

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

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Transmittal:	05-INF-15						
To:	Local District Commissioners						
Issuing Division/Office:	Division of Employment and Transitional Supports						
Date:	August 9, 2005						
Subject:	Revisions to Mandatory Client Notices						
Suggested	Temporary Assistance Staff						
Distribution:	Food Stamp Benefits Staff						
	Medicaid Directors						
	CAP Coordinators						
	Employment Coordinators						
	WMS Coordinators						
	Staff Development Coordinators						
Contact	Forms Questions: Bob Gullie 1-800-343-8859 Extension 6-1095						
Person(s):	Program Questions:						
	Food Stamp Bureau - (518) 473-1469						
	Temporary Assistance Bureau - (518) 474-9344						
	HEAP - (518) 473-0332						
	Metro Region - (212) 961-8207						
	Medicaid Local District Liason - Upstate (518) 474-8216 or NYC (212) 417-4500						
	WMS Questions: (518) 474-8749						
Attachments:	LDSS-3152; LDSS-3152 NYC; LDSS-4013A; LDSS-4013B; LDSS-4013A NYC;						
	LDSS-4013B NYC; LDSS-4014A; LDSS-4014B; LDSS-4014A NYC and LDSS-						
	4014B NYC						
Attachment Avail Line:	lable On –						

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
See Attachment I	See Attachment I	See Attachment I	See Attachment I	See Attachment I	See Attachment I

Section 2

I. Purpose

The purpose of this release is to introduce 10 revised client notices.

The primary reason for the revisions was as a result of a request from the State Education Department to include Food Stamp Benefits information about the "National School Lunch/Breakfast Programs" on the State printed "Action Taken Notices".

The following are the notices that now include that information.

LDSS-3152: "Action Taken on Your Food Stamp Benefits Case" (Rev.5/05)

LDSS-3152 NYC: "Action Taken on Your Food Stamp Benefits Case" (Rev.5/05) (NYC)

LDSS-4013A: "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev.5/05)

LDSS-4013B: "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev.5/05)

LDSS-4013A NYC: "Action Taken on Your Application: PA, FS and MA Coverage PART-A" (Rev.5/05) (NYC)

LDSS-4013B NYC: "Action Taken on Your Application: PA, FS and MA Coverage PART-B" (Rev.5/05) (NYC)

LDSS-4014A: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-A" (Rev.5/05)

LDSS-4014B: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-B" (Rev.5/05)

LDSS-4014A NYC: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-A" (Rev.5/05) (NYC)

LDSS-4014B NYC: "Action Taken on Your Recertification: PA, FS and MA Coverage and Services PART-B" (Rev.5/05) (NYC)

II. Program Implications:

The following is a general listing of the revisions to the Client Notices:

LDSS-3152: "Action Taken on Your Food Stamp Benefits Case"

FRONT

- 1. The Revision Date was **changed** to 5/05.
- 2. The title of the form was **changed** to "Action Taken on Your Food Stamp Benefits Case".
- 3. The following checked box and information was **added** after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits.
- 4. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

5. The prechecked box regarding "Responsibility to Report Changes" was **moved** to the reverse side of the notice.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following "Free Lunch Program" information was **added** below the "case name" and "address" section at the top of the page.

The information reads as follows:

<u>National School Lunch and/or Breakfast Programs</u> - The child(ren) listed below are approved to receive free lunch and/or breakfast if he or she attends a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a copy of this notice to the school that your child attends.

This notice also entitles your child(ren) to free meals if they attend a program such as a school, club or camp that participates in the Summer Food Service Program. Make a copy for your records so you can provide it to the sponsor.

List Child(ren)'s nar	me(s):		

- 3. The prechecked box regarding "Responsibility to Report Changes" that was **removed** from the front of this notice was **added** directly after the "Free Lunch Program" information.
- 4. The "LIFELINE" service information was **removed** from the top of the notice.

LDSS-3152 NYC: "Action Taken on Your Food Stamp Benefits Case" (NYC)

COVER – The Revision date was **changed** to 5/05.

FRONT

- 1. The Revision Date was **changed** to 5/05.
- 2. The title of the form was **changed** to "Action Taken on Your Food Stamp Benefits Case" (NYC).
- 3. The following checked box and information was **added** after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.
- 4. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.

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List Child(ren)'s name(s):					

- 3. The prechecked box regarding "Responsibility to Report Changes" that was **removed** from the front of this notice was **added** directly after the "Free Lunch Program" information.
- 4. The "LIFELINE" service information was **removed** from the top of the notice.
- 5. The 2nd paragraph in the "Access to Your File and Copies of Documents" was **changed** to mirror the same paragraph that appears on the Upstate version of this notice.

That second paragraph now reads:

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.

<u>LDSS-4013A</u>: Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART A

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

1. The Revision Date was **changed** to 5/05.

2. The "LIFELINE" service information was **removed** from the top of the notice.

<u>LDSS-4013B</u>: Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART B

FRONT:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.
- 3. With the addition of the new question 6, the previous number 6 question was **renumbered** to 7.
- 4. The prechecked box regarding "Responsibility to Report Changes" was **moved** to the reverse side of the notice.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following Free Lunch information was **added** directly below the case name and address section at the top of the page.

The information reads as follows:

<u>National School Lunch and/or Breakfast Programs</u> - The child(ren) listed below are approved to receive free lunch and/or breakfast if he or she attends a school that participates in the National School Lunch and/or Breakfast Programs. To receive this benefit, you must take or send a copy of this notice to the school that your child attends.

This notice also entitles your child(ren) to free meals if they attend a program such as a school, club or camp that participates in the Summer Food Service Program. Make a copy for your records so you can provide it to the sponsor.

List Child(ren)'s name(s):					

3. The prechecked box regarding "Responsibility to Report Changes" that was removed from the front of this notice was **positioned** directly after the Free Lunch Program information.

<u>LDSS-4013A NYC:</u> Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART A (NYC)

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The "LIFELINE" service information was **removed** from the top of the notice.

LDSS-4013B NYC: Action Taken on Your Application: Public Assistance, Food Stamp Benefits and Medical Assistance Coverage – PART B (NYC)

FRONT:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

The information reads as follows:

- 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.
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<u>LDSS-4014A</u>: Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The "LIFELINE" service information was **removed** from the top of the notice.

<u>LDSS-4014B</u>: Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B

FRONT:

- 1. The Revision Date was **changed** to 5/05.
- 2. The following checked box and information was **added** directly after number "5" of the "Approved" section.

The information reads as follows:

6. If you applied for Public Assistance and are approved, your Food Stamp Benefits may go down or may stop. If this happens, you will not get a notice about your Food Stamp Benefits.

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List Child(ren)'s name(s):					

3. The prechecked box regarding "Responsibility to Report Changes" that was removed from the front of this notice was **positioned** directly after the Free Lunch Program information.

LDSS-4014A NYC: Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART A (NYC)

FRONT:

The Revision Date was **changed** to 5/05.

REVERSE:

- 1. The Revision Date was **changed** to 5/05.
- 2. The "LIFELINE" service information was **removed** from the top of the notice.

<u>LDSS-4014B NYC:</u> Action Taken on Your Recertification: Public Assistance, Food Stamp Benefits, Medical Assistance Coverage and Services – PART B (NYC)

FRONT:

- 1. The Revision Date was **changed** to 5/05.
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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.

III. Forms Implications:

We expect that all of the above referenced Client Notices will be printed and delivered to the Albany and NYC/HRA warehouses by the end of October, 2005.

