LDSS-4015 B NYC (Rev. 5/16) **NOTICE OF INTENT TO CHANGE BENEFITS: PART B** PA, MA, SNAP, Serv Change

PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY & ADEQUATE) (NYC)

NOTICE DATE:	CASE NUMBER	CIN NUMBER	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE

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

We are CHANGING your benefits, as explained below and on Part A , next to the checked box(es) ☑ :

SEE PART A FOR PUBLIC ASSISTANCE, MEDICAL ASSISTANCE AND SERVICES INFORMATION.

If you do not use your SNAP account for a period of 365 consecutive days, any SNAP benefit remaining in the account that is at least 365 days old will be expunged (removed) from the account. Expunged SNAP benefits cannot be reissued.

SNAP

1. ☐ **INCREASE** your SNAP benefits from $ _____ to $ _____ effective _____ .

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

☐ Your SNAP certification period has been extended. Your benefits will now end in _____

2. ☐ **CONTINUE** your SNAP benefits at $ _____ effective _____

for [name(s)] _____.

☐ Your SNAP certification period has been extended. Your benefits will now end in_____.

3. ☐ **REDUCE** your SNAP benefits from $ _____ to $ _____ effective _____.

☐ Your SNAP certification period has been extended. Your benefits will now end in _____.

4. ☐ **DISCONTINUE** your SNAP benefits as of _____

5. ☐ **OTHER:** _____

_____

6. ☐ **OVERPAYMENT INFORMATION (Check All That Apply)**

☐ We are establishing a SNAP overpayment because you or your household got more in SNAP 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 based on 18 NYCRR 387.19**.

☐ The benefit above reflects a ____% reduction (Recoupment) of $_____ in your benefits in order to repay your overpayment. **This decision is based on 18 NYCRR 387.19.**

In the future if your case is closed, you will receive a separate notice providing repayment options and guidelines to ensure paying back the remaining balance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance.

7. ☐ We cannot add the following individuals to your case:

Name:_____ Reason(s)_____

Name:_____ Reason(s)_____

_____

8. ☐ If you are getting Public Assistance and/or Medical Assistance, this change will NOT affect those benefits.

9. ☐ **OTHER INFORMATION:**

_____

_____

The reason for this action is:_____

_____

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

☑ Responsibility To Report Changes – See enclosed LDSS-3151: "SNAP Change Report Form" for information on when to report changes.

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

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

NAME:	ADDRESS:	CASE NUMBER:

CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

If you think our decision is wrong, you can ask for a review of our decision. We will correct our mistakes. You can do both 1 and 2:

1. Ask for a meeting (conference) with one of our supervisors; 2. Ask for a State fair hearing with a State hearing officer.

The Office of Temporary and Disability Assistance (OTDA) policy issuances and manuals are posted on the OTDA website at otda.ny.gov/legal. These issuances and manuals are available to you or your representative to determine whether a fair hearing should be requested or to prepare for a fair hearing. In addition, upon request to your local social services district, specific OTDA policy issuances and manuals will also be available to assist you or your representative.

1. **CONFERENCE** (Informal meeting with us) - If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the **front** of this notice or write to us at the address on the **front** of this notice. Sometimes this is the fastest way to solve any problem you may have. We encourage you to do this even when you have asked for a fair hearing.

   If you only ask for a meeting with us, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a State fair hearing. (See "Keeping Your Benefits The Same" below.)

2. **STATE FAIR HEARING –** You have the following number of days from the date of this notice to ask for a fair hearing:

BENEFIT AREA	TIME LIMIT
Public Assistance, Medical Assistance, Social Services	60 days
SNAP Benefits	90 days

If this notice is telling you that you owe a Public Assistance overpayment, and if you do not agree that you owe this overpayment, you must call for a fair hearing within 60 days of the date of this notice. If you do not call for a fair hearing within 60 days of the date of this notice, you cannot claim in the future that the agency's decision that you owe the debt was wrong.

KEEPING YOUR BENEFITS THE SAME: We will not change your Public Assistance, SNAP, Medical Assistance and Social Services benefits, if you ask for a fair hearing before the effective date stated in this notice. However, if you lose the fair hearing, you will have to pay back any Public Assistance and SNAP benefits you got but should not have gotten, while you were waiting for the decision. Also, we may recover Medical Assistance Benefits.

If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a fair hearing or, if you send back this notice, check the box or boxes below:

I do not want to "keep my benefits the same" until the Fair Hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ SNAP ☐ Social Services

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by **mail,** by **phone,** by **fax,** by **walk-in** or **online.**

Mail: Send a copy of **Part A and Part B** to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy of each notice for yourself.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

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** or

Walk-In: Bring a copy of this entire notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn.

Online: Complete an online request form at: **http://www.otda.ny.gov/oah/forms.asp.**

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, fax, by 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.