LDSS-4013A NYC (Rev. 5/16) **ACTION TAKEN ON YOUR APPLICATION:** **PART A** **PA, MA, SNAP App**

PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) AND MEDICAL ASSISTANCE COVERAGE (NYC)

NOTICE DATE: 10/16/2023

CASE NUMBER

CIN NUMBER

CASE NAME (And C/O Name if Present) AND ADDRESS

30 WALL STREET
Apt 8F
NEW YORK NY 10005-0000

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
Waverly Job Center
109 E 16th St, 1st Fl
New York NY 10003

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.
013	CCR	WMCJT	R. Johnson	( )

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP (718) 557-1399
OR Agency Conference (718) 557-1399
Fair Hearing Information and assistance (718) 557-1399
Record Access (718) 722-5012
Legal Assistance Information (718) 557-1399

The action(s) taken on your application dated 08/29/2023 is explained below and on Part B, next to the checked box(es) ☑ :

SEE PART B FOR SNAP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☑ **ACCEPTED** for the period from 8-29-2023 to 1-31-2024
for [name(s)] .
You will get $114.81, which will cover the period from 8-29-2023 to 9-9-2023. After this you will get $145.50.

☐ The above grant is based on a reduced budget because:
☐ _____ failed without good cause to cooperate with the Office of Child Support Enforcement (OSCE) 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.

☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance. The reason for this recoupment is:
_____. 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:
If **ALL** is listed in the first **Name(s)** field, every member of your household was **DENIED** for the same stated **Reason(s)**.

Name(s): _____ Reason(s): _____
Name(s): _____ Reason(s): _____
Name(s): _____ Reason(s): _____
Name(s): _____ Reason(s): _____

The above decision(s) is based on 18 NYCRR. 18 NYCRR 352.29

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

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

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DOCUMENTS NEEDED

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

MEDICAL ASSISTANCE

☑ **ACCEPTED** for Medical Assistance effective 8-1-2023 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 18 NYCRR 352.29

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 action(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 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.

LDSS-4013B NYC (Rev. 5/16)

ACTION TAKEN ON YOUR APPLICATION: PART B

PA, MA, SNAP, App

PUBLIC ASSISTANCE, SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
AND MEDICAL ASSISTANCE COVERAGE (NYC)

NOTICE DATE: 10/16/2023

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OFFICE NO.	UNIT NO.	WORKER NUMBER	UNIT OR WORKER NAME	TELEPHONE NUMBER
013	CCR	WMCJT	R. Johnson	(929) 221-6686

The action(s) taken on your application dated 08/29/2023 is explained below and on Part A, next to the checked box(es) ☑. **SEE PART A FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE 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.

☑ **APPROVED** for SNAP from 8-29-2023 to 1-31-2024 for [name(s)]

1. ☐ You will get $_____ for the month of _____ because we must figure your first month's benefit from:
   1a. ☐ 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. 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 _____ and _____. This is because you applied/provided proof after the 15th of the month. Your first 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 _____.
3. ☐ Beginning _____ you will get $_____ monthly in SNAP benefits. You may access these benefits on the _____ day of each month.
4. ☑ Beginning November you will get $291.00 monthly in SNAP benefits. You may access these benefits on the 04 day of each month.
5. ☐ So you could get SNAP 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 SNAP in the future unless you provide this proof. This proof will be used to determine the SNAP benefits you can get. If your SNAP benefits change due to this proof, you will **not** be notified.
6. ☑ If you applied for Public Assistance and are approved, your SNAP benefits might go down or might stop. If this happens, you will not get a notice about your SNAP.
7. ☐ Other information: _____

☑ **DENIED** for the following individuals:

Name(s): _____ Reason(s): You are not a United States citizen or an eligible non-citizen.
Name(s): _____ Reason(s): _____
Name(s): _____ Reason(s): _____
Name(s): _____ Reason(s): _____

☐ You did not give us the proof we need to see if you can get SNAP 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.

☐ **PENDING** Your application for SNAP benefits is pending because we are still reviewing your eligibility for SNAP. We will notify you of our decision. You do not need to file another application for SNAP.

☐ **OTHER:** _____

The above decision(s) is based on 18 NYCRR:
18 NYCRR 387.14, CFR 273.2(j)(1)(IV)

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

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

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NAME:	ADDRESS:	CASE NUMBER:

DOCUMENTS NEEDED

☐ **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 in Line 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 Line 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.

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 claim balance. You will have 30 days from the date you receive this notice to make arrangements for repayment of the remaining balance.

National School Lunch and/or Breakfast Programs - 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):

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

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.
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

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.**

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

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

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

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