Upon receipt of any of these revised notices, Document Services will immediately distribute supplies to local districts.

When any of the revised notices are received, local district staff **must immediately destroy** previous versions and replace them with the newly revised forms.

Additionally, for local district staff, electronic PDF versions of all of the notices referenced in this INF can be accessed on the OTDA Intranet website at http://otda.state.nyenet/otda/ldss_eforms/default.htm .

Any future requests for printed copies of the revised English and Spanish notices or English or Spanish master copies, if that notice is not printed, should be submitted on OTDA-876 (Rev.6/98): "Request For Forms or Publications" form, and should be sent to:

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

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

Issued By	<i>y</i>

Name: Russell Sykes

Title: Deputy Commissioner

Division/Office: Division of Employment and Transitional Supports

ATTACHMENT I

Previous ADMs/INFs	Releases Cancelled	Dept, Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 ADM-21 89 ADM-8 89 ADM-6 88 ADM-4 87 ADM-48 87 ADM-48 86 ADM-7 85 ADM-17 85 ADM-55 82 ADM-55 82 ADM-55 81 ADM-55 80 ADM-90 04 INF-26 03 INF-41 03 INF-17 99 INF-05 92 INF-46 92 INF-42 92 INF-42 92 INF-34 91 INF-57 89 INF-28 88 INF-83		350.5,351.22 351.23 355,358-3.3 360-2.4,2.5, 2.6,6.4,7.5 369.6 387.14 387.20 505.14 (b) (5) (v),(viii),(x) 385.3 385.14	SSL 22 SSL 366-a	MARG pp. 374-382 TASB Section 8 A-J FSSB Sections 4.3.b; 5; 5.2; 5.3.h; 5.3.i; 5.6; 6.2; 6.5; 7.1; 7.1.e; 7.2; 7.2.b; 7.3; 7.4; 7.6; 7.7; 15.3; 15.1.c; 15.1.c; 15.1.c; 15.1.c; 15.3; 15.4; 15.5; 15.1.c	GIS 89 MA007 DCL 7/13/83 89 LCM-155 89 LCM-22

OTDA (Rev.8/2005)

11

FS App/Reapp/OP Recoup/Ad Only

LDSS-3152 (Rev. 5/05)

ACTION TAKEN ON YOUR FOOD STAMP BENEFITS CASE

NOTICE DATE:				NAME AND ADDRESS OF AGE	ENCY/CENTER OR DISTRICT OFFICE
CASE NUMBI	ER	CIN NUMBE	R	-	
	CASE NAME (And C/O Na	me if Present) AND	ADDRESS	+	
	ONOE WINE VIIIA OF THA	110 11 1 1000111, 7 1112	7.DBR.EGG	GENERAL TELEPHONE NO. FO	
I			I	OR Agency Conference	
				Fair Hearing information	 on
				and assistance	
				Record Access	
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NA	Legal Assistance inform ME	TELEPHONE NO.
				od Stamp Benefits dated _	
is explaine	ed below, next to the c	` '		TUIN 070 DAVO CANNOT	DE DEDI AGED
				THIN 270 DAYS CANNOT	
APPR	OVED for Food Stamp	Benefits from _		to	·
1. 🗌	You will get \$your first month's ben		for the month	n of	because we must figure
1.0	_		of the month. Vou m	any anggan your banafit an	
1a	a. The date you app	pileu to the end	oi ine month. You m	iay access your benefit on ,	·
1b	•			s because you gave us pro	
2. 🗌				bined benefit for the month	
∠. □	and		which is a com This is because you	applied/provided proof after	er the 15 th of the month. Your first
			was figu		ed/provided proof to the end of the
				is for the entire	
3.	•				 _ monthly in Food Stamp Benefits.
J. _	You may access thes		•		
4.					nonthly in Food Stamp Benefits.
	You may access thes				ionany art ood oldrip zonome.
5. 🗌	-				ut all the necessary proof. Listed here
	-	-	-	-	
					s proof. This proof will be used to ge due to this proof, you will not be
6. 🗹	If you applied for Pub happens, you will not	lic Assistance a get a notice ab	nd are approved, yo out your Food Stam _l	ur Food Stamp Benefits mi o Benefits.	ght go down or might stop. If this
7.	Other Information:				
_ DENIE	ED for Food Stamp Be	enefits because:			
_					
					you give us this proof we listed t date, you will have to reapply.
OVER	PAYMENT INFORMA			- · ·	
	We are establishing Benefits than you sh	a Food Stamp nould have. See	Benefits overpayme the Demand Letter		usehold got more in Food Stamp osing, the Repayment Agreement) 87.19.
		-		t. If your case is closing, se ount you owe and how you	ee the Demand Letter and will repay this overpayment.
			ects a% reductions sion is based on 18		in your benefits in order to
			ects a% reductions sion is based on 18		in your benefits in order to
	Other:				
The abov	/e decision(s) is base	ed on 18 NYCRI	 R		

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

LD	SS-3152 (Rev. 5/05) Reverse		FS App/Reapp/Op Recoup/Ad Only No A/C
NA	ME:	ADDRESS:	CASE NUMBER:
he tak Thi	or she attends a school that participates e or send a copy of this notice to the sch is notice also entitles your child(ren) to	Programs - The child(ren) listed below are approved in the National School Lunch and/or Breakfast Programool that your child attends. free meals if they attend a program such as a schopy for your records so you can provide it to the spons	rams. To receive this benefit, you must mool, club or camp that participates in the
	ist Child(ren)'s name(s):		
<u></u>	Responsibility To Report Changes – S report changes.	See the enclosed LDSS-3151: "Food Stamp Change	Report Form" for information on when to
$\overline{\checkmark}$		rits, please tell this agency if you are later approved mean you can get Food Stamp Benefits.	for Supplemental Security Income (SSI) or
		get Public Assistance, Food Stamp Benefits or Medi g for the Home Energy Assistance Program (HEAP). er on the front of this notice.	
	CONFERENCE	AND FAIR HEARING SECTION – DO YOU THINK	WE ARE WRONG?
If y	ou think our decision was wrong, you ca 1. Ask for a meeting (conference) with	n ask for a review of our decision. We will correct our one of our supervisors; 2. Ask for a State fair	mistakes. You can do both 1 and 2: hearing with a State hearing officer.
1.	call us to set up a meeting. To do this	with us) – If you think our decision was wrong, or if y, call the conference phone number on the front of this is the fastest way to solve any problem you may j.	this notice or write to us at the address on
2.	STATE FAIR HEARING - You	u have 90 days from the date of this notice to ask for	a fair hearing.
но	W TO ASK FOR A FAIR HEAR	RING: You can ask for a fair hearing in w	riting, by phone, by fax or online.
		notice <i>completed</i> to the Office of Administrative Hea Albany, New York 12201. Please keep a copy for you	
	I want a fair hearing. I do not agre include a written explanation.)	e with the agency's action. (You may explain why yo	ou disagree below, but you do not have to
	·	E THIS NOTICE WITH YOU WHEN YOU CALL)
<u>Fa</u>	x: Fax a copy of the front and revers	se 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 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.

IMPORTANT NOTICE

Important Notice: If you need help reading this notice, contact your worker.

Aviso importante: Si necesita ayuda para leer este aviso, comuníquese con su trabajador(a) de casos.

إخطار هام: إذا احتجت إلى مساعدة في قراءة هذا الإخطار، خاطب مسؤول ملفك.

