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Local Commissioners Memorandum

Section 1

Transmittal:	16-LCM-09
To:	Local District Commissioners
Issuing Division/Office:	Strategic Operations, OTDA Executive Office
Date:	June 27, 2016
Subject:	Revisions to the LDSS-2921, PUB-1301, LDSS-3174, PUB-1313, LDSS-4148A-C, LDSS-4826, LDSS-4826A, LDSS-4942, and LDSS-2291
Contact Person(s):	OTDA Strategic Operations: (518) 408-5962
Attachments:	Attachment 1 - LDSS-2921: "New York State Application for Certain Benefits and Services" Attachment 2 - PUB-1301: "Instructions for Completing the New York State Application for Certain Benefits and Services" Attachment 3 - LDSS-3174: "New York State Recertification Form for Certain Benefits and Services" Attachment 4 - PUB-1313: "Instructions for Completing the New York State Recertification Form for Certain Benefits and Services" Attachment 5 - LDSS-4148A: "Book 1: What You Should Know About Your Rights and Responsibilities" Attachment 6 - LDSS-4148B: "Book 2: What You Should Know About Social Services Programs" Attachment 7 - LDSS-4148C: "Book 3: What You Should Know If You Have an Emergency" Attachment 8 - LDSS-4826: "Supplemental Nutrition Assistance Program (SNAP) Application/Recertification" Attachment 9 - LDSS-4826A: "How to Complete the Supplemental Nutrition Assistance Program (SNAP) Application/Recertification and Applicant/Recipient Rights and Responsibilities for SNAP" Attachment 10 - LDSS-4942: "SNAP Authorized Representative Request Form" Attachment 11 - LDSS-2291: "Request for Replacement of Food Purchased with Supplemental Nutrition Assistance Program (SNAP) Benefits"
Attachment Available Online:	<input checked="" type="checkbox"/>

Section 2

I. Purpose

The purpose of this Local Commissioners Memorandum (LCM) is to inform social services districts (SSDs) of recent revisions to the following documents:

- LDSS-2921: “New York State Application for Certain Benefits and Services” (formerly, “New York State Application for:”)
- PUB-1301: “Instructions for Completing the New York State Application for Certain Benefits and Services” (formerly, New York State How to Complete the...Application”)
- LDSS-3174: “New York State Recertification Form for Certain Benefits and Services” (formerly, “New York State Recertification Form for:”)
- PUB-1313: “Instructions for Completing the New York State Recertification Form for Certain Benefits and Services” (formerly, New York State How to Complete the...Recertification Form”)
- LDSS-4148A: "Book 1: What You Should Know About Your Rights and Responsibilities"
- LDSS-4148B: "Book 2: What You Should Know About Social Services Programs"
- LDSS-4148C: "Book 3: What You Should Know if You Have an Emergency"
- LDSS-4826: “Supplemental Nutrition Assistance Program (SNAP) Application/Recertification”
- LDSS-4826A: “How to Complete the Supplemental Nutrition Assistance Program (SNAP) Application/Recertification and Applicant/Recipient Rights and Responsibilities for SNAP”
- LDSS-4942: “SNAP Authorized Representative Request Form”
- LDSS-2291: “Request for Replacement of Food Purchased with Supplemental Nutrition Assistance Program (SNAP) Benefits”

This LCM is intended to convey significant changes made to the documents listed above, and to provide information to SSDs regarding the distribution and use of these revised documents.

II. Background

As a result of a court-ordered Stipulation of Settlement in Rafferty v. OTDA, DOH, HRA, et al. (Rafferty), the New York State Office of Temporary and Disability Assistance (OTDA), the NYS Department of Health (DOH), and the New York City Human Resources Administration (HRA) will provide certain written materials in alternative formats, upon request, to blind or seriously visually impaired applicants and recipients. Alternative formats include large print, audio format (an audio transcription of the document), data format (a screen reader-accessible electronic file), and Braille, if an applicant or recipient asserts that none of the previously mentioned alternative formats will be equally effective for them. Language informing applicants and recipients of the availability of alternative formats and the procedure for requesting the same has been added to the applications, instructions, and publications listed above. A directive containing additional information concerning the Rafferty Stipulation of Settlement,

alternative formats, and how to process an applicant or recipient's request for the same is forthcoming.

In addition to the revisions discussed above, other modifications were made in response to changes in federal requirements, such as those associated with federal health care reform, as well as in response to recommendations made by SSDs. A group of 13 SSDs representing small, medium, and large districts, was consulted regarding revisions to these documents, and their feedback was incorporated into the final versions of the documents.

III. Program Implications

Major revisions to the documents are as follows:

LDSS-2921: "New York State Application for Certain Benefits and Services" and LDSS-3174: "New York State Recertification Form for Certain Benefits and Services"

- Language informing applicants and recipients of the availability of alternative formats has been added to the first page of both the LDSS-2921 and LDSS-3174. Questions have also been added to the first page of both forms that allow applicants and recipients to indicate whether they would like to receive written notices in an alternative format.
- Both forms now have perforated edges, to allow for easier separation and scanning of pages.
- The new version of the LDSS-2921 will no longer be printed with green ink. The form will be printed in grayscale.
- References to "Medical Assistance" have been replaced with "Medicaid." References to Family Health Plus, Child Health Plus, and the Medicare Savings Plan have been removed.
- Language has been added to direct applicants for Medicaid only to use a separate form, DOH-4220: "Health Insurance Application for Children, Adults, and Families," to apply.
- References to "Lifeline" have been removed.
- References to "Temporary Assistance" or "TA" have been replaced with the statutorily defined term of "Public Assistance" or "PA."
- The content of the section formerly titled "Non-Custodial Parent/Child Support/Medical Support Information" has been modified. This section is now called "Information Regarding Referral to the Child Support Enforcement Unit" and can be found on page 6 of both forms.
- A "Tax Filing/Dependent Status" section has been added to these forms for Medicaid purposes. This section appears on page 7 of both forms.
- The "Income Information" section has been expanded for Medicaid purposes to include questions regarding federal tax deductions. These questions can be found on page 9 of both forms.
- The "Education/Training" section of these forms has been expanded to allow the applicant or recipient to provide more information regarding the highest level of education obtained.

- The “Notices” and the “Assignments, Authorizations, and Consents” sections have been updated, reorganized, reformatted and consolidated into one section on pages 19 through 25, titled “Notices, Assignments, Authorizations, and Consents.”
- The sections for consenting to withdraw the application and consenting to case closure have been moved to the end of each form.

PUB-1301: “Instructions for Completing the New York State Application for Certain Benefits and Services” and PUB-1313: “Instructions for Completing the New York State Recertification Form for Certain Benefits and Services”

- The PUB-1301 and PUB-1313 now contain language regarding the availability of alternative formats to blind and seriously visually impaired applicants and recipients. These publications now also contain instructions on how to request written notices in an alternative format, as well as how to request another accommodation.
- The instructions contained in these publications were modified to be more comprehensive, and to be consistent with any corresponding changes made to the LDSS-2921 and LDSS-3174.
- The new version of the PUB-1301 will no longer be printed with green ink. The publication will be printed in grayscale.
- The formats of these publications have been modified to facilitate easier reading.

LDSS-4148A: “Book 1: What You Should Know About Your Rights and Responsibilities,” LDSS-4148B: “Book 2: What You Should Know About Social Services Programs,” and LDSS-4148C: “Book 3: What You Should Know if You Have an Emergency”

- Language regarding the availability of alternative formats to blind and seriously visually impaired applicants or recipients was added to the LDSS-4148A, LDSS-4148B, and LDSS-4148C.

LDSS-4826: “Supplemental Nutrition Assistance Program (SNAP) Application/Recertification

- The LDSS-4826 now contains language regarding the availability of alternative formats to blind and seriously visually impaired applicants and recipients. This form now also contains questions that allow applicants and recipients to request written notices in an alternative format, as well as instructions on how to request another accommodation.
- Corrections were made to cross-references of page numbers.
- Updates were made to the “SNAP Penalty Warning,” “Consent,” and “Changes” sections, and to the language pertaining to the release of applicant and recipient information.

LDSS-4826A: “How to Complete the Supplemental Nutrition Assistance Program (SNAP) Application/Recertification and Applicant/Recipient Rights and Responsibilities for SNAP”

- The LDSS-4826A now contains language regarding the availability of alternative formats to blind and seriously visually impaired applicants and recipients. This document now also contains instructions on how to request an alternative format or another accommodation.
- Corrections were made to cross-references of page numbers.
- Updates were made to the “SNAP Penalty Warning” and “Consent” sections, and to the language pertaining to able-bodied adults without dependents and release of applicant and recipient information.

