January 1, 2015 or later.

**\$246 New NYSNIP “High” Shelter Cost Threshold**

**New** NYSNIP households having cases opened, and existing NYSNIP households recertified, effective January 1, 2015 or later and having shelter costs **greater than \$246** will be considered to be “High Shelter” (Shelter Type 94 or 96) cases by the standard of the project. Conversely, effective January 1, 2015, **new** and recertifying NYSNIP households having shelter costs of **\$246 or less** will be considered to be “Low Shelter” (Shelter Type 95 or 97) cases by the standard of the project. This change to the shelter threshold was migrated on December 2014 for budgets having a **FROM Date** of January 1, 2015 or later.

Only benefits in Shelter Types 95, 96 and 97 are affected by the SSI COLA increase.

**NYSNIP BENEFITS MATRIX BY SHELTER TYPES**  
*01/01/15 - 09/30/15*

HOUSEHOLD		MONTHLY FOOD STAMP BENEFIT AMOUNT		
		New York City	Nassau/Suffolk	Upstate
Shelter Type 94 (High Shelter/SUA)	SSI Only	\$194	\$194	\$194
	Other Income	\$194	\$194	\$194
Shelter Type 95 (Low Shelter/SUA)	SSI Only	\$194	\$188	\$163
	Other Income	\$194	\$179	\$154
Shelter Type 96 (High Shelter/ SUA/\$21 HEAP)	SSI Only	\$194	\$194	\$194
	Other Income	\$194	\$194	\$194
Shelter Type 96 (No SUA)	SSI Only	\$26	\$26	\$26
	Other Income	\$17	\$17	\$17
Shelter Type 97 (Low Shelter/ SUA/\$21 HEAP)	SSI Only	\$194	\$188	\$163
	Other Income	\$194	\$179	\$154
Shelter Type 97 (No SUA)	SSI Only	\$16	\$16	\$16
	Other Income	\$16	\$16	\$16
Shelter Type 98 (No Shelter or SUA Data)	SSI Only	\$16	\$16	\$16
	Other Income	\$16	\$16	\$16

A sample of the letter being sent to affected New York City households is attached to this GIS.

**NOTICE OF INTENT TO CHANGE BENEFITS:  
NYC PA COLA**

Notice Date: **December 8, 2014**

Case Number:  
Loc. Off./Unit/Worker:

General Telephone No. for  
Questions or Help:

**This Notice is to tell you that this agency intends to change your benefits as follows:**

**PUBLIC ASSISTANCE GRANT** YOUR PUBLIC ASSISTANCE GRANT WILL BE **REDUCED FROM** \_\_\_\_\_ **TO** \_\_\_\_\_  
EFFECTIVE JANUARY 1, **2015**.

The reason for this action is that according to our records you and/or your dependent(s) are receiving Social Security and/or SSI payments and/or Veteran's Benefits from the Federal Government and a Family Assistance (FA) or Safety Net Assistance (SNA) grant from this Department. As you probably know, Congress has passed a Law (Public, 93-233) providing for an automatic cost of living adjustment in Social Security and/or SSI benefits and/or Veteran's Benefits. This has resulted in an **increase of 1.7** percent which will take effect in December **2014** and be contained in payments received in **January 2015**. Under Law these increases must be counted in determining the amount of the grant you receive from this Department. However, SSI grants are never used to calculate FA payments. SSI can only be counted in SNA cases when the SSI recipient is also receiving SNA.

**INCREASE TO SOCIAL SECURITY/SSI/VETERAN'S BENEFITS**

WE CALCULATE THAT STARTING **JANUARY 2015**, THE MONTHLY FEDERAL BENEFIT(S) OF YOU AND/OR YOUR DEPENDENTS WILL BE INCREASED BY A TOTAL OF \$ \_\_\_\_\_.

Because of this increase, your FA or SNA grant must be reduced by an equal amount.

This decision is based on Department Regulation 352.29.

**MEDICAL ASSISTANCE:** Your Medical Assistance will continue unchanged. This decision is based on Department Regulation 360-3.3.