重要通知:如需幫助閱讀此通知,請與您的個案負責人接洽。

Avis important: Si vous avez besoin d'assistance pour lire cet avis, veuillez contacter votre travailleur.

Avi enpòtan. Si w bezwen èd pou li avi sa a, antre an kontak ak travayè w la.

중요한 통지서: 이 통지서를 읽는데 도움이 필요하시면, 담당 직원에게 연락하십시오.

Важная информация. Если при чтении этого извещения у Вас возникнут трудности, обратитесь к сотруднику, ведущему Ваше дело.

Thông báo quan trọng. Nếu cần được giúp đỡ để đọc bản thông báo này, xin liên lạc với nhân viên xã hội của quý vị.

וויכטיגע מעלדונג איז: אויב איר דארפט הילף צו לייענען די מעלדונג, פארבינדט זיך מיט אייער ארבעטער. LDSS-3152 NYC (Rev. 5/05) FS App/Reapp/OP Recoup/Ad Only

NOTICE	ACTION	TAKEN OF	N YOUR FOOD	NAME AND ADDRESS OF AGE	S CASE (NYC) ENCY/CENTER OR DISTRICT OFFICE
DATE: CASE NUMBE	:D	CIN NUMBE	D	<u> </u> 	
CAGE NOMBE		CINTOMBL		_	
	CASE NAME (And C/O Na	me if Present) AND	ADDRESS	GENERAL TELEPHONE NO. F	OR
				OR Agency Conference	
				Fair Hearing information	on
1			1	Record Access	
<u> </u>				Legal Assistance infor	rmation
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAI	ME	TELEPHONE NO.
The action	(s) taken on your app	lication/recertific	cation request for Fo	od Stamp Benefits dated	
	ed below, next to the o			•	
	FOOD STAM	IP BENEFITS N	IOT PICKED UP WI	THIN 270 DAYS CANNO	T BE REPLACED.
APPRO	OVED for Food Stamp	Benefits from _		to	·.
1. 🗌	You will aet \$		for the mont	th of	because we
	must figure your first				
1a.	. The date you app	olied to the end	of the month. You m	ay access your benefit on	
1b.	The latest date v	ou provided pro	of we needed. This i	s because you gave us pro	oof after it was due
10.	•	•			
2. 🗌	You will get \$				and
	first month's benefit o	f \$.This is becau	se you applied/provided prosections as figured from the date vo	roof after the 15 th of the month. Your ou applied/provided proof to the end
	of the month. Your se	cond month's b	enefit of \$	is for the	entire month.
					monthly in Food Stamp Benefits.
	You may access thes		•		
	You may access thes				monthly in Food Stamp Benefits.
	-				
	-	-		culated your benefit withou	ut all the necessary proof. Listed here
					s proof. This proof will be used to ge due to this proof, you will not be
	If you applied for Pub happens, you will not				ight go down or might stop. If this
7. 🗌	Other Information:				
□ <u>DENIEI</u>	o for Food Stamp Be	nefits because:			
					you give us this proof we listed date, you will have to reapply.
	PAYMENT INFORMA				
				hoogung you are seen by	pohold got mare in Food Ot
	Benefits than you sho	uld have. See t	he Demand Letter (a		sehold got more in Food Stamp sing, the Repayment Agreement) for .19.
	Agreement for more i	nformation on th	ne amount you owe a	and how you will repay this	
	The benefit in Section repay your overpaym				in your benefits in order to
	repay your overpaym	ent. This decis i	on is based on 18	NYCRR 387.19.	in your benefits in order to
	Other:				
The above	e decision(s) is base	d on 18 NYCRI	₹		

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

LD	SS-3152 NYC (Rev. 5/05) Reverse		FS App/Reapp/OP Recoup/Ad Only/No A/C
NA	ME:	ADDRESS:	CASE NUMBER:
she		rams - The child(ren) listed below are approved to re National School Lunch and/or Breakfast Programs. Toyour child attends.	
		free meals if they attend a program such as a school for your records so you can provide it to the sponsor	
Li 	st Child(ren)'s name(s):		
	Responsibility To Report Changes – Se report changes.	ee the enclosed LDSS-3151: "Food Stamp Change	Report Form" for information on when to
	If you were denied Food Stamp Benefit Family Assistance (FA), since this may r	s, please tell this agency if you are later approved for mean you can get Food Stamp Benefits.	or Supplemental Security Income (SSI) or
V		get Public Assistance, Food Stamp Benefits or Medic for the Home Energy Assistance Program (HEAP). You the front of this notice.	
	CONFERENCE A	AND FAIR HEARING SECTION – DO YOU THINK V	<u>VE ARE WRONG?</u>
If y	ou think our decision was wrong, you can	ask for a review of our decision. We will correct our r	nistakes. You can do both 1 and 2:
1. /	Ask for a meeting (conference) with one or	f our supervisors; 2. Ask for a State fair hearing with	a State hearing officer.
1.	call us to set up a meeting. To do this,	rith us) – If you think our decision was wrong, or if you call the conference phone number on the front of the sist the fastest way to solve any problem you may	nis notice or write to us at the address on
2.	STATE FAIR HEARING – You	have 90 days from the date of this notice to ask for a	ı fair hearing.
но	W TO ASK FOR A FAIR HEARING: You	can ask for a fair hearing by:	
		mpleted to the Office of Administrative Hearings, New York 12201. Please keep a copy for yourself.	New York State Office of Temporary and
	I want a fair hearing. I do not agree include a written explanation.)	with the agency's action. (You may explain why you	u disagree below, but you do not have to
	<u> </u>	S NOTICE WITH YOU WHEN YOU CALL.)	
<i>Wa</i> Bro	nlk-In: Bring a copy of this entire notice poklyn, New York or 330 West 34 th Street,	to the New York State Office of Temporary and D NYC.	isability Assistance at 14 Boerum Place,

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, fax or walk-in, 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

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.

LDSS-4013A (Rev.5/05)