LDSS-4942: “SNAP Authorized Representative Request Form”

- The LDSS-4942 now contains language regarding the availability of alternative formats to blind and seriously visually impaired applicants and recipients. This form now also contains questions that allow applicants and recipients to request written notices in an alternative format, as well as instructions on how to request another accommodation.
- Updates were made to the “SNAP Penalty Warning” section.

LDSS-2291: “Request for Replacement of Food Purchased with Supplemental Nutrition Assistance Program (SNAP) Benefits

- The LDSS-2291 now contains language regarding the availability of alternative formats to blind and seriously visually impaired recipients. This form now also contains questions that allow recipients to request written notices in an alternative format, as well as instructions on how to request another accommodation.

Please note that the alternative format documents have modified publication numbers. For example, the publication number of the Braille version of the LDSS-2921 is “LDSS-2921 BR.”

Effective July 1, 2016, all previous versions of the documents listed above must be recycled and replaced with the most current versions. SSDs may only distribute the July 2016 versions of these documents after July 1, but must accept and process any applications or recertification forms submitted by applicants or recipients using the previous versions of these forms.

Prior to July 1, 2016, SSDs will receive “drop” shipments of the most recent versions of the documents listed above in non-alternative format only. These documents have a revision date of July 2016. Both non-alternative and alternative format versions of the documents will be available for download and/or ordering at http://otda.state.ny.net/ldss_eforms/. These documents can be ordered from OTDA by submitting a completed OTDA 876EL (DOC) or OTDA 876 EL (PDF) form, available at the link above, via mail, e-mail, or fax to:

Office of Temporary and Disability Assistance
BMS Document Services and Operational Support
PO Box 1990
Albany, NY 12201

Email: forms.orders@otda.ny.gov

Fax: (518) 402-0084

These documents can also be ordered through the OTDA Bureau of Management Services' (BMS') Electronic Forms and Publications Online System: <http://formorders/>. For more information on how to download or order these documents in alternative formats, please consult the forthcoming policy directive concerning the Rafferty Stipulation of Settlement.

Translations of the above listed documents into languages other than English will be available following July 1, 2016. To provide meaningful access in the interim, SSDs must not use previous versions of these documents that have been translated into languages other than English. SSDs must utilize interpreter services for applicants and recipients with limited English proficiency (LEP) who require assistance with the completion of the newest versions of these forms. For further information regarding the provision of services to LEP individuals, SSDs should refer to 06-ADM-05, "Providing Access to Temporary Assistance Programs for Persons with Disabilities and/or Limited English Proficiency (LEP)."

Any questions concerning revisions to the LDSS-2921, PUB-1301, LDSS-3174, PUB-1313, and LDSS-4148A, LDSS-4148B, or LDSS-4148C should be directed to OTDA's Strategic Operations unit at (518) 408-5962. Questions concerning revisions to the LDSS-4826, LDSS-4826A, LDSS-4942, or LDSS-2291 should be directed to OTDA's SNAP Bureau at (800) 343-8859. Contact OTDA's BMS unit at (800) 343-8859, ext. 4-9522, with any questions regarding the ordering of documents described herein.

Issued By

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CENTER/ OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	SERV. IND	CASE NUMBER	REGISTRY NUMBER	VERS	DISTRICT	SUFFIX	SNAP SUFFIX	CATEGORY	LANG	NUMBER REUSE INDICATOR	
CASE NAME						EFFECTIVE DATE	DISPOSITION			SERVICES TRANSACTION TYPE					
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							DENIAL	REASON CODE	WITHDRAWAL	02	NEW OPENING	10	REOPEN	06	RECERTIFICATION
ELIGIBILITY DETERMINED BY (WORKER):			DATE	ELIGIBILITY APPROVED BY (SUPERVISOR):			DATE	SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION			DATE				
								FORM _____							
								OF _____			x _____				
DATE RECEIVED BY AGENCY		EMPLOYED BY: <input type="checkbox"/> SOCIAL SERVICES DISTRICT <input type="checkbox"/> PROVIDER AGENCY SPECIFY: _____													
PA AUTHORIZATION PERIOD				MA AUTHORIZATION PERIOD				SNAP AUTHORIZATION PERIOD				SERVICES AUTHORIZATION PERIOD			
FROM		TO		FROM		TO		FROM		TO		FROM		TO	

NEW YORK STATE APPLICATION FOR CERTAIN BENEFITS AND SERVICES

If you are blind or seriously visually impaired and need this application in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request an application in an alternative format, see the instruction book (PUB-1301 Statewide), available at

www.otda.ny.gov or <https://www.health.ny.gov/>.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? Yes No

If yes, check the type of format you would like: Large Print; Data CD;

Audio CD; Braille, if you assert that none of the other alternative formats will be equally effective for you.

If you require another accommodation, please contact your social services district.

We are committed to assisting and supporting you in a professional and respectful manner. You are responsible for participating in activities, including work activities for Public Assistance and the Supplemental Nutrition Assistance Program, where required, so you can become self-sufficient. Whenever you see "Public Assistance" or "PA" on the application, it means "Family Assistance" and/or "Safety Net Assistance." We call both programs "Public Assistance." These PA programs are meant to assist you only until you can fully support yourself and your family. **Please refer to the instruction book (PUB-1301 Statewide) and "What You Should Know" Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this application, and contact your social services district with any questions.**

When you see "MA" on the application, it means "Medicaid." You may apply for MA using this application only if you are also applying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only apply for MA, you can go online at <https://nystateofhealth.ny.gov/> and/or call 1-855-355-5777 for more information or to apply, or you may use the MA-only paper application - Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to apply only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH- 4220 MA application form.

SECTION 6 – HOUSEHOLD INFORMATION – List everybody who lives with you, even if they are not applying with you. List yourself on the first line.

DOES THIS PERSON (INCLUDING MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU?

HIGHEST SCHOOL GRADE COMPLETED

SOCIAL SECURITY NUMBER OF APPLYING HOUSEHOLD MEMBERS
(See instruction book, PUB-1301 Statewide, or talk to your social services district)

YES NO

(Middle Initial)				THIS PERSON IS APPLYING FOR:								DATE OF BIRTH			SEX M OR F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER OF APPLYING HOUSEHOLD MEMBERS (See instruction book, PUB-1301 Statewide, or talk to your social services district)	YES	NO
RI	LN	FIRST NAME	M.I.	LAST NAME	PA	SNAP	MA	CC	FC	S	EMR G	Month	Day	Year					
	01															SELF			
	02																		
	03																		
	04																		
	05																		
	06																		
	07																		
	08																		

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAVE BEEN KNOWN

Line No.	ONC	FIRST NAME	M.I.	LAST NAME
Line No.	ONC	FIRST NAME	M.I.	LAST NAME

IS ANYONE SANCTIONED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, WHO	REASON	END DATE
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NON-APPLICANT INFORMATION

LN	FIRST NAME	LAST NAME	LEGALLY RESPONSIBLE		FOR WHOM?	CONTRIBUTION/DEEMED INCOME	CHECK IF MEMBER OF SNAP HOUSEHOLD
			YES	NO			

NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS INFORMATION

INDIVIDUAL EDUCATION

CONSIDER

LN	NON-CITIZEN STATUS	STATUS ADJUSTED			DATE OF ENTRY/STATUS			APPLIED FOR CITIZENSHIP		SPONSORED		LN	DEGREE RECEIVED	LN	DEGREE RECEIVED
		YES	NO		MONTH	DAY	YEAR	YES	NO	YES	NO				
												01		05	
												02		06	
												03		07	
												04		08	

✓ RCA/RMA REFERRAL

LN	SECTION 7 – RACE/ETHNICITY – Providing this information is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for requesting this information is to ensure that program benefits are distributed without regard to race, color, or national origin.							CLIENT IDENTIFICATION NUMBER	ENTER APPROPRIATE CODES								
	H	I	A	B	P	W	U		REL	SSN	SFUI	MS	SI	LA	EM	CI	EL
	ENTER Y (YES) OR N (NO) FOR HISPANIC OR LATINO																
	ENTER Y (YES) OR N (NO) FOR EACH RACE																
01																	
02																	
03																	
04																	
05																	
06																	
07																	
08																	
ANTICIPATED FUTURE ACTION				CASE TYPE	RELATED CASE NUMBERS			CONSIDER				REQUESTED	DOCUMENTATION		IN FILE		
LINE NO.	CODE	DATE						✓ Relationship ✓ Filing Unit ✓ Legally Responsible Relative ✓ Single Economic Unit ✓ SNAP Household Composition ✓ SNAP Aged/Disabled Individual ✓ Photo ID ✓ AFIS (PA Only) ✓ CBIC/PIN ✓ RFI/OCA ✓ Health Insurance					Photo ID				
													Birth Verification				
													Marriage License				
SERVICE ELIGIBILITY PROCESS CODE													Social Security Card				
SFUI	CODE	SFUI	CODE										Code 9 Resolution				
SFUI	CODE	SFUI	CODE										Immigration Status				
NEEDED		REFERRALS			COMPLETED								Multi-Suffix/Co-op Case Notice (Single Economic Unit Questionnaire)				
		Legal															
		Services															
		SSA															
		NYSoH															
		Chronic Care/SSI-Related															
		MA-Only															
		Medicare Savings Program															

SECTION 11 – TAX FILING/DEPENDENT STATUS - Please select the tax status for each individual living in the household.

