LDSS-4014A NYC (Rev. 11/06) **ACTION TAKEN ON YOUR RECERTIFICATION: PART A** PA, MA, FS, Serv-Recert

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

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
	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 recertification dated _____ is explained below and on Part B, next to the checked box(es) ☑:

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **RECERTIFIED** for the period from _____ to _____

☐ **REDUCE** your monthly Public Assistance benefit for that period effective _____ from $ _____ to $_____ .

☐ 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 _____ by _____ [18NYCRR 352.3(d)]:

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)]:

☐ screening ☐ assessment ☐ rehabilitation

☐ or, has not provided consent or revoked consent to disclose treatment information to the agency.

☐ **INCREASE** your monthly Public Assistance benefit for that period effective _____ from $ _____ to $ _____ .

☐ [name(s)] _____ has been added to your case.

☐ We cannot add the following individuals to your case:

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

Name(s): _____ Reason(s)_____

☐ **CONTINUE** your Public Assistance benefit unchanged at $ _____ .

☐ **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).

☐ **DISCONTINUE** your Public Assistance benefit effective _____ .

The **REASON** for this action is _____

_____ .

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

MEDICAL ASSISTANCE

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____ unchanged.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)]

_____

pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

☐ **CONTINUE** the Medical Assistance coverage for [name(s)] _____ _____ pending our review of eligibility. We will send you our decision within thirty days.

☐ **REDUCE** the Medical Assistance coverage effective_____ for [name(s)] _____ _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____ . Your total monthly deductions are $_____ . The difference between these is your monthly net income for Medical Assistance. This is $ _____ . The allowable income standard for a family household your size is $ _____ . The difference 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.

☐ **DISCONTINUE** Medical Assistance for [name(s)]_____ effective _____ because _____ _____

☐ Medical Assistance coverage will continue under Transitional Medical Assistance (See attached Medical Assistance Fact Sheet).

☐ Medical Assistance coverage will continue until _____due to receipt of/increase in child or spousal support payments.

The above decision(s) is based on _____ .

SERVICES – If you are getting Social Services and lose your Public Assistance and Medical Assistance Benefits, we will need to see if you still can get Social Services at your next scheduled recertification. This 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 PART B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

Enclosures **DISTRIBUTION:** White -CLIENT/FAIR HEARING COPY Yellow – CLIENT COPY Pink – AGENCY COPY

NAME:	ADDRESS:	CASE NUMBER:

To Lift a Sanction for Non-cooperation with a Child Support Requirement

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 (_____)_____.

☑ 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.

☑ **Animal Population Control Program (APCP)** - If you have been approved to continue to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for $20.00. If this notice says you are approved to continue to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, a copy of this notice is proof that you are eligible to participate in the animal population control program. To receive an application voucher for this program, call 1-888-669-0870.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.