ACTION TAKEN ON YOUR APPLICATION: PART A PA, MA, FS App

PUBLIC ASSISTANCE, F	FOOD STA	MP BENEFI			
NOTICE DATE:			NAME AND ADDRESS OF AGE	NCY/CENTER OR L	DISTRICT OFFICE
CASE NUMBER	CIN NUMBER				
CASE NAME (And C/O Name if Pr	resent) AND ADDR	ESS			
			GENERAL TELEPHONE NO. QUESTIONS OR HELP		
I		I	OR Agency Conference		
			Fair Hearing inform and assistance	ation	
			Record Access		
			Legal Assistance in	formation	
OFFICE NO. UNIT NO. WO	RKER NO. UN	IT OR WORKER NA	ME	TELEPHONE NO	
The action(s) taken on your application dat	ted		is explained below and or	n <u>Part B</u> , next to th	ne checked box(es) 🗹 :
SEE <u>PART E</u>	B FOR FOOD	STAMP BENEFI	TS AND FAIR HEARING I	NFORMATION.	
PUBLIC ASSISTANCE					
☐ ACCEPTED for the period fro	m		to		You will get
\$ which this you will get \$	n will cover th	e period		to	After
☐ A RECOUPMENT at the			s being taken against vo	our Public Ass	istance.
If you believe the recou					
worker to explain your re		•	•		_
pay for shelter or utilities, covered by Medical Assi	-			•	
recoupment at this rate	will cause ar	n undue hards	hip. If we decide that	the recoupme	nt will cause an undue
hardship, the recoupmer least 5%. This decision is		-)%. The recou	upment rate must be at
☐ DENIED for [name(s)]			because		
OTHER					
The above decision(s) is base	d on 18 NYC	RR			
MEDICAL ASSISTANCE ACCEPTED for Medical Assis	stance effectiv	/	for Iname(s)	I	
ACCEL TED TO INTEGRICAL ASSIS	stance enectiv			l 	
☐ ACCEPTED for Medical As	sistance with	a SPENDD	OWN, effective		for [name(s)]
Your total monthly income is \$ The difference between these					
The allowable income standard					
between your net income and	this standard	(\$) is y	our monthly e	xcess income (18
NYCRR 360-4.8). The enclose Program.	ed letter expla	ıns eligibility ur	nder the Excess Income	Program and	Optional Pay-In
☐ DENIED Medical Assistance	effective		for [name(s)]	
because					
In the event that you are hosp	oitalized, vou i	mav be eligible	for Medical Assistance	and should co	ontact this Department.
□ PENDED	manzoa, you .	nay be engine	To Modical Accidentes	and one did	maot and Doparanoma
☐ We do not have enough i	nformation to	decide vour el	igibility under the Medic	al Assistance	nrogram Please
contact us no later than _		•	•		. •
the information we need.					
☐ Your application for Medi	cal Assistanc	e is being revie	ewed. We will send you	our decision w	ithin thirty days.
Not applying for Medical Assistance.	Assistance.	ou did not ind	licate on the application	that you wan	ted to apply for Medical
□ OTHER					
This above decision(s) is based	d on				

BE SURE TO READ THE BACK OF $\underline{\mathsf{PART}\,\mathsf{B}}$ FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

- Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.
 - Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.
 - For further information, please contact your services worker or call the general phone number on the front of this notice.
- If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
- Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.
- Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4013B (Rev. 5/05)

ACTION TAKEN ON YOUR APPLICATION:	PART B	PA, MA, FS, A
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NOTICE			PUBLIC AS	SIST	ANCE, FO	OOD S	STAMP	BENEFI		MEDICAL D ADDRES					OFFICE	
DATE:									INAIVIE AIN	D ADDRES	S OF AGEN	ICT/CEN	HER OR D	STRICT	OFFICE	
CASE NUM	1BER				CIN NUM	BER										
	CA	SE N	AME (And C/O Na	me if P	resent) AND	ADDR	ESS		•							
							-		GENER QUEST	AL TELEPH IONS OR H	IONE NO. F ELP	OR				
·										Agency C	Conference ring informat					
1								1		Record A	ccess					
OFFICE NO	<u> </u>	- 1	UNIT NO.	WO.	RKER NUME	RED I	INIT OR W	VORKER N	JAME	Legal Ass	sistance info	ormation	TELEPHOI			
The acti box(es)			en on your app SEE <u>P</u>							is exp					xt to the	checked
			FOOD S	ГАМР	BENEFI	rs nc	OT PICK	ED UP \	NITHIN 2	70 DAYS	CANNO	T BE I	REPLAC	ED.		
API	PRO'	<u>VED</u>	for Food Stan	np Ber	nefits from	າ				to						
			will get \$ month's benefi				for	the mor	nth of					becaus	se we mu	ust figure
•	1a. [] 7	The date you a	pplied	I to the en	nd of t	he montl	h. You n	nay acces	ss your be	enefit on _					.
•	1b. [The latest date You may acces	-	-						-		r it was d	ue.		
2. [r t	and _ nontl he n	will get \$ h's benefit of \$ nonth. Your sess your combin	S econd	month's	 bene	This is I	because v	you app vas figure	olied/provi ed from th	ided proo ne date y	f after ou app	the 15 th lied/prov	of the	month. `oof to th	Your first ne end of
3. [Begir	nning				you will g	get \$				mo	nthly in F	ood Sta	amp Ber	nefits.
	١	ou r	may access the	ese be	enefits on	the _		day	of each m	nonth.						
4. [_	nning				-	-				_ mon	thly in Fo	od Star	mp Bene	efits.
5 . [_	So yo	may access the ou could get For roof you still no	ood S	tamp Ben	efits r	right awa	ay, we ca	alculated	your bene						d here is
	C		will not be ab mine the Food ed.													
6. l			i applied for Pi vill not get a no							Stamp Be	enefits mi	ght go	down or	might s	top. If th	is happens,
7. [Ot	her I	nformation:													
□ <u>DE</u>	NIED	for l	Food Stamp B	enefits	s for [nan	ne(s)] becaus	se:								
			not give us th											oroof w	e listed a	above by
□ <u>o</u> т	HER	<u>:</u>														
□ <u>ov</u>	ERP	AYM	ENT INFORM	ATIOI	<u>N</u> (check a	all tha	it apply)									
	thar	n you	establishing a u should have ion on this ove	e. See	the Der	mand	Letter (and als	o, if you	r case is						
			rently have a ent for more in											Letter	and Re	payment
			efit in Section our overpayme								f \$		in y	your be	nefits in	order to
	rep	ay y	efit in Section our overpayme ion(s) is base	ent. Th	nis decisio	on is b	ased on	18 NYC	CRR 387.	19.			in <u>y</u>	your be	enefits in	order to
THE du	.ve 0	CUS	ionia) is base	u UII	10 INT CK											

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

NAME:		PART B	1	S App – No A/C – Adequate
V WIL.	ADDRESS:		CASE NUMBER:	
National School Lunch/or Breakfast Preshe attends a school that participates in send a copy of this notice to the school that	the National School Lun			
This notice also entitles your child(ren) to Food Service Program. Make a copy for your child the service Program.	free meals if they attend		ol, club or camp that part	icipates in the Summe
List Child(ren)'s name(s):				
Responsibility To Report Changes – changes.	See enclosed LDSS-315	1: "Food Stamp Change Re	eport Form" for information	on on when to report
CONFERENCE AND	FAIR HEARING SE	ECTION - DO YOU TH	HINK WE ARE WRO	NG?
f you think our decision was wrong, y and 2:	ou can ask for a revie	w of our decision. We w	ill correct our mistake	s. You can do both
I. Ask for a meeting (conference) with	none of our supervisor	s; 2. Ask for a Sta	te fair hearing with a S	State hearing officer
 CONFERENCE (Informal meeting please call us to set up a meeting. the address on the front of this encourage you to do this even whe 	To do this, call the connotice. Sometimes the	nference phone number his is the fastest way to	on the front of this no	otice or write to us a
2. STATE FAIR HEARING – You hav	e the following numbe	r of days from the date o	of this notice to ask for	a fair hearing:
	BENEFIT ARE	Α		TIME LIMIT
Public Assistance Medical Assis	tance, Social Services			60 days
Fublic Assistance, Medical Assis				
Food Stamp Benefits				90 days
Food Stamp Benefits	G: You can ask for a fa	air hearing by mail, by p	hone, by fax or onlin	•
Food Stamp Benefits HOW TO ASK FOR A FAIR HEARIN Mail: Send a copy of Part A and Pa	art B to the Office of A	Administrative Hearings,	New York State Office	e. ce of Temporary an
Food Stamp Benefits HOW TO ASK FOR A FAIR HEARIN Mail: Send a copy of Part A and Pa	art B to the Office of A Albany, New York 122 ree with the agency's	Administrative Hearings, 201. Please keep a copy	New York State Office of each notice for you	e. ce of Temporary an rself.
Food Stamp Benefits HOW TO ASK FOR A FAIR HEARIN Mail: Send a copy of Part A and Pa Disability Assistance, P.O. Box 1930, I want a fair hearing. I do not age	art B to the Office of A Albany, New York 122 ree with the agency's	Administrative Hearings, 201. Please keep a copy	New York State Office of each notice for you	e. ce of Temporary an rself.