			TAX STATUS						
FIRST NAME	MIDDLE INITIAL	LAST NAME	SINGLE	MARRIED FILING JOINTLY	MARRIED FILING SINGLE	HEAD OF HOUSEHOLD (WITH QUALIFYING INDIVIDUAL)	QUALIFYING WIDOW(ER) WITH DEPENDENT CHILD	DEPENDENT AND WILL BE FILING TAXES	WILL NOT BE FILING TAXES

Tax dependents not living in the household. Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip this question.

NAME OF TAX DEPENDENT			NAME OF TAX FILER		
FIRST NAME	MIDDLE INITIAL	LAST NAME	FIRST NAME	MIDDLE INITIAL	LAST NAME

SECTION 12 – ABSENT/DECEASED SPOUSE INFORMATION – If the spouse of anyone applying lives someplace else or is deceased, please indicate below.

NAME OF PERSON APPLYING	NAME OF SPOUSE	DATE OF SPOUSE'S BIRTH	DATE OF SPOUSE'S DEATH, IF APPLICABLE	SPOUSE'S SOCIAL SECURITY NUMBER	
SPOUSE'S ADDRESS, IF APPLICABLE		CITY	COUNTY	STATE	ZIP CODE

SECTION 13 – ABSENT CHILD INFORMATION – If anyone applying has a child under the age of 21 living someplace else, please indicate below.

NAME OF PERSON APPLYING	NAME OF ABSENT CHILD	DATE OF BIRTH	ADDRESS OF CHILD (STREET, CITY, COUNTY, STATE, AND ZIP CODE)	PATERNITY ESTABLISHED?		DO YOU PAY CHILD SUPPORT?	
				Yes	No	Yes	No

SECTION 14 – TEEN PARENT INFORMATION

TEEN PARENT	TEEN PARENT CHILDREN
Is there a parent under the age of 18 ("teen parent") in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ Does the teen parent's child live in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of teen parent's child _____	LN NO. _____ Marital Status _____ High School Diploma/High School Equivalent? _____ LN NO. _____ Marital Status _____ High School Diploma/High School Equivalent? _____ LN NO. _____ LN NO. _____

Deductions: Certain types of Medicaid budgeting allow applicants/recipients to reduce their countable income with deductions that they take on their federal taxes. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Only record deductions here if you will claim them on the current year's tax return.	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY
Educator expenses	1					
Individual Retirement Account (IRA) deduction	2					
Student loan interest deduction	3					
Tuition and fees	4					
Certain business expenses (reservists, artists, fee-based government officials)	5					
Health savings account deduction	6					
Job-related moving expenses	7					
Deductible part of self-employment (S/E) tax	8					
S/E, SIMPLE & qualified plans	9					
S/E health insurance deduction	10					
Penalty on early withdrawal of savings	11					
Alimony paid	12					
Domestic production activities deduction	13					
Additional adjustments added on line 36 (IRS Form 1040 only)	14					
Archer MSA deduction	15					
Other Adjustment (Please Specify)						

SECTION 16 – STEP-PARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

Answer all questions listed below.

	YES	NO	WHO?
Does the step-parent of any children who live with you have any resources or receive income of any kind?			
Is anyone in your household a non-citizen with satisfactory immigration status who was sponsored for admission into the U.S.?			

NAME OF SPONSOR: _____ PHONE NO.: _____

ADDRESS: _____

NEEDED	REFERRAL	COMPLETED
	UIB	

SECTION 17 – EMPLOYMENT INFORMATION

I am currently: employed self-employed unemployed

Gross Income \$ _____ Hours Worked Monthly _____

(Include wages, salary, overtime pay, commissions, and tips)

Paid: Weekly Bi-Weekly Monthly Day of the week paid: _____

Employer's Name and Address: _____ 1

Phone No. _____

Is anyone else who lives with you currently: employed self-employed

Who: _____

Gross Income \$ _____ Hours Worked Monthly _____

Paid: Weekly Bi-Weekly Monthly Day of the week paid: _____ 2

Employer's Name and Address: _____

Phone No. _____

Is health insurance available through your employer? Yes No

Does anyone who lives with you have health insurance with an employer? Yes No

Who: _____ 3

Name of Insurance Company: _____

Do you or anyone who lives with you have a child or dependent care expenses due to employment? Yes No

Who: _____ 4

Do you or anyone who lives with you have other employment-related expenses? Yes No

Who: _____ 5

REQUESTED	DOCUMENTATION	IN FILE
	CINTRAK/RFI/IRCS	
	1099	
	Employment Verification	
	Income Tax Return	
	Self-Employment Worksheet	
	Wage Stubs	
	Work Registration Form	
	Dependent/Child Care Form/Statement	
	Approval of Informal Child Care Provider	

NEEDED	REFERRALS	COMPLETED
	CAP	
	Disability	
	Employment	
	TPHI/COBRA	
	UIB	
	Workers' Compensation	
	Drug/Alcohol	
	Domestic Violence	
	Refugee Cash Assistance	

CONSIDER
✓ Limited English Proficiency
✓ Earned Income Tax Credit (see PUB-4786)
✓ Explaining Periodic Reporting Requirements
✓ Net Loss of Cash Income
✓ P.A.S.S. Income Amount and Sources
✓ Employment Sanctions
✓ Temporary Employment
✓ Disability Review
✓ Individual Development Account (IDA)
✓ Voluntary Quit

SECTION 18 – EDUCATION/TRAINING

What is your highest level of education completed?

- Less than high school diploma
If so, last grade completed? _____
- Completion of an Individualized Education Plan (IEP)
- High school diploma or General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™) 1
- Associate's Degree (2-year college degree)
- Bachelor's Degree (4-year college degree) or higher

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Educational Grant Worksheet	
	Child Care Statement	

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

Does anyone else in the household have a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education? Yes No

If yes, who: _____

Degree attained: _____

Date completed: _____

2

Indicate if you or anyone who lives with you who is applying for or getting assistance:

Is or has been in any training program? Yes No

Who _____

Where _____

Program _____

Dates attended _____

Dates completed _____

3

Is 16 years of age or older and is attending school or college? Yes No

Who _____

Where _____

4

Is under 16 years of age and is attending school? Yes No

Who _____

School _____

Who _____

School _____

Who _____

School _____

Who _____

School _____

5

CONSIDER	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the SNAP student eligibility requirement?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone pay for child or dependent care to attend school or training?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a 16-19 year-old parent who does not have a high school or equivalency diploma and who is not attending school?	<input type="checkbox"/>	<input type="checkbox"/>
Is anyone in training?	<input type="checkbox"/>	<input type="checkbox"/>
Are any other supportive services appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any training related expenses?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 19 – RESOURCES INFORMATION						
Indicate if you or anyone who lives with you who is applying:	YES	NO	WHO	AMOUNT/VALUE	WHO	AMOUNT/VALUE
Has cash available 1						
Has a checking account(s) 2						
Has a savings account(s) or certificate(s) of deposit 3						
Has a credit union account(s) 4						
Has life insurance 5						
Has title or registration to a motor vehicle(s) or other vehicle(s): Year _____ Make/Model _____ Year _____ Make/Model _____ Other _____ 6						
Has stocks, bonds, certificates or mutual funds 7						
Has savings bonds 8						
Has an IRA, Keogh, 401(k) or deferred compensation account(s) 9						
Has an irrevocable burial trust 10						
Has a burial fund 11						
Has a burial space 12						
Has his/her own home 13						
Has real estate, including income-producing and non-income-producing property 14						
Is eligible for an income tax refund 15						
Has an annuity 16						
Is the beneficiary of a trust 17						
Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources 18						
Has an "in trust" account(s) 19						
Has a safe deposit box(es) 20						
Has resources other than those listed above 21						
Has anyone (including your spouse, even if not applying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months? 22						
Has anyone (including your spouse, even if not applying or living with you) ever created a trust in the past or transferred any assets to a trust within the past 60 months? If yes, when? _____ 23						

NEEDED	REFERRAL	COMPLETED
	Legal	
	Resource	

LIFE INSURANCE	
FACE AMOUNT	CASH VALUE

REQUESTED	DOCUMENTATION	IN FILE
	Resource Checklist	
	Market Value	
	DMV Clearance	
	Bank Statement	
	Assignment of Proceeds	
	Car/Vehicle Title	
	Car/Vehicle Registration (Older Models)	
	Bank Clearance	
	RFI/OCA	
	1099	

- | CONSIDER | |
|-------------------------------------|--------------------------------------|
| <input checked="" type="checkbox"/> | Children's Resources |
| <input checked="" type="checkbox"/> | Lump Sum |
| <input checked="" type="checkbox"/> | Boats, Campers, Snowmobiles |
| <input checked="" type="checkbox"/> | Individual Development Account (IDA) |
| <input checked="" type="checkbox"/> | Exempt Vehicles |

VEHICLE INFORMATION									
YR.	MAKE	MODEL	OWNER'S NAME	AMOUNT OWED	NADA VALUE	EXEMPT		LIEN HOLDER	ACCOUNT NO.
						YES*	NO		
				\$	\$				
				\$	\$				

*IF EXEMPT, WHY?