**Supplemental Nutrition Assistance Program (SNAP):** Even though your public assistance grant will change, your SNAP benefits will not change unless you get a separate notice telling you that your SNAP benefits will change. This decision is based on Department Regulation(s) 387.10 and 387.15.

If you do not understand this notice or are in disagreement with the action we are taking, you may request a conference. To do so, visit your center or call on the telephone as soon as possible.

**THE TELEPHONE NUMBER TO CALL FOR A CONFERENCE IS (            )            -            .**

BY REQUESTING A CONFERENCE YOU ARE NOT GIVING UP YOUR RIGHTS TO A FAIR HEARING PROVIDED THAT YOU REQUEST A HEARING WITHIN THE TIME LIMITS DESCRIBED ON THE ENCLOSED PAGE. SEE THE ENCLOSED PAGE FOR APPEAL PROCESS INFORMATION.

SEE BELOW FOR EXPLANATION OF YOUR NEW PA GRANT.

PRE-ADD CONCESIÓN PRE-SUMADA	_____	SSA INCOME INGRESO DE SEGURO SOCIAL	_____
SHELTER VIVIENDA	_____	SSI INCOME INGRESO DE SSI	_____
ENERGY ENERGÍA	_____	OTHER INCOME OTRO INGRESO	_____
ENERGY SUPPLEMENT SUPLEMENTO DE ENERGÍA	_____	TOTAL INCOME INGRESO TOTAL	_____
OTHER NEEDS OTRAS NECESIDADES	_____		
TOTAL NEEDS TOTAL DE NECESIDADES	_____	PA GRANT CONCESIÓN DE PA	_____

Sincerely,  
Matthew Brune, Executive Deputy Commissioner  
Family Independence Administration

Notice of Intent To Change Public Assistance Benefits Due To An Increase In Social Security, SSI and/or Veteran's Benefits

**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.

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 **60 days** from the date of this notice to ask for a fair hearing:

**KEEPING YOUR BENEFITS THE SAME:** We will restore your Public Assistance benefits to the same level they were before this notice, 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 benefits you got, but should not have gotten, while you were waiting for the decision.

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 below:

I do not want to keep my Public Assistance Benefits the same until the Fair Hearing decision is issued.

If at the hearing, the hearing officer determines that you are not complaining about an incorrect computation of your benefits or that there has been a misapplication or misinterpretation of Federal Law or regulations, the hearing officer may determine that you were not entitled to have your Public Assistance benefits continue unchanged until the fair hearing decision is issued, and order that the reduction take effect immediately.

**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 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.)

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**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.

**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, fax, walk-in or on-line, 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.

**Notice Date: December 8, 2014**

**Effective Date: January 1, 2015**

**NYC PA COLA '15**  
XL074C (11/14)

P.O. BOX 02-9121  
Brooklyn GPO  
Brooklyn, N.Y. 11202-9121

**The City Of New York**  
HUMAN RESOURCES ADMINISTRATION  
FAMILY INDEPENDENCE ADMINISTRATION

CONFERENCE PHONE  
NÚMERO PARA CONFERENCIA

Center :  
CASE No :

FAM SIZE:  
DATE: December 8, 2014  
FECHA: 8 de diciembre de 2014

**NOTICE OF MASS CHANGE  
PREAVISO DE REDUCCIÓN EN SU SUBSIDIO SNAP**

DEAR SIR/MADAM:  
ESTIMADO(A) SR./SRA./SRITA:

THIS IS TO INFORM YOU THAT YOUR SNAP BENEFITS MAY BE REDUCED EFFECTIVE JANUARY 1, 2015 FOR THE FOLLOWING REASON:

BEGINNING JANUARY 2015, SOCIAL SECURITY, SSI AND/OR VETERAN'S BENEFITS WILL INCREASE BY 1.7%. IF YOU ARE IN RECEIPT OF ANY OF THESE FEDERAL BENEFITS, THIS INCREASE IN INCOME TO YOUR HOUSEHOLD MUST BE CONSIDERED IN DETERMINING YOUR SNAP BENEFIT LEVEL. **IF YOU ARE IN RECEIPT OF BOTH SOCIAL SECURITY BENEFITS AND SSI, YOUR JANUARY SSI BENEFITS WILL BE REDUCED BY THE AMOUNT OF YOUR SOCIAL SECURITY BENEFIT INCREASE. THESE INCOME CHANGES MUST ALSO BE CONSIDERED IN DETERMINING YOUR SNAP BENEFITS.**