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.

PA. MA. FS App LDSS-4013A NYC (Rev. 5/05) **ACTION TAKEN ON YOUR APPLICATION:** PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC) NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE CASE NUMBER CIN NUMBER CASE NAME (And C/O Name if Present) AND ADDRESS GENERAL TELEPHONE NO FOR QUESTIONS OR HELP ————— Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information OFFICE NO. LINIT NO WORKER NO UNIT OR WORKER NAME TELEPHONE NO is explained below and on Part B, next to the checked box(es) lacksquare: The action(s) taken on your application dated _ SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION. **PUBLIC ASSISTANCE** ACCEPTED for the period from ____ to ___ . You will get \$ ____ to ____ ____. After this you will get \$ _____. ☐ The above grant is based on a reduced budget because: _ failed without good cause to cooperate with the Office of Child Support Enforcement (OCSE) on [18NYCRR 352.3(d)]: ___ by ___ To lift this sanction, call (_____)____. Read the detailed instructions on the back of this notice. ___ failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]: ☐ rehabilitation □ screening ☐ assessment ☐ or, has not provided consent or revoked consent to disclose treatment information to the agency. A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance. The reason for this If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d). ☐ **DENIED** for [name(s)]_ The above decision(s) is based on 18 NYCRR __ **MEDICAL ASSISTANCE** ACCEPTED for Medical Assistance effective _______ for [name(s)] _____ □ ACCEPTED for Medical Assistance with a SPENDDOWN, effective ______ for [name(s)] Your total monthly income is \$. Your total monthly deductions are \$ The difference between these figures is your monthly net income for Medical Assistance. This is \$ ___ The allowable income standard for a family household your size is \$ ______ between your net income and this standard (\$_ ____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program. In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department. We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than so we can tell you the information we need. ☐ Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.

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

Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical

 \Box OTHER

This above decision(s) is based on _

Assistance.

living arrangements or address.

this notice.

A sanction for non-cooperation with a child support requirement is open-ended and will continue until

	contacts the Child Support Enforcement Unit and cooperates.
	When contacts the Child Support Enforcement Unit, he or she will be told what
	action(s) must be taken to end the sanction. The sanction will end when he or she takes the required
	actions(s). If did not cooperate but now wants to report a good reason for not
	cooperating with child support he or she should call ()
	Some examples of a good reason for not cooperating with child support are:
	fear of emotional or physical harm to you or the children in your family; or,
	 the child was born due to rape or incest; or,
	• the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put
	the child up for adoption and discussions have not gone on for more than three months.
	To find out more information about how to end the sanction, call ()
$\overline{\checkmark}$	Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.
	Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.
	For further information, please contact your services worker or call the general phone number on the front of this notice.
V	If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.

Regulations require that you immediately notify this Department of any changes in needs, income, resources,

Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

ACTION TAKEN ON YOUR APPLICATION: PART E

PA	MA	FS	qqA

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC) NOTICE NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE DATE: CASE NUMBER CIN 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 NUMBER | UNIT OR WORKER NAME TELEPHONE NUMBER The action(s) taken on your application dated _ _ is explained below and on Part A, next to the checked box(es) ✓. SEE PART A FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE INFORMATION. FOOD STAMP BENEFITS NOT PICKED UP WITHIN 270 DAYS CANNOT BE REPLACED. APPROVED for Food Stamp Benefits from ____ __ for the month of _ □ You will get \$ your first month's benefit from: 1a.

The date you applied to the end of the month. You may access your benefit on 1b. \square The latest date you provided proof we needed. This is because you gave us proof after it was due. You may access your benefit on _ 2.

You will get \$ _ which is a combined benefit for the months of . This is because you applied/provided proof after the 15th of the month. Your first and month's benefit of \$ was figured from the date you applied/provided proof to the end of the month. Your second month's benefit of \$___ ____ is for the entire month. You may access your combined benefit on ____ __ you will get \$____ 3. Beginning _ monthly in Food Stamp Benefits. ____ day of each month. You may access these benefits on the ___ ____ you will get \$_ 4.

Beginning ____ monthly in Food Stamp Benefits. You may access these benefits on the __ __ day of each month. 5.
So you could get Food Stamp Benefits right away, we calculated your benefit without all the necessary proof. Listed here is the proof you still need to provide: You will not be able to get Food Stamp Benefits in the future unless you provide this proof. This proof will be used to determine the Food Stamp Benefits you can get. If your Food Stamp Benefits change due to this proof, you will not be notified. 6. If you applied for Public Assistance and are approved, your Food Stamp Benefits might go down or might stop. If this happens, you will not get a notice about your Food Stamp Benefits. 7.

Other Information: ___ ☐ **DENIED** for Food Stamp Benefits for [name(s)] because:___ ☐ You did not give us the proof we need to see if you can get Food Stamp Benefits. If you give us this proof we listed above by _____, you will not have to reapply. After that date, you will have to reapply. OTHER: OVERPAYMENT INFORMATION (check all that apply) ☐ We are establishing a Food Stamp Benefits overpayment because you or your household got more in Food Stamp 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. This decision is base on 18 NYCRR 387.19. ☐ You currently have a Food Stamp Benefits 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 in Section 3 above reflects a ____ % reduction (recoupment) of \$ _____ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19. The benefit in Section 4 above reflects a ____ $_$ % reduction (recoupment) of \$ $_$ in your benefits in order to repay your overpayment. This decision is based on 18 NYCRR 387.19. The above decision(s) is based on 18 NYCRR:

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

LDSS-4013B NYC (Rev. 5/05) (Part B) Reverse	PART B - NYC	PA, MA, FS App - No A/C - Adequat
NAME:	ADDRESS:	CASE NUMBER:
	e National School Lunch and/or Breakfas	pproved to receive free lunch and/or breakfast if he st Programs. To receive this benefit, you must take
This notice also entitles your child(ren) to fre Food Service Program. Make a copy for you		a school, club or camp that participates in the Summsor.
List Child(ren)'s name(s):		
Responsibility To Report Changes when to report changes.	- See enclosed LDSS-3151: "Food S	stamp Change Report Form" for information on
CONFERENCE AND F	FAIR HEARING SECTION - DO Y	OU THINK WE ARE WRONG?
If you think our decision is wrong, you can as	sk for a review of our decision. We will cor	rect our mistakes. You can do both 1 and 2:
1. Ask for a meeting (conference) with	one of our supervisors; 2. Ask f	or a State fair hearing with a State hearing officer.
please call us to set up a meeting. To do	this, call the conference phone number of	was wrong, or if you do not understand our decision the front of this notice or write to us at the address ou may have. We encourage you to do this even wh
2. STATE FAIR HEARING – You hav	e the following number of days from the d	ate of this notice to ask for a fair hearing:
	BENEFIT AREA	TIME LIMIT
Public Assistance, Medical Assistance,	Social Services	60 days
Food Stamp Benefits		90 days
HOW TO ASK FOR A FAIR HEARING: You	can ask for a fair hearing by mail, by ph	one, by fax, by walk-in or online.
Mail: Send a copy of Part A and Part B Assistance, P.O. Box 1930, Albany, New Yo	to the Office of Administrative Hearings rk 12201. Please keep a copy of each not	s, New York State Office of Temporary and Disabi ice for yourself.
	the agency's action (Vou may explain wh	y you disagree below, but you do not have to include

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.