SECTION 20 – MEDICAL INFORMATION			
Indicate if you or anyone who lives with you who is applying:	YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses 1			
Is on Medicaid with a spend-down 2			
Has health or hospital/accident insurance (including insurance from employer) 3			
Has health insurance available through an employer 4			
Has Medicare (red, white, and blue card) 5			
Has a health attendant/home health aide 6			
Is blind, sick or disabled 7			
Is a child with a developmental disability 8			
Is in a hospital, nursing home or other medical institution 9			
Has paid or unpaid medical bills within 3 months preceding the month of this application 10			
Is or was drug or alcohol dependent 11			
Needs home care/personal care 12			
Is on SSI or has ever applied for SSI 13			
Is pregnant If pregnant, due date: _____ Expected number of births: _____ 14			
Receives treatment from a drug abuse or alcohol treatment program 15			
Has not been able to work for at least 12 months because of a disability or illness 16			
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months 17			
Has been in a car accident or work-related accident in the past two years 18			
Has had a government agency (public program) besides Medicaid or Medicare pay any of your medical bills If yes, what agency _____ 19			
Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of Medicaid? 20			

POLICY NO.:
AMOUNT:
FREQUENCY OF PAYMENT:
INSURANCE COMPANY NAME:
WHO IS COVERED:
EFFECTIVE DATE:

Is the answer to question 7 in this section consistent with Section 17 asking if the applicant or any other adult who lives in the household have any medical conditions that limit their ability to work or the type of work that they can perform?

REQUESTED	DOCUMENTATION	IN FILE
	Pregnancy Statement	
	Med/Psych Statement	
	Drug/Alcohol Screening (LDSS-4571)	
	Drug/Alcohol Statement	
	Paid or Unpaid Medical Bills	
	SSI Application Verification (PA ONLY)	
CONSIDER		
<ul style="list-style-type: none"> ✓ AD/SSI Related ✓ SNAP Aged/Disabled Indicator ✓ SNAP Medical Deduction ✓ TPHI Reimbursement ✓ Buy-In Eligibility ✓ Kreiger (LDSS-3664) ✓ Domestic Violence ✓ SSI Referral ✓ Earned Income Credit 		
NEEDED	REFERRALS	COMPLETED
	SSI (D-CAP)	
	Disability Interview (LDSS-1151)	
	Medical Report (LDSS-486, 486t)	
	Disability Report	
	AD	
	TPHI	
	ACCES-VR	
	CTHP	
	Family Planning	
	SSA (RSDI)	
	Veteran's Benefits	
	Veteran's Counseling	
	Child Health Plus	
	COBRA Eligibility	
	Nurse's Aide Service	
	Home Care	
	NYSOH	
	MA-Only (DOH-4220)	
	SSI-Related/Chronic Care (DOH-4220 with Supplement A)	
	LDSS-4526 or local equivalent	

RETROACTIVE MEDICAID	WHO	DATE	RECURRING MEDICAL EXPENSES	WHO	AMOUNT \$		

MEDICAL BILLS: YES NO **TPHI:** YES NO

HEALTH PLAN SELECTION

Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call 1-800-505-5678.

Name of Plan You Are Enrolling In	Last Name	First Name	Date Of Birth mm/dd/yy	Sex M/F	ID# (from Medicaid Card if you have one)	Social Security # (optional if pregnant)	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID# of OB/GYN (check box if current provider)
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

SECTION 21 – SHELTER

WHAT IS YOUR LANDLORD'S NAME?

WHAT IS YOUR LANDLORD'S ADDRESS?

WHAT IS YOUR LANDLORD'S PHONE NUMBER?
() _____

	YES	NO	IF YES, AMOUNT
Do you or anyone who lives with you have a rent, mortgage or other shelter expense?			\$
Do you or anyone who lives with you have a heat bill separate from your rent or other shelter expense?			\$

SHELTER COSTS	MONTHLY ACTUAL COST
A. Room and Board	
B. Rent	
C. Trailer Lot Rent	
D. Mortgage Payment	
1. Principal	
2. Interest	
3. Property Tax (including School Tax)	
4. Homeowner's Insurance (incl. Fire Insurance)	
5. Taxes Included in Mortgage (Escrow Payment)	
6. Assessments (Sewer, etc.)	
E. Total Mortgage Payment (Line 1-6)	
TOTAL (Lines A - E)	

REQUESTED	DOCUMENTATION	IN FILE
	Landlord Statement	
	Rent Receipt	
	Tenant of Record	
	Customer of Record	
	Voluntary Restrict	
	Mandatory Restrict	
	Subsidized Housing	
	Mortgage/Title Search	
	Section 8 Lease or Statement from Section 8 Office	
	Property Lien	
	Shelter/Utility Repayment Agreement	

CONSIDER

- ✓ Utility and/or Fuel Restrict
- ✓ Utility Guarantee
- ✓ HEAP
- ✓ Subsidized Housing May Show Total Rent, NOT Client Amount
- ✓ Foster Care-Related Additional Allowances
- ✓ SNAP Household Composition Rules
- ✓ SNAP Aged/Disabled Indicator
- ✓ Real Property Tax Credit
- ✓ AIDS/HIV Emergency Shelter Allowance
- ✓ Property Lien
- ✓ If Shelter Expenses/Living Quarters Are Shared by More than One Household

SECTION 21 – SHELTER (CONT.)			
Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?	YES	NO	IF YES, AMOUNT
Electricity (for needs other than heat; example: lights, cooking, hot water, etc.) 1			\$
Natural Gas (for needs other than heat; example: cooking, hot water, etc.) 2			\$
Water 3			\$
Air Conditioning 4			\$
Propane (for needs other than heat) 5			\$
Sewer 6			\$
Trash 7			\$
Other Utilities and Expenses 8 Specify _____			\$
Do you live in public housing? 9			
Do you live in Section 8, HUD, or other subsidized housing? 10			
Do you live in a drug/alcohol treatment facility? 11			

***Check Primary Heat Type:**

- Natural Gas Oil PSC Electric Coal
 Kerosene Propane Municipal Electric Wood
 Other _____

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	ACCOUNT NUMBER	IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD)	WHO IS THE TENANT OF RECORD?
A. Heat*					
B. Electricity (for cooking, lights, hot water)					
C. Gas (for cooking, hot water)					
D. Liquid Propane Gas					
E. Other Utilities or Expenses					
F. Air Conditioning					
G. Utility Installation Fees					
H. Sewer					
I. Trash					
J. Water					

ADDITIONAL INFORMATION

SECTION 22 – OTHER EXPENSES

Indicate if you or anyone who lives with you who is applying:	YES	NO	IF YES, AMOUNT
Pays child support 1			\$
Pays spousal support 2			\$
Pays for child care 3			\$
Pays for dependent care 4			\$
Pays tuition, fees, or other educational expenses 5			\$
Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.) Specify: _____ 6			\$
Do you or anyone who lives with you who is applying owe at least four months of support for a child under the age of 21? 7	<input type="checkbox"/> YES <input type="checkbox"/> NO		