BEGINNING IN JANUARY 2015, IF YOU ARE AN SSI RECIPIENT LIVING ALONE IN THE COMMUNITY WHO IS PARTICIPATING IN THE NEW YORK STATE NUTRITION IMPROVEMENT PROJECT (NYSNIP) AND YOUR RENT IS ABOVE or below \$246.00 and you either incur a separate bill or charge for heating or air conditioning costs or you have received Home Energy Assistance (HEAP) benefits of more than \$20 during the month this letter is dated or the during the immediately preceding twelve (12) months, YOUR MONTHLY SNAP BENEFIT OF \$194.00 WILL NOT CHANGE. HOWEVER, IF YOUR RENT IS above \$246.00 and you do not incur a separate bill or charge for heating or air conditioning costs or have not received Home Energy Assistance (HEAP) benefits of more than \$20 during the month this letter is dated or the during the immediately preceding twelve (12) months, BEGINNING IN JANUARY 2015, YOU WILL RECEIVE \$26 IN SNAP BENEFITS and if you receive income in addition to SSI, you will receive \$17 in SNAP benefits.

**IF YOU ARE A NYSNIP PARTICIPANT WHO WAS RECEIVING \$16 PER MONTH IN SNAP BENEFITS, BEGINNING IN JANUARY 2015 YOU WILL continue to RECEIVE \$16 PER MONTH.**

PAGE 2 OF THIS NOTICE IS A FINANCIAL FACT SHEET WHICH SHOWS YOUR NEW SNAP BENEFIT AMOUNT AND ALL THE INCOME INFORMATION ON OUR COMPUTER FILE THAT WAS USED TO CALCULATE YOUR NEW SNAP BENEFIT. WE HAVE ENCLOSED BUDGET WORKSHEETS WHICH YOU CAN USE TO DETERMINE WHETHER WE HAVE CORRECTLY DETERMINED YOUR NET SNAP INCOME. SEE 18 NYCRR 387.10, 387.12 AND 387.15.

POR MEDIO DE LA PRESENTE LE INFORMAMOS QUE REDUCIREMOS SU SUBSIDIO SNAP A PARTIR DEL 1º DE ENERO DE 2015 POR LA SIGUIENTE RAZÓN:

COMENZANDO EN ENERO DE 2015, LOS SUBSIDIOS DE SEGURO SOCIAL, SSI Y SUBSIDIOS PARA VETERANOS, AUMENTARÁN POR UN 1.7 %. SI USTED RECIBE ALGUNO DE LOS SUBSIDIOS FEDERALES ANTES MENCIONADOS, ESTE AUMENTO EN EL INGRESO DE SU GRUPO FAMILIAR DEBERÁ TOMARSE EN CUENTA EN EL CÁLCULO DEL MONTO DEL SUBSIDIO SNAP QUE USTED RECIBE. **SI USTED ACTUALMENTE RECIBE AMBOS SUBSIDIOS: SEGURO SOCIAL Y SSI, EL MONTO DEL SUBSIDIO DE SSI PARA EL MES DE ENERO SERÁ REDUCIDO POR EL MONTO DEL AUMENTO EN SU SUBSIDIO DE SEGURO SOCIAL. ESTOS CAMBIOS EN INGRESO TAMBIÉN DEBEN TOMARSE EN CUENTA EN EL CÁLCULO DE SU SUBSIDIO SNAP.**