<u>Walk-In</u>: 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 34th 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, fax, 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 file that we will provide 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 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 (718) 722-5012, 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.

LDSS-4014A (Rev. 5/05) ACTION TAKEN ON YOUR RECERTIFICATION:

PART A PA, MA, FS, Serv-Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES

NOTIO DA					NAME AND ADDRESS OF AGENCY/CE	NTER OR DISTRICT OFFICE
CASE	NUMBER		CIN NUMBER		-	
	21251		**S *** *** *** *** *** *** *** *** ***	2500		
	— CASE N	NAME (And C/O Name	e if Present) AND ADD	THESS	GENERAL TELEPHONE NO. FOR	
l						
					OR Agency Conference Fair Hearing information and assistance	
				1	Record Access	
L	_	I	I		Legal Assistance information	
OFFIC	E NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER I	NAME	TELEPHONE NUMBER
			rtification dated		is explained	d below and on Part B, next to
the	checked box	` '	T B FOR FOOD S	STAMP BENEFIT	S AND FAIR HEARING INFORM	IATION.
PUE	BLIC ASSIST		<u></u>	<u> </u>		
	RECERTIFIE	ED for the period f	from		to	·
	REDUCE	your monthly Pub	blic Assistance ben	efit for that period	effective	
	from \$		to \$			
	INCREAS	SE your monthly P	Public Assistance be	enefit for that perio	d effective	
	from \$		to \$		·	
	CONTIN	UE your Public A	ssistance benefit	unchanged at \$ _		
A RECOUPMENT at the rate of percent (%) is being taken against your Public Assistance. If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d).						
	DISCONTIN	UE your Public As	ssistance benefit ef	fective	·	
The	REASON for	this action is				
The	above decis	ion(s) is based o	on 18 NYCRR			
ME	DICAL ASSI	STANCE				
	CONTINUE	the Medical Assist	tance coverage for	[name(s)]		pending
			-		Please contact us no later than	
					so we can te	
					review of eligibility. We will send yo	
	REDUCE the	e Medical Assistar	nce coverage effect	tive	for [name(s)]	
	coverage to deductions a	=	SPENDDOWN. You	r total gross month	nly income is \$	
	\$	The diffe			net income for Medical Assistance	
					S The difference income (18 NYCRR 360-4.8). The	
	under the Ex	cess Income Prog	gram and Optional	Pay-In Program.		
			tance for (name(s))			
		=			cal Assistance (See attached Medic due to receipt o	
	support payn	nents.				
					pietones and Madical Assistance P	
still	can get Socia	ou are getting Soc al Services at you	ur next scheduled i	recertification. This	sistance and Medical Assistance B s does not necessarily mean that	you will no longer be able to get

Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any questions, please contact your Services worker or call the general phone number at the top of this notice.

BE SURE TO READ THE BACK OF <u>PART B</u> FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

LDSS-4014A (Rev. 5/05) (Part A) Reverse	PART A	PA, MA, FS, Serv – Recert
NAME:	ADDRESS:	CASE NUMBER:

Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

For further information, please contact your Services worker or call the general phone number on the front of this notice.

- If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
- Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.
- Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

LDSS-4014B (Rev. 5/05) ACTION TAKEN ON YOUR RECERTIFICATION: PART B

PA, MA, FS, Serv Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEF	FITS, MEDICAL ASSISTANCE C	OVERAGE AND SERVICES
NOTICE DATE:	NAME AND ADDRESS OF AGE	NCY/CENTER OR DISTRICT OFFICE
CASE NUMBER CIN NUMBER		
CASE NAME (And C/O Name if Present) AND ADDRESS		
CASE NAIVE (And G/O Name it Present) AND ADDRESS	GENERAL TELEPHONE NO. F	FOR
	OR Agency Conference	
	Fair Hearing information and assistance	
	Record Access	
_	Legal Assistance in	formation
OFFICE NO. UNIT NO. WORKER NUMBER UNIT OR WO	RKER NAME	TELEPHONE NUMBER
The action(s) taken on your recertification dated	is explained	below and on Part A, next to the checked
box(es) : SEE PART A FOR PUBLIC ASSISTA		
FOOD STAMP BENEFITS NOT PICK	ED UP WITHIN 270 DAYS CAN	NOT BE REPLACED
☐ APPROVED for continued Food Stamp Benefits from		
1. \(\sum \) You will get \$ for the more month's benefit from:	nth of	because we must figure your first
1a. \Box The date you applied to the end of the month.	You may access your benefit on	
1b. The latest date you provided proof we needed. You may access your benefit on	, ,	oof after it was due.
2. U You will get \$ which is a	combined benefit for the months	s of and
of \$ was figured from the date	you applied/provided proof to the	of the month. Your first month's benefit end of the month. Your second month's
benefit of \$is for the entire mon		
3. Beginning You may access these benefits on the		monthly in Food Stamp Benefits.
3a. You will continue to get the benefit above until Stamp Benefits. You are not required to repor during your transition period that may increase application in order to receive any increase. Eperiod, otherwise, your transitional period and	This is because any changes until the end of this your benefits, you must contact tarly recertifications that result in	s transition period. If you have changes your worker to file an early recertification a benefit increase will end your transition
4. Beginningyou		
You may access these benefits on the	_	
5. So you could get Food Stamp Benefits right away, proof you still need to provide:	we calculated your benefit withou	ut all the necessary proof. Listed here is the
You will not be able to get Food Stamp Benefits in the Food Stamp Benefits you can get. If your Food	Stamp Benefits change due to the	nis proof, you will not be notified.
6. ✓ If you applied for Public Assistance and are approve will not get a notice about your Food Stamp Benefits		ght go down or might stop. If this happens, you
7. Other information:		
□ <u>DENIED</u> for Food Stamp Benefits because:		
	and Fred Oteres Benefits Keep	·
You did not give us the proof we need to see if you callines by, you will not ha	ve to reapply. After that date, you	
OTHER:		
OVERPAYMENT INFORMATION		
 We are establishing a Food Stamp Benefits overpaym you should have. See the Demand Letter (and also, if this overpayment. This decision is based on 18 NY 	your case is closing, the Repayn	
You currently have a Food Stamp Benefits overpayment Agreement for more information on the amount you or		
☐ The benefit in Section 3 above reflects a% re repay your overpayment. This decision is based on		in your benefits in order to
☐ The benefit in Section 4 above reflects a% re repay your overpayment. This decision is based on The above decision(s) is based on 18 NYCRR:	duction (recoupment) of \$	in your benefits in order to
22010 2001011(0) 10 20000 011 10 111 01(1).		