HOW OFTEN PAID	LEGALLY OBLIGATED		CHILD IN SNAP HH	
	YES	NO	YES	NO

SECTION 23 – OTHER INFORMATION						OTHER INFORMATION (CONT.)			YES	NO	WHO
Do you buy or plan to buy meals from a home delivery or communal dining service? 8		<input type="checkbox"/> YES	<input type="checkbox"/> NO			Have you or anyone who lives with you who is applying moved into this county from another New York State county within the past two months?					
Are you able to cook or prepare meals at home? 9		<input type="checkbox"/> YES	<input type="checkbox"/> NO	VETERAN STATUS	VETERAN CODE						
Have you or anyone in your household ever been in the U.S. military? Who? _____ 10		<input type="checkbox"/> YES	<input type="checkbox"/> NO			Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Public Assistance and/or the Supplemental Nutrition Assistance Program (SNAP) because of fraud/an Intentional Program Violation?					
Has your spouse ever been in the U.S. military? 11		<input type="checkbox"/> YES	<input type="checkbox"/> NO			Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?					
Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? _____ 12		<input type="checkbox"/> YES	<input type="checkbox"/> NO			Have you or anyone who lives with you received assistance or services now? <input type="checkbox"/> YES <input type="checkbox"/> NO 13					
IF YES, WHO	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED			Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive Public Assistance in two or more states?					
						Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP Benefits in any state after September 22, 1996?					
Have you or anyone who lives with you received assistance or services in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO 14						Have you or any member of your household been convicted of buying or selling SNAP Benefits for a combined amount of over \$500 or more after September 22, 1996?					
IF YES, WHO (Please list all previous names)	TYPE OF ASSISTANCE	LOCATION RECEIVED	DATES RECEIVED			Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?					
						Are you or any member of your household fleeing to avoid prosecution, custody or confinement after conviction of a felony or attempted felony and actively being pursued by law enforcement?					
NEEDED	REFERRALS	COMPLETED	CONSIDER				Are you or any member of your household violating probation or parole according to a court order?				
	Services		✓ SNAP Dependent Care Deductions				PROPERTY TRANSFER STATUS				
	UIB						I have <input type="checkbox"/> I have not <input type="checkbox"/> sold, transferred or given away any of my property to anyone to get Public Assistance or SNAP Benefits.				
						REQUESTED	DOCUMENTATION	IN FILE			
							Educational Grant Worksheet				
							Child/Dependent Care Statement				
							Recoupments				
							Outstanding Overpayment				
							Pending Disqualification				

NOTICES, ASSIGNMENTS, AUTHORIZATIONS, and CONSENTS

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS – The collection of Social Security Numbers (SSNs) is authorized for each household member with respect to the Supplemental Nutrition Assistance Program (SNAP), pursuant to the Food and Nutrition Act of 2008 (as amended). Anyone applying for SNAP must provide an SSN in order to receive benefits. If you or anyone applying does not have an SSN, that person must apply for an SSN with the Social Security Administration (visit www.SSA.gov or call 1-800-772-1213).

With respect to all other programs for which this application form requires an SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: Section 205(c) of the Social Security Act (42 U.S. Code 405), Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) and Section 7(a)(2) of the Privacy Act of 1974. See the instruction book (PUB-1301 Statewide) or talk to your social services district if you have questions.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. The information will be used to check identity, to verify earned and unearned income, to determine if absent parents can receive health insurance coverage for applicants or recipients, to determine if applicants or recipients can obtain child or spousal support, and to determine if applicants or recipients can receive money or other help. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. Besides using the information you give us in this way, the state will use the information to prepare statistics about all of the people receiving benefits from the Home Energy Assistance Program (HEAP) (see below).

This information may be disclosed to other state and federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. Information collected with respect to applicants for and recipients of Family Assistance and Safety Net Assistance, including SSNs, may be used to assist in the formation of jury pools. If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

SSNs of ineligible household members will also be used and disclosed in the manner above.

Besides using the information you give us in this way, the State also uses the information to prepare statistics about all the people receiving benefits from HEAP. The information is used for quality control by the State to make sure social services districts are doing the best job they can. It is used to verify your energy supplier and to make certain payments to such vendors.

NONDISCRIMINATION NOTICE – This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

The United States Department of Agriculture (USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a Supplemental Nutrition Assistance Program (SNAP) complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201, or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

CONSENT FOR INVESTIGATION – I agree to any investigation to verify or confirm the information I have given in connection with my request for Public Assistance (PA), Medicaid, Supplemental Nutrition Assistance Program (SNAP) Benefits, Home Energy Assistance Program Benefits, Services or Child Care Assistance. If additional information is requested, I will provide it. I will also cooperate fully with state and federal personnel in any PA and/or SNAP Quality Control Review.

If I am applying for SNAP, I understand that the social services district will request and use information available through the Income and Eligibility Verification System to investigate my application, and may verify this information through collateral contacts if discrepancies are found. I also understand that such information may affect my eligibility for SNAP and/or the level of SNAP Benefits I receive.

CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE INFORMATION – I authorize the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance (UI) purposes to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with state and local agency employees working in social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of, Public Assistance, Medicaid, Supplemental Nutrition Assistance Program Benefits, Home Energy Assistance Program Benefits or Child Care Assistance, applied for in this application and for investigations to determine whether I received benefits to which I was not entitled. OTDA may also share the information with the New York State Office of Children and Family Services (OCFS) and the New York State Department of Health (DOH). OCFS will use the information to monitor the Child Care Assistance program.

RELEASE OF INFORMATION TO SERVICE PROVIDERS – I give permission to the social services district and New York State to share information regarding Public Assistance or Supplemental Nutrition Assistance Program benefits that I or any member of my household for whom I can legally give authorization have received, for purposes of verifying my eligibility for services and payment related to program administration provided by a State or local contractor. Such services may include, but are not limited to, job placement or training services provided to help me or members of my household obtain and retain employment.

CHANGE REPORTING – I agree to inform the agency **promptly** of any change in my address, needs, income, and property, able-bodied adult without dependents (ABAWD) status, pregnancy status or living arrangements, to the best of my knowledge or belief.

If I am applying for Child Care Assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my home, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

PENALTIES – Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Public Assistance, Medicaid, Supplemental Nutrition Assistance Program, Services or Child Care Assistance (“Assistance, Benefits or Services”) or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility

for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Assistance, Benefits or Services. If you are an authorized representative, such Assistance, Benefits or Services must be used for the other person and not for yourself. Federal and state laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within 60 months prior to the first of the month in which the individual is both in receipt of nursing facility services and has submitted an application for Medicaid, may render the individual ineligible for nursing facility services or home and community-based waived services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM DISQUALIFICATION PENALTIES – Any information you provide in connection with your application for the Supplemental Nutrition Assistance Program (SNAP) will be subject to verification by federal, state and local officials. If any information is incorrect, you may be denied SNAP Benefits. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to \$250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable federal and state laws. Anyone who is violating a condition of probation or parole, or anyone who is fleeing to avoid prosecution, custody or confinement of a felony and is actively being pursued by law enforcement, is not eligible to receive SNAP Benefits.

You may be found ineligible for SNAP or found to have committed an Intentional Program Violation (IPV) if you make a false or misleading statement, or misrepresent, conceal or withhold facts, in order to qualify for benefits or receive more benefits; purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or commit or attempt to commit any act that constitutes a violation of federal or state law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking SNAP Benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system. Additionally, the following is not allowed and you may be disqualified from receiving SNAP Benefits and/or be subject to penalties for actions that include:

- Using SNAP benefits to buy non-food items, such as alcohol or cigarettes;
- Using SNAP benefits to pay for food previously purchased on credit;
- Allowing someone else to use your EBT card in exchange for cash, firearms, ammunition or explosives, or drugs, or to purchase food for individuals who are not members of your SNAP household; or
- Using or having in your possession EBT cards that do not belong to you, without the card owner's consent.

Individuals found to have committed an IPV either through an administrative disqualification hearing or by a federal, State or local court, or have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution shall be ineligible to participate in SNAP for a period of:

- 12 months for the first SNAP IPV;
 - 24 months for the second SNAP IPV;
 - 24 months for the first SNAP IPV that is based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
 - 120 months if the individual is found to have made a fraudulent statement about who he/she is or where he/she lives in order to get multiple SNAP Benefits simultaneously, unless permanently disqualified for a third SNAP IPV.
- Additionally, a court may bar an individual from participating in SNAP for an additional 18 months.

An individual can be permanently disqualified from receiving SNAP Benefits for:

- The first SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of firearms, ammunition or explosives;
- The first SNAP IPV based on a court conviction for trafficking SNAP Benefits for a combined amount of \$500 or more (trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices);
- The second SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- A third SNAP IPV.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – Your household must report child care and utility expenses in order to get a Supplemental Nutrition Assistance Program (SNAP) deduction for these expenses. Your household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a SNAP deduction for these expenses. Failure to report/verify the above expenses will be seen as a statement by your household that you do not want to receive a deduction for these unreported/unverified expenses. A deduction for these expenses may make you eligible for SNAP or may increase your SNAP benefits. You may report/verify these expenses at any time in the future. The deduction would then be applied to the calculation of SNAP benefits in future months, in accordance with the rules for change reporting (see Change Reporting, above).