COMENZANDO EN ENERO DE 2015, SI USTED ES UN BENEFICIARIO DE SSI QUE VIVE SOLO(A) EN LA COMUNIDAD Y PARTICIPA EN EL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP) Y SU ALQUILER ES SUPERIOR o inferior a los \$246.00 y usted ya sea: **recibe facturas o cargos por separado de calefacción o aire acondicionado, o ha recibido el Subsidio de Energía para el Hogar (HEAP) por un monto mayor de \$20 en el mes de la fecha de esta carta o en los últimos 12 meses;** EL MONTO MENSUAL DE SU SUBSIDIO SNAP DE \$194.00 NO CAMBIARÁ. SIN EMBARGO, SI SU ALQUILER ES superior a los \$246.00 y usted no incurre facturas o cargos por separado de calefacción o aire acondicionado o no ha recibido el Subsidio de Energía para el Hogar (HEAP) por un monto mayor a los \$20 en el mes de la fecha de esta carta o en los últimos 12 meses; COMENZANDO EN ENERO DE 2015, USTED RECIBIRÁ \$26 EN SUBSIDIO SNAP y si usted recibe ingreso adicional al SSI, usted recibirá \$17 en subsidio SNAP.

**SI USTED ES UN PARTICIPANTE DEL PROYECTO DE MEJORA NUTRICIONAL DEL ESTADO DE NUEVA YORK (NYSNIP) QUE RECIBÍA \$16 AL MES EN SUBSIDIO SNAP, COMENZANDO EN ENERO DE 2015, USTED CONTINUARÁ recibiendo \$16 AL MES.**

LA PÁGINA 2 DE ESTE AVISO ES UNA HOJA DE DATOS FINANCIEROS LA CUAL MUESTRA SU NUEVO MONTO DE SUBSIDIO SNAP COMO TAMBIÉN TODOS LOS DATOS SOBRE INGRESOS REGISTRADOS EN NUESTRO ARCHIVO COMPUTARIZADO Y EL CUAL FUE UTILIZADO EN EL CÁLCULO DE SU NUEVO MONTO DE SUBSIDIO SNAP. HEMOS ADJUNTADO HOJAS DE CÁLCULO DE PRESUPUESTO LAS CUALES USTED PUEDE UTILIZAR PARA DETERMINAR SI HEMOS CALCULADO CORRECTAMENTE SU INGRESO NETO EN RELACIÓN CON LA SUBVENCIÓN SNAP. CONSULTE 18 NYCRR 387.10, 387.12 Y 387.15.

SINCERELY,  
ATENTAMENTE,  
MATTHEW BRUNE, EXECUTIVE DEPUTY COMMISSIONER / SUBCOMISIONADO  
EXECUTIVO FAMILY INDEPENDENCE ADMINISTRATION

XL0263 (11/14)

**YOUR FINANCIAL FACTS CURRENTLY ON FILE  
SUS DATOS FINANCIEROS ACTUALMENTE EN ARCHIVO**

**Previous Net Supplemental Nutrition Assistance Program (SNAP)**  
*Ingreso anterior del subsidio de Asistencia Nutricional Suplementaria (SNAP)*

**New Net SNAP Income**  
*Nuevo Ingreso neto del subsidio SNAP*

**Previous Monthly Benefit Amount**  
*Monto anterior mensual del subsidio*

**New Monthly Benefit Amount**  
*Nuevo monto mensual del subsidio*

**A. MONTHLY INCOME**  
*Ingreso Mensual*

<b>1a. Monthly Gross Income from Employment or Training.</b> <i>Ingreso bruto mensual por empleo o entrenamiento.</i>	
<b>b. Monthly Net Income from Self Employment.</b> <i>Ingreso neto mensual por trabajo por cuenta propia.</i>	
<b>2a. Net Monthly Income from Boarder/Lodger.</b> <i>Ingreso neto mensual que recibe del huésped/ inquilino</i>	
<b>b. Net Monthly Income from Lodger.</b> <i>Ingreso neto mensual que recibe del inquilino</i>	
<b>3. Total of Lines 1 and 2.</b> <i>Total de las líneas 1 y 2.</i>	
<b>4a. Monthly Gross Unearned Income.</b> <i>Ingreso bruto mensual no devengado.</i>	
<b>b.</b>	
<b>c.</b>	
<b>5. Monthly Income from Educational Loans, Scholarships.</b> <i>Ingreso mensual por préstamos y becas educacionales.</i>	
<b>6. Total of Lines 3, 4 and 5.</b> <b>A.</b> <i>Total de líneas 3, 4 y 5</i>	\$

