ACTION TAKEN ON YOUR APPLICATION: PART A
PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) AND MEDICAL ASSISTANCE COVERAGE

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 NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The action(s) taken on your application dated _____ is explained below and on Part B, next to the checked box(es) ☑ :

SEE PART B FOR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **ACCEPTED** for the period from _____ to _____ for [name(s)] _____ _____. You will get $_____, which will cover the period from _____ to _____. After this you will get $ _____.

_____

_____

☐ 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).

☐ **DENIED** for the following individuals:

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

Name(s): _____Reason(s)_____

☐ **OTHER**_____

_____

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 $ _____. 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.

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

In the event that you are hospitalized, you may be eligible for Medical Assistance and should contact this Department.

☐ **PENDED**

- ☐ We do not have enough information to decide your eligibility under the Medical Assistance program. Please contact us no later than _____ at_____ 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.
- ☐ Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance.

☐ **OTHER** _____

This above decision(s) is based on _____.

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

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

☑ 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 your application for Public Assistance or Medical Assistance was denied, Social Services may provide information and education about family planning for up to 90 days from the date you applied.

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, SNAP 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.