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to apply for Supplemental Nutrition Assistance Program (SNAP) Benefits for you. You can also authorize someone outside your household to get SNAP Benefits for you or to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may authorize someone by printing the person's name, address, and phone number immediately below, and having them sign in the signature section at the end of this application. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, both the Authorized Representative and a responsible adult member of the household must sign and date the signature section at the end of this application, unless the SNAP household has otherwise designated the Authorized Representative to do so in writing.

NAME, ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE (PLEASE PRINT):

STANDARD UTILITY ALLOWANCE – I understand that Public Assistance and Supplemental Nutrition Assistance Program (SNAP) recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). I also understand that if I have not received a HEAP benefit of greater than \$20 in the current month or previous 12 months, or a similar energy assistance benefit, I must pay for heating or air conditioning separately from my rent in order to receive the heating/cooling standard utility allowance (i.e., a deduction) for SNAP. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

RELEASE OF MEDICAL INFORMATION – I consent to the release of any medical information about me and any members of my family for whom I can give consent by my primary care provider, any other health care provider or the New York State Department of Health (DOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to DOH and other authorized federal, state, and local agencies for purposes of administration of Medicaid; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I authorize the release of any health-related information about me and any members of my family for whom I can legally give authorization related to the provision of assistance and services and my ability to participate in work activities, including employment, to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services or the local social services district, as reasonably necessary for the provision of Public Assistance benefits; for services, including child welfare services; for determining appropriate work activity assignments; for determining the need to apply and for making application for Supplemental Security Income Benefits; for establishing appropriate treatment plans for restoring employability; and for determining eligibility for exemptions from the State sixty-month time limit on cash assistance receipt. If I am required to apply for benefits administered by the Social Security Administration, the information specified above may be shared with the Social Security Administration. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law, unless a box is checked below. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain information regarding treatment, diagnosis and procedures on their behalf.

Do not disclose HIV/AIDS information Do not disclose drug and alcohol information
 Do not disclose mental health information

RELEASE OF EDUCATIONAL RECORDS – I give permission to the New York State Department of Health and the social services district to:1) obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming Medicaid reimbursement for health-related educational services; and 2) provide the appropriate federal government agency access to this information for the sole purpose of audit.

RELEASE OF INFORMATION FOR THE EARLY INTERVENTION PROGRAM – If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the social services district and New York State to share my child’s Medicaid eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medicaid.

CHILD/TEEN HEALTH PROGRAM – I understand that if my child is on Medicaid, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the social services district.

MEDICARE – I authorize payments under “Medicare” (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

MEDICAID – You have a right as part of your Medicaid application, or within two years from the date of your application, to request reimbursement of expenses you paid for covered medical care, services and supplies received during the three-month period prior to the month of your application. After the date of your application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

ASSIGNMENT OF INSURANCE/OTHER BENEFITS AND DIRECT PAYMENT – For Public Assistance and Medicaid, I agree to file any claims for health or accident insurance benefits, and to pursue any personal injury claims or any other resources to which I may be entitled, and do hereby assign any such resources to the social services district to whom this application is made. In addition, I will assist in making any assigned benefits available to the social services district to whom this application is made.

I authorize payments owed to me or members of my household for health or accident insurance benefits to be made directly to the appropriate social services district for medical and other health services furnished while we are eligible for Medicaid.

MEDICAID RECOVERIES – Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. MA paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. MA may also recover the cost of services and premiums incorrectly paid.

I understand that effective April 1, 2014, if I get Medicaid through New York State of Health:

- No lien will be placed on my real property prior to my death.
 - Recovery from assets in my estate upon my death is limited to the amount Medicaid paid for the cost of nursing home care, home and community-based services, and related hospital and prescription drug services received on or after my 55th birthday.
-

PUBLIC ASSISTANCE RECOVERIES – Public Assistance (PA) you receive for yourself and for persons for whom you are legally responsible to support is recoverable from property or money you possess or may acquire. You may be required, as a condition of receiving PA, to execute a deed or mortgage of real property you own. Your tax refunds and portions of lottery winnings may be taken to repay your debt for PA.

AUTHORIZATION TO REPAY PUBLIC ASSISTANCE BENEFITS FROM RETROACTIVE SUPPLEMENTAL SECURITY INCOME – I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of Supplemental Security Income (SSI); i.e. my retroactive SSI payment) to reimburse the local social services district (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for SSI. SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SSA can reimburse the SSD in two situations:

- (1) It will repay the SSD if I apply for SSI and SSA finds me eligible.
- (2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called “interim assistance.” The period begins: 1) with the first month I become eligible for payment of SSI benefits; or 2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and that, if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

This authorization applies to any SSI application or appeal I now have pending before SSA. This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called “What You should Know About Social Services Programs.” I understand what it says about interim assistance.

SUPPORT – Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or Title IV-E foster care operates as an assignment to the State and the social services district of any rights to support from any other person that the applicant or recipient may have in his or her own right or on behalf of any other family member for whom the applicant or recipient is applying for, or receiving, assistance (Social Services Law, Sections 158 and 348). This assignment is limited in certain situations. Other sections of this application contain additional assignments.

ASSIGNMENT OF SUPPORT RIGHTS – I assign to the state and social services district any rights I have to support from persons having legal responsibility for my support and any rights I have to support on behalf of any family member for whom I am applying for or receiving assistance. Where applying for or receiving Family Assistance or Safety Net Assistance, my assignment of support rights is limited to support which accrues during the period that I and/or any family member receives assistance. However, any support rights that I assigned to the state on behalf of myself or any family member prior to October 1, 2009, continue to be assigned to the state.

HOME ENERGY ASSISTANCE PROGRAM – I understand that by signing this application/certification, I consent to any investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this application to be used in referrals to available weatherization assistance programs and my utility company’s low income programs.

I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

SEXUAL ASSAULT INFORMATION – If you are a victim of sexual assault, you have the right to request referral information from the social services district. If you request referral information, the social services district must provide you with the addresses and phone numbers of any: 1) local hospitals offering sexual assault forensic examiner services certified by the NYS Department of Health; 2) local rape crisis centers; and 3) local advocacy, counseling, and hotline services appropriate for victims of sexual assault. In addition, the social services district must provide you with the NYS Hotline for Sexual Assault and Domestic Violence numbers: (800) 942-6906 and (800) 818-0656 (TTY).

CERTIFICATION FOR CHILD CARE ASSISTANCE – If I am applying for Child Care Assistance, I certify that my family’s income does not exceed 85 percent of the State median income for a family of the same size, and my family resources do not exceed \$1,000,000.

I have read and understand the notices above. I understand and agree to the assignments, authorizations and consents above. I swear and/or affirm under the penalties of perjury that the information I have given or will give to the social services district is complete and correct.			
APPLICANT SIGNATURE x	DATE SIGNED	SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE x	DATE SIGNED
AUTHORIZED REPRESENTATIVE SIGNATURE x	DATE SIGNED		

I Consent to Withdraw My Application For:

- Public Assistance (PA) Child Care in lieu of PA Supplemental Nutrition Assistance Program (SNAP) Medicaid and SNAP
- Medicaid and PA Services, including Foster Care Child Care Assistance Emergency Assistance Only

I understand that I may reapply at any time.

APPLICANT/AUTHORIZED REPRESENTATIVE SIGNATURE

DATE SIGNED

x



NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

YES If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below

NO because I choose not to register **OR**

I am already registered at my current address **OR**

I asked for and received a mail registration form

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____/_____/_____
Signature Date

Please Print Name

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料: 若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদি আপনি এই ফর্মটি ইংরেজীতে পেতে চান তাহলে 1-800-367-8683 নম্বরে ফোন করুন

Rev. 2/2015

VOTER REGISTRATION APPLICATION (instructions on back)

Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** Yes, I would like to be an Election Day worker