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

.DSS-4014B (Rev. 5/05) (Part B) Reverse		PART B	PA. MA. FS.	Serv Recert - Timely - A/C No FS
NAME:	ADDRESS:		CASE NUMBER:	
lational School Lunch/or Breakfast Protection as school that participates in the Naf this notice to the school that your child a	ntional School Lund Ittends.	ch and/or Breakfast Progr	ams. To receive this benefit, y	ou must take or send a copy
This notice also entitles your child(ren) to cood Service Program. Make a copy for you				participates in the Summer
List Child(ren)'s name(s):				
	ee enclosed LDSS	-3151: "Food Stamp Char	nge Report Form" for information	on on when to report
	<u>D FAIR HEARI</u>	NG SECTION - DO	<u>YOU THINK WE ARE W</u>	RONG?
you think our decision is wrong, you can	ask for a review of	our decision. We will corn	ect our mistakes. You can do	both 1 and 2:
1. Ask for a meeting (conference) with o	one of our supervis	sors; 2. Ask for	a State fair hearing with a State	e hearing officer.
to set up a meeting. To do this, call the notice. Sometimes this is the fastest was fair hearing.	conference phone	e number on the front of	this notice or write to us at the	address on the front of this
If you <u>only</u> ask for a meeting with us, we for a State fair hearing. (See "Keeping \			you appeal. Your benefits will s	stay the same only if you ask
2. STATE FAIR HEARING – You have	the following num	ber of days from the date	of this notice to request a fair I	nearing:
	BENEFIT	AREA		TIME LIMIT
Public Assistance, Medical Assistance), Social Services			60 days
Food Stamp Benefits				90 days
this notice is telling you that you owe a learn a fair hearing within 60 days of the date laim in the future that the agency's decision	e of this notice. If y	ou do not call for a fair h		
EEPING YOUR BENEFITS THE SAME: evel they were before this notice, if you a learing, your Food Stamp Benefits cannot hown in this notice. If you lose the fair hear hown were waiting for the decision. Also you do not want your benefits to stay the end back this notice, check the box or box	sk for a fair hearin ot be continued i earing, you will ha to, we may recover the same until the co	ng before the effective date in the same amount as we to pay back any Publi r Medical Assistance Bene	te stated in this notice. However before your recertification, but a Assistance benefits you got efits.	rer, even if you ask for a fair ut will be in the new amount but should not have gotten,
		paring decision is isolad.		
do not want to "keep my benefits the sam				
☐ Public Assis		☐ Medical Assistance	☐ Social Service	S
HOW TO ASK FOR A FAIR HEARING: Yo Mail: Send a copy of Part A and Part B to P.O. Box 1930, Albany, New York 12201. F	the Office of Adm	ninistrative Hearings, New	York State Office of Tempora	ry and Disability Assistance,
I want a fair hearing. I do not agree v written explanation.)	vith the agency's a	action. (You may explain	why you disagree below, but y	ou do not have to include a
Phone: 800-342-3334 (PLEASE HAVE TH	HIS NOTICE WITH	YOU WHEN YOU CALL	.)	
Fax: Fax a copy of the front and reverse of	this notice to: (51	8) 473-6735 or		
Online: Complete an online request form a	ıt: http://www.otd	a.state.ny.us/oah/forms	asp.	
you cannot reach the New York State Clearing before the deadline	of Temporary	y and Disability Assistanc	e by phone, by fax or online,	please write to ask for a fair
VHAT TO EXPECT AT A FAIR HEARING	: The State will sen	nd you a notice that tells you	u when and where the fair hearir	ng 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 number on the front of this notice or write to us at the address on the front of this notice.

LDSS-4014A NYC (Rev. 5/05) ACTION TAKEN ON YOUR RECERTIFICATION: PART A PA, MA, FS, Serv-Recert

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (NYC)

NOTI DA	CE ATE:				NAME AND ADDRESS OF AGENCY/CE	NIER OR DISTRICT OFFICE
CASE	NUMBER		CIN NUMBER		-	
	CASE N	NAME (And C/O Nam	ne if Present) AND ADD	RESS		
	_				GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	
					OR Agency Conference Fair Hearing information and assistance	
1				ſ	Record Access	
L			T		Legal Assistance information	
OFFIC	CE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER I	NAME	TELEPHONE NUMBER
			rtification dated		is explained	below and on Part B, next to
the	checked box	` ,	T D FOD FOOD (STAMD DENEET	C AND FAIR LIFARING INFORM	ATION
PUI	BLIC ASSIST		TIB FOR FOOD	STAMP BENEFIT	S AND FAIR HEARING INFORM	ATION.
			from		to	
[blic Assistance ben to \$		effective	
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L			discreption of the discreption o		d effective	
[
[aken against your Public Assistance	
	If you beli reason. A clothing, t what kind recoupme	ieve the recoupm in undue hardship to buy general ite If of proof you wi ent will cause an i	ent at this rate will o means that a pers ms of need, or to pa Il need to show th	cause your family son does not have ay for medical need at the recoupment re recoupment rate	an undue hardship, you should co enough income to eat, to pay for sh ds not covered by Medical Assistan t at this rate will cause an undue will be changed to a rate between s	ntact your worker to explain your selter or utilities, to get necessary ce. Your worker will let you know hardship. If we decide that the
		-			·	
The	REASON for	this action is				
The	above decis	ion(s) is based o	on 18 NYCRR			
ME	DICAL ASSIS	STANCE				
	CONTINUE	the Medical Assis				
	CONTINUE		stance coverage for			
		the Medical Assis	_	[name(s)]		unchanged.
	the receipt of		tance coverage for	[name(s)]		unchanged. pending
	-	f information nece	tance coverage for	[name(s)] [name(s)] ntinued eligibility. F		unchanged. pending
	at	f information nece	essary to decide constance coverage for	[name(s)] [name(s)] ntinued eligibility. F [name(s)]	Please contact us no later than so we can te	unchanged. pending Il you the information we need.
	continue	f information nece	essary to decide contained tance coverage for	[name(s)] [name(s)] ntinued eligibility. F [name(s)] pending our	Please contact us no later than so we can te	unchanged pending Il you the information we need. u our decision within thirty days.
	continue	f information nece	essary to decide contained tance coverage for	[name(s)] [name(s)] ntinued eligibility. F [name(s)] pending our	Please contact us no later thanso we can te review of eligibility. We will send you for [name(s)]	unchanged. pending If you the information we need. u our decision within thirty days.
	CONTINUE to REDUCE the coverage to 0	f information necether Medical Assistance Medical Assistance coverage with a S	essary to decide constance coverage for	[name(s)] [name(s)] ntinued eligibility. F [name(s)] pending our tive	Please contact us no later than so we can te	unchanged. pending Il you the information we need. u our decision within thirty days. from full
	CONTINUE to REDUCE the coverage to deductions a \$	f information nece the Medical Assis e Medical Assista coverage with a S re The diffe	essary to decide contains tance coverage for nee coverage effects	[name(s)] [name(s)] Intinued eligibility. F [name(s)] pending our tive Intitute gross month ese is your monthly	Please contact us no later than so we can te so we can te review of eligibility. We will send you for [name(s)] ally income is \$ ret income for Medical Assistance.	unchanged pending Il you the information we need our decision within thirty days from full Your total monthly
	at CONTINUE to REDUCE the coverage to deductions at \$ The allowable	the Medical Assistance Medical Assistance with a Sire The difference income standar	essary to decide contract coverage for trance coverage for trance coverage effects of the coverage eff	[name(s)] [name(s)] ntinued eligibility. F [name(s)] pending our tive ir total gross month ese is your monthly ehold your size is \$	Please contact us no later than so we can te so we can te review of eligibility. We will send you for [name(s)] sly income is \$ snet income for Medical Assistance shows a first income shows a f	unchangedpending Il you the information we need. u our decision within thirty daysfrom full Your total monthly This is \$ nce between your net income
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	REDUCE the coverage to deductions a \$ The allowabl and this stan under the Ex Medical Assi	the Medical Assistance Medical Assistance coverage with a Streem	essary to decide constance coverage for essary to decide constance coverage effects. SPENDDOWN. You erence between the dror a family house is you gram and Optional estance for [name(s)]	[name(s)]	Please contact us no later than so we can te so we can te review of eligibility. We will send you for [name(s)] sly income is \$ ret income for Medical Assistance \$ The difference income (18 NYCRR 360-4.8). The eligible income (18 NYCRR 360-4.8).	unchangedpending Il you the information we need. u our decision within thirty daysfrom full Your total monthly This is \$ nce between your net income enclosed letter explains eligibility al Assistance Fact Sheet).
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Social Services. At your recertification, we will do a redetermination to see if you can continue to get Social Services. If you have any questions, please contact your Services worker or call the general phone number at the top of this notice.