**B. DEDUCTIONS**  
*Deducciones*

<b>7.</b> % of Line 3. % de línea 3	
<b>8. Standard Deduction</b> <b>Monthly</b> <i>Deducción mensual estándar</i>	
<b>9. Monthly Child Care/Dependent Care Costs.</b> <i>Gastos mensuales por cuidado de niños / de dependientes</i> (Maximum ) (Máximo )	
<b>10. Monthly Automatic Recoupment (from Public Assistance Grant)</b> <i>Recuperación mensual automática (de subsidio de Asistencia Pública)</i>	
<b>11. Monthly Tuition and Mandatory Fees</b> <i>Gastos mensuales de colegiatura y cuotas obligatorias</i>	
<b>12a. Monthly Medical Expense (less \$35 Deductible)</b> <i>Gasto médicos mensuales (menos \$35 de deducible)</i>	
<b>b.</b>	
<b>13. Total Lines 7, 8, 9, 10, 11, and 12</b> <b>B.</b> <i>Total de líneas 7, 8, 9, 10, 11, y 12</i>	\$

**C. ADJUSTED INCOME**  
*Ingreso ajustado*

<b>14. Subtract B from A. (Line 13 from Line 6.)</b> <i>Reste B de A. (Línea 13 de línea 6.)</i>	<b>C.</b>	\$
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**D. SHELTER COSTS**  
*Gastos de Vivienda*

<b>15. Monthly Rent or Mortgage actually paid.</b> <i>Renta o hipoteca actualmente pagada cada mes.</i>	
<b>16. Monthly Heating Expense</b> <i>Gasto mensual por calefacción.</i>	
<b>17. Monthly Utility Expense</b> <i>Gasto mensual por utilidades.</i>	
<b>18. Monthly Telephone Expense</b> <i>Gasto mensual por teléfono.</i>	
<b>19. Other Monthly Shelter Expense. (Real Estate Taxes, Insurance, Installation of Utilities, etc.)</b> <i>Otros gastos mensuales de vivienda. (Impuestos inmobiliarios, seguro, conexión de servicios públicos etc.)</i>	
<b>20. Total of Lines 15, 16, 17, 18, and 19.</b> <b>D.</b> <i>Total de líneas 15, 16, 17, 18, y 19</i>	\$

**E. SNAP NET INCOME**  
*Ingreso neto por subsidio SNAP*

<b>21. Excess Shelter Deduction (Line 20 minus ½ of Line 14. The total cannot be more than</b>  <i>Deducción de gastos de vivienda en exceso (línea 20 menos ½ de línea 14. El total no puede ser más de)</i>	
<b>22. MONTHLY NET SNAP INCOME (Subtract Line 21 from Line 14.)</b> <i>Ingreso neto mensual por subsidio SNAP (reste línea 21 de línea 14)</i>	
<b>23. MONTHLY COUPONS AMOUNT</b> <i>Cantidad mensual del subsidio SNAP</i>	<b>E.</b>

MINUS RECOUPMENT OF  
MENOS EL REEMBOLSO DE

ADJUSTED SNAP AMOUNT  
MONTO AJUSTADO DEL  
SUBSIDIO SNAP

Notice of Intent To Change SNAP Benefits Due To An Increase In Social Security, SSI and/or Veteran's Benefits

**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.

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 **90 days** from the date of this notice to ask for a fair hearing:

**KEEPING YOUR BENEFITS THE SAME:** We will restore your SNAP Benefits to the same level they were before this notice, 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 SNAP Benefits you got, but should not have gotten, while you were waiting for the decision.

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 below:

I do not want to keep my SNAP Benefits the same until the Fair Hearing decision is issued.

If at the hearing, the hearing officer determines that you are not complaining about an incorrect computation of your benefits or that there has been a misapplication or misinterpretation of Federal Law or regulations, the hearing officer may determine that you were not entitled to have your SNAP Benefits continue unchanged until the fair hearing decision is issued, and order that the reduction take effect immediately.

**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.

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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.

**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, fax, walk-in or on-line, please write to ask for a fair hearing before the deadline.

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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.

**Notice Date: December 8, 2014**

**Effective Date: January 1, 2015**

**NYC SNAP COLA '15**

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