1	Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If you answered NO, do not complete this form</small>	2	Will you be 18 years old on or before election day? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If you answered NO, do not complete this form unless you will be 18 by the end of the year</small>	For Board Use Only	
3	Last Name _____ First Name _____ Middle Initial _____ Suffix _____				
4	Address where you live (do not give P.O. box) _____ Apt. No. _____ City/Town/Village _____ Zip Code _____ County _____				
5	Address where you get your mail (if different than above) _____ P.O. Box, Star Route, etc. _____ Post Office _____ Zip Code _____				
6	Date of Birth _____	7	Sex <input type="checkbox"/> M <input type="checkbox"/> F	8	Telephone (optional) _____ Email (optional) _____
10	The last year you voted _____	Your address was (give house number, street and city) _____		9	ID Number (Check the applicable box and provide your number) <input type="checkbox"/> New York State DMV number _____ <input type="checkbox"/> Last four digits of your Social Security number _____ <input type="checkbox"/> I do not have a New York State DMV or Social Security number
	In county/state _____	Under the name (if different from your name now) _____			
11	Political Party I wish to enroll in a political party <input type="checkbox"/> Democratic party <input type="checkbox"/> Independence party <input type="checkbox"/> Republican party <input type="checkbox"/> Women's Equality party <input type="checkbox"/> Conservative party <input type="checkbox"/> Reform party <input type="checkbox"/> Green party <input type="checkbox"/> Other _____ <input type="checkbox"/> Working Families party I do not wish to enroll in a political party <input type="checkbox"/> No party			12	Affidavit: I swear or affirm that <ul style="list-style-type: none"> I am a citizen of the United States. I will have lived in the county, city or village for at least 30 days before the election. I will meet all requirements to register to vote in New York State. This is my signature or mark on the line below. The above information is true, I understand that if it is not true, I can be convicted and fined up to \$5,000 and/or jailed for up to four years. <p>_____/_____/_____ Signature or Mark in ink Date</p>

(Optional) Register to donate your organs and tissues

Last Name		
First Name	Middle Initial	Suffix
Address		
Apt Number	City/Town/Village	Zip Code
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Eye Color	Height	Ft. In.

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.



_____/_____/_____
Signature Date

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections

40 North Pearl St, Suite 5

Albany, NY 12207-2729

Telephone: 1-800-469-6872;

TDD/TTY users contact the New York State Relay at 711;

or visit our web site - www.elections.ny.gov

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state party rules allow otherwise.



INSTRUCTIONS FOR COMPLETING THE NEW YORK STATE APPLICATION FOR:

- **PUBLIC ASSISTANCE**
- **CHILD CARE IN LIEU OF PUBLIC ASSISTANCE**
- **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM**
- **MEDICAID AND SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM**
- **MEDICAID AND PUBLIC ASSISTANCE SERVICES, INCLUDING FOSTER CARE**
- **CHILD CARE ASSISTANCE**
- **EMERGENCY ASSISTANCE ONLY**

If you are blind or seriously visually impaired and need an application or these instructions in an alternative format, you may request them from your social services district (SSD). The following alternative formats are available:

- Large print;
- Data format (a screen reader-accessible electronic file);
- Audio format (an audio transcription of the instructions or application questions); and
- Braille, if you assert that none of the alternative formats above will be equally effective for you.

Applications and instructions are also available for download in large print, data format and audio format from www.otda.ny.gov or www.health.ny.gov. Please note that applications are available in audio format and Braille solely for informational purposes. In order to apply, you must submit an application in written, non-alternative format.

If you have any disabilities that prevent you from completing this application and/or from waiting to be interviewed, please notify your SSD. The SSD will make every effort to provide a reasonable accommodation to address your needs.

If you require another accommodation or need other help completing this application, please contact your SSD. We are committed to assisting and supporting you in a professional and respectful manner.

TIPS FOR COMPLETING THE APPLICATION

Whenever you see “Public Assistance” or “PA” on the application, it means “Family Assistance” and/or “Safety Net Assistance.” We call both programs “Public Assistance.” PA and the other programs for which you can apply using this application were created to give temporary help to those in need. Certain programs limit how long you can get help, so it is important for you to achieve self-sufficiency as soon as you can. The SSD is there to help you with achieving self-sufficiency. In order to do so, we must know who you are and what you need. This is why you must fill out an application.

As a part of the application process, the SSD will ask you to provide and verify information about yourself and other individuals for whom you are applying. A listing of documentation requirements, which can be found at the end of these instructions, shows the kinds of information you may need to provide and the kinds of documents that can verify this information. For instance, in order to prove who you are, you can supply photograph identification, a driver’s license, a United States passport, a naturalization certificate, hospital or doctor’s records, or adoption papers. In addition, the SSD will interview you as part of the application process. The SSD will combine interviews for multiple programs where possible.

The application and these instructions are numbered by section to help you. Please keep the following in mind when filling out the application:

- **PLEASE PRINT CLEARLY.**
- **DO NOT WRITE IN THE SHADED AREAS.**
- **BE SURE TO COMPLETE EACH SECTION RELEVANT TO THE PERSON(S) FOR WHOM YOU ARE APPLYING.**
- **ALWAYS USE LEGAL NAMES, UNLESS OTHERWISE INSTRUCTED.**
- **IF YOU ARE APPLYING AS SOMEONE’S REPRESENTATIVE, PLEASE PROVIDE INFORMATION ABOUT THAT PERSON, NOT YOURSELF. MAKE SURE THAT BOTH YOU AND THE PERSON YOU ARE REPRESENTING SIGN THE LAST PAGE OF THE APPLICATION.**
- **IF YOU ARE UNSURE ABOUT HOW TO COMPLETE ANY PART OF THIS APPLICATION, ASK YOUR SSD FOR HELP.**

In addition to the LDSS-2921: "New York State Application for Certain Benefits and Services," make sure you have copies of the following informational booklets, available from the SSD or www.otda.ny.gov:

- **LDSS-4148A: "Book 1: What You Should Know About Your Rights and Responsibilities"**
- **LDSS-4148B: "Book 2: What You Should Know About Social Services Programs"**
- **Supplement to Book 1, LDSS-4148A and Book 2, LDSS-4148B: "Important Changes in the Medicaid Program"**
- **LDSS-4148C: "Book 3: What You Should Know if You Have an Emergency"**

PAGE 1 OF THE APPLICATION

If you are blind or seriously visually impaired, you may choose to receive notices regarding the program(s) for which you apply/enroll in an alternative format. Alternative formats are available in large print, data CD, audio CD, or Braille, if you assert that none of the other alternative formats will be equally effective for you.

IF YOU ARE BLIND OR SERIOUSLY VISUALLY IMPAIRED, WOULD YOU LIKE TO RECEIVE WRITTEN NOTICES IN AN ALTERNATIVE FORMAT? If you are blind or seriously visually impaired, check (✓) “Yes” or “No” to indicate whether you would like to receive written notices regarding the program(s) for which you apply/enroll in an alternative format.

IF YES, CHECK THE TYPE OF FORMAT YOU WOULD LIKE: If you are blind or seriously visually impaired and would like to receive notices regarding the program(s) for which you apply/enroll in an alternative format, check (✓) the type of format you prefer: large print, data CD, audio CD, or Braille. Braille is available as an alternative format if you assert that none of the other alternative formats will be as effective for you as Braille.

If you require another accommodation or need other help completing this application, please contact your SSD.

PAGE 2 OF THE APPLICATION

SECTION 1: CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE APPLYING FOR

Check (✓) the box for each program that you or any household member wants to apply for.

Medicaid includes the Medicaid, Medicaid Buy-In for Working People with Disabilities, and Family Planning Benefit programs. When you see “MA” on the application, it means “Medicaid,” which was previously called “Medical Assistance.” You may apply for MA using this application only if you are also applying for Public Assistance (PA) or the Supplemental Nutrition Assistance Program (SNAP) at the same time. If you want to apply for Medicaid and SNAP, check (✓) the “Medicaid (MA) and SNAP” box. If you want to apply for Medicaid and PA, check (✓) the “Medicaid (MA) and PA” box.

If you wish to only apply for MA, you can go online at <https://nystateofhealth.ny.gov/> and/or call 1-855-355-5777 for more information or to apply, or you may use the MA-only paper application – Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to apply only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH-4220 MA application form.

If you are eligible for Public Assistance, but decide you only need Child Care Assistance, check (✓) the “Child Care in lieu of PA” box. If you change your mind and decide you need Public Assistance, you can apply for this program at any time.

If you check (✓) the “Emergency Assistance Only (EMRG)” box, you are indicating that you are applying for a one-time-only emergency payment and an eligibility determination will not be made for any other programs.

SECTION 2

WHAT IS YOUR PRIMARY LANGUAGE? Check (✓) the “English,” “Spanish,” or “Other” box to indicate the language you use most often. If you check (✓) the “Other” box, print your preferred language.

DO YOU WANT TO RECEIVE NOTICES IN: You will receive notices regarding the programs for which you apply/enroll. Check (✓) the "English Only" or "English and Spanish" box to indicate the language(s) in which you would like to receive these notices.

SECTION 3: APPLICANT INFORMATION

NAME: Print your name, including your first name, middle initial (M.I.), and last name.

MARITAL STATUS: Print whether you are now single, married, widowed, legally separated or divorced. If you have ever been married print the appropriate status, do not print "single."

PHONE NUMBER: Print the phone number at which you can be reached most easily. Include your area code.