LDSS-4014A NYC (Rev. 5/05) (Part A) Reverse	PART A - NYC	PA, MA, FS, Serv – Recert
NAME:	ADDRESS:	CASE NUMBER:

Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

For further information, please contact your Services worker or call the general phone number on the front of this notice.

- If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.
- Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.
- Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.

NOTICE		PUB	LIC ASSISTANC	E, FOOD	STAMP	BENEFI	TS, MED			SE AND SERVICES (NYC) ENTER OR DISTRICT OFFICE	
DATE:								INAIVIE AINI	D ADDRESS OF AGENCY/CI	ENTER OR DISTRICT OFFICE	
CASE NU	JMB	ER		CIN	NUMBER						
		CASE	NAME (And C/O Nam	e if Present)	AND ADD	RESS					
	-		, , , , , ,	,			\neg		AL TELEPHONE NO. FOR		
ı							'		Agency Conference		
									Fair Hearing information and assistance		
									Record Access		
	_								Legal Assistance information	on	
OFFICE N	VO.		UNIT NO.	WORKER N	NUMBER	UNIT OR \	WORKER N	IAME		TELEPHONE NUMBER	
The ac	ctio	n(s) tal	ken on vour recer	tification c	lated				is explained below	and on <u>Part A,</u> next to the che	ecked
box(es		: '	-							RVICES INFORMATION.	
			FOOD S	TAMP BE	<u>NEFITS</u>	NOT PIC	CKED UP	WITHIN	270 DAYS CANNOT E	BE REPLACED	
□ <u>A</u>	PP	ROVE	of for continued Fo	ood Stamp	Benefi	ts from			to		_•
1.			will get \$ hth's benefit from:			for the m	nonth of _			because we must figure your firs	st
	1a	a. 🗆	The date you app	lied to the	end of	the month	h. You m	ay access	s your benefit on		_
	1t		The latest date yo You may access		•				e you gave us proof afte	er it was due.	
2.		l You	will get \$			_ which is	s a comb	ined bene	efit for the months of	and	_
		of S	\$	was fig	gured fro	om the da	ite you ap	plied/pro	vided proof to the end	e month. Your first month's bene of the month. Your second month	า'ร
								-	•	nefit on	
3.										_ monthly in Food Stamp Benefi	ts.
	26		may access thes				•			vou are eligible for Transitional	Food
	Se	i. ப	Stamp Benefits. during your trans application in ord	You are resition perioder to rece	not requod that related the relationship in the relationship in the relationship in the relationship in the requirement of the	ired to re may incre increase	eport any ease your e. Early	changes benefits, recertifica	until the end of this tr , you must contact you	you are eligible for Transitional ansition period. If you have chaur worker to file an early recertificenefit increase will end your trange.	anges cation
4.		l Beg	inning				you will g	et \$		_ monthly in Food Stamp Benefi	ts.
		You	may access thes	e benefits	on the		day of	each mo	nth.		
5.			ou could get Foo of you still need to		Benefits	right awa	ay, we cal	culated y	our benefit without all th	he necessary proof. Listed here is	s the
		the	Food Stamp Bend	efits you c	an get. I	f your Fo	od Stam	Benefits	s change due to this pro	of. This proof will be used to dete pof, you will not be notified.	
6.	. ⊻	If yo you w	u applied for Pub vill not get a notic	lic Assista e about yo	nce and our Food	l are appr I Stamp B	oved, yo Benefits.	ur Food S	Stamp Benefits might go	o down or might stop. If this happ	ens,
7.	. \square	l Othe	er information:								
											<u> </u>
□ <u>DI</u>	EN	IED for	Food Stamp Ber	nefits beca	ause:						_
										us this proof we listed on the aboave to reapply for benefits.	 ove
□ <u>o</u>	TH	<u>ER</u> :									
_ 	VE	RPAYI	MENT INFORMA	TION							<u>—</u>
)	ou sho		e Demand	d Letter ((and also	, if your c	ase is clo		ot more in Food Stamp Benefits the agreement) for more information of	
									is closing, see the Den will repay this overpay	nand Letter and Repayment ment.	
			nefit in Section 3 our overpayment							in your benefits in order	to
☐ The al	1	ерау у	nefit in Section 4 your overpayment ision(s) is based	. This ded	cision is	s based o				in your benefits in order	to
									DIGUES ON HOW TO	ADDEAL THE DECICION	

DSS-4014B NYC (Rev. 5/05) (Part B) I		PART B – NYC		Recert - Timely – A/C No F
NAME:	ADDRESS:		CASE NUMBER:	
tends a school that participates in opy of this notice to the school that his notice also entitles your child(note)	ast Programs - The child(ren) list on the National School Lunch and one is your child attends. Ten) to free meals if they attend a one of the province of the	or Breakfast Programs. T	o receive this benefit, y	you must take or send
List Child(ren)'s name(s):	, . , , , , ,			
List Child(ren)'s name(s).				
Responsibility To Report Chang changes.	es – See enclosed LDSS-3151: "F	Food Stamp Change Repo	rt Form" for information	on when to report
CONFEREN	NCE AND FAIR HEARING SE	CTION – DO YOU THII	NK WE ARE WRONG	<u> </u>
you think our decision is wrong, yo				
. Ask for a meeting (conference) w	ith one of our supervisors; 2.	Ask for a State fair hearing	g with a State hearing of	ficer.
<u>CONFERENCE</u> (Informal meet to set up a meeting. To do this, ca notice. Sometimes this is the faste fair hearing.	all the conference phone number of	on the front of this notice	or write to us at the add	dress on the front of t
you only ask for a meeting with us				
			. Your benefits will stay	the same only if you a
or a State fair hearing. (See "Keepi	ng Your Benefits The Same" below	w.)		
or a State fair hearing. (See "Keepi	ng Your Benefits The Same" below	w.)		
or a State fair hearing. (See "Keepi	ng Your Benefits The Same" below have the following number of day BENEFIT AREA	w.)		ing: TIME LIMIT 60 days
STATE FAIR HEARING — You Public Assistance, Medical Assistance Food Stamp Benefits	ng Your Benefits The Same" below have the following number of day BENEFIT AREA ce, Social Services	w.) vs from the date of this not	ice to ask for a fair hear	ing: TIME LIMIT 60 days 90 days
STATE FAIR HEARING — You Public Assistance, Medical Assistance Food Stamp Benefits f this notice is telling you that you come a fair hearing within 60 days of the	BENEFIT AREA ce, Social Services owe a Public Assistance overpaymed date of this notice. If you do not	w.) rs from the date of this not the date of this not nent, and if you do not agr ot call for a fair hearing wit	ice to ask for a fair heari	ing: TIME LIMIT 60 days 90 days erpayment, you must o
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330 West 34th 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, fax, 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 file that we will provide 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 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 (718) 722-5012, 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.