RESIDENTIAL ADDRESS: Street Address: Print the house or building number, street, avenue, road, etc., where you live.

Apt. No.: Print the number of your apartment, if applicable.

City: Print the name of the city you live in.

County: Print the name of the county you live in.

State: Print the name of the state you live in.

Zip Code: Print the zip code for your address.

IN CARE OF NAME: If someone else receives your mail for you, print that person's name.

MAILING ADDRESS: If you get your mail somewhere other than where you live, print the street address (and apartment number, if applicable) or post office box, city, county, state, and zip code of this location.

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?: Print the number of years and/or months that you have lived at your current address.

IS THIS A SHELTER?: Check (✓) "YES" or "NO" to indicate whether the place you are living is a shelter.

ANOTHER PHONE WHERE YOU CAN BE REACHED: Print another phone number where you can be reached and, if applicable, the name of the person to whom the number belongs. Include the area code.

DIRECTIONS TO CURRENT ADDRESS: Print directions on how to find your home. Use commonly known landmarks.

FORMER ADDRESS: Print the address where you lived before you moved to your present address.

IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK HERE: If you do not have anywhere to live/do not have an address, check (✓) this box.

AGENCY HELPING APPLICANT/CONTACT PERSON: If someone is helping you to apply, print the name of that person, their agency, if any, and the person's phone number.

DO YOU NEED THE MEDICAID PORTION OF THIS APPLICATION AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL?: Check (✓) "YES" or "NO" to indicate on the application and/or tell your worker whether you need your application and/or correspondence related to the receipt of any Medicaid coverage to be kept confidential.

SECTION 4: IF YOU ARE APPLYING FOR SNAP

Read the statement in Section 4 of the application, and sign and date underneath the statement if it applies to you or anyone for whom you are applying. Please contact the SSD if you have questions about this section.

SECTION 5: DO ANY OF THESE APPLY TO YOU?

Check (✓) each situation that applies to you or someone for whom you are applying

PAGE 3 OF THE APPLICATION**SECTION 6: HOUSEHOLD INFORMATION**

NAME: Print the first name, middle initial (M.I.), and last name of everyone who lives with you, even if they are not applying. List yourself first.

THIS PERSON IS APPLYING FOR: Check (✓) the type(s) of assistance each person is applying for: PA for Public Assistance, SNAP for the Supplemental Nutrition Assistance Program, MA for Medicaid, CC for Child Care Assistance, FC for Foster Care, S for Services (such as child or adult preventive/protective services), or EMRG for an Emergency Assistance Only.

DATE OF BIRTH: Print the date of birth of each person who is applying.

SEX: Print "M" for male or "F" for female for each person who is applying.

RELATIONSHIP TO YOU: For each person, print their relationship to you (for example: spouse, son, foster child, friend, roommate, boarder, etc.).

SOCIAL SECURITY NUMBER OF APPLYING HOUSEHOLD MEMBERS: Print the Social Security number of each person who is applying unless that person is:

- A pregnant woman who is applying only for Medicaid;
- A non-citizen who is applying only for Medicaid or benefits as a result of an emergency medical condition;
- An adult who is applying only for adult protective services; or
- Applying only for Child Care Assistance. If the person is applying for Child Care Assistance and preventive services or in lieu of Public Assistance, print that person's Social Security number.

Other Services, such as foster care, child protective services, child preventive services, and counseling, are funded by a variety of sources, many of which require that a Social Security number be provided. While applicants for some Services are not required to provide a Social Security number, these Services may be unavailable if you do not furnish a Social Security number. We are, therefore, requesting a Social Security number for all applicants for these Services, in order to help them get all the benefits for which they may qualify.

HIGHEST SCHOOL GRADE COMPLETED: Enter the highest school grade (1 through 12) completed for each person who is applying. If more than 12 years, enter 13. If no formal schooling, enter 0. If you are applying only for Services, you do not have to answer this question.

DOES THIS PERSON (INCLUDING MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU?: It is important to check (✓) "YES" or "NO" to this question for every person who lives with you, whether or not they are applying. Sometimes, people who buy food and prepare meals separately may get more SNAP benefits.

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAVE BEEN KNOWN: Print any maiden names, names from a previous marriage, or other names used by anyone listed in this section. Include first name, middle initial (M.I.), and last name.

PAGE 4 OF THE APPLICATION

SECTION 7: RACE/ETHNICITY

Complete this section for each person applying. Enter “Y” for “YES” or “N” for “NO” in the column labeled “H” to indicate whether the person is Hispanic and/or Latino. Enter “Y” for “YES” or “N” for “NO” in each of the race columns to indicate each person’s racial background:

- H = Hispanic or Latino
- I = Native American or Alaskan Native
- A = Asian
- B = Black or African American
- P = Native Hawaiian or Pacific Islander
- W = White
- U = Unknown

Providing this information is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for requesting this information is to ensure that program benefits are distributed without regard to race, color, or national origin.

PAGE 5 OF THE APPLICATION

SECTION 8: CITIZENSHIP/ NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS

Complete this section for each person who is applying for any of the following programs:

- Child Care Assistance;
- Foster Care; or
- Other Services.

In addition, if you or anyone in your household is applying for the Supplemental Nutrition Assistance Program (SNAP), you must list everyone in the household, even if they are not applying for SNAP. You must also list any siblings and parents who live with any children applying for Public Assistance (PA). If applying for Child Care Assistance or Foster Care only, complete this section only for the children who need child care or foster care. If you do not complete this section for a person who is applying, that person may not receive assistance.

NAME: Print the first name, middle initial (MI), and last name of each person who is applying or who must be listed.

CHECK EITHER “CITIZEN/NATIONAL” OR “NON-CITIZEN” FOR EACH PERSON: Next to each person’s name, check (✓) either the “CITIZEN/NATIONAL” box to indicate that the person is a U.S. citizen, Native American, or national, or “NON-CITIZEN” box to indicate that the person is not a U.S. citizen, Native American, or national.

USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER: Enter the person’s U.S. Citizenship and Immigration Services (USCIS) number or non-citizen number, if applicable.

SECTION 9: CERTIFICATION

Read carefully the statements at the bottom of this section, then sign and date the certification attesting to the citizenship or non-citizen with satisfactory immigration status of each person who is applying for any of the following programs. (If applying for Child Care Assistance or Foster Care only, complete this section only for the children who need child care or foster care.) If anyone applying is not a U.S. citizen, Native American, or national, check (✓) the programs for which that person is applying and has non-citizen with satisfactory immigration status:

- Public Assistance (PA);
- Supplemental Nutrition Assistance Program (SNAP);
- Medicaid (MA), unless the person applying is pregnant;
- Child Care Assistance (CC);
- Foster Care (FC);
- Other Services (S); or
- Emergency Assistance (EMRG).

“Satisfactory non-citizen status” means a non-citizen status that does not make the person ineligible for benefits from a given program. Please note that different programs have different non-citizen status requirements. LDSS-4148B, “Book 2: What You Should Know About Social Services Programs,” contains more information about satisfactory non-citizen statuses. You may also contact your SSD for more information.

Any adult household member or authorized representative may sign the certification for all applying household members. For example, a parent without citizenship or satisfactory non-citizen status may sign the certification for a child with citizenship or satisfactory non-citizen status. If an applying household member is under age 18 (or is age 18 or older but unable to sign his/her own name due to a medical impairment or disability), a household member who is age 18 or older must sign for him/her. When signing for another household member, sign your own name. For example, Mary Doe, when signing for infant Johnny Doe, should sign “Mary Doe.”

Checking a box and signing the certification means that you certify, under penalty of perjury, that you and/or the persons for whom you are signing are a U.S. citizen, Native American, national, or non-citizen with satisfactory immigration status, for each program for which you/they are applying. If you do not check one of the boxes or provide a U.S. Citizenship and Immigration Services (USCIS) number for a non-citizen who is applying, that person may not receive assistance.

You should not sign the certification for yourself or any other person who is not a U.S. citizen, Native American, or national, or who does not have non-citizen with satisfactory immigration status. Non-citizens without satisfactory immigration status are not eligible for PA, SNAP benefits, or Medicaid (except Medicaid for a pregnant person or treatment of an emergency medical condition). Such persons also may be ineligible for certain Services.

We may confirm the non-citizen status of any or all household members applying for PA, SNAP benefits, Medicaid, or Services by submitting the information you give us to the USCIS. Information received from USCIS may affect your household’s eligibility and level of benefits.

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SECTION 10: INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT

You do not need to fill out this section if you are applying only for Medicaid and you are pregnant, gave

birth within the past sixty days, or are applying for children under 21 only, or if you are applying for child care assistance only.

1. Check (✓) “Yes” or “No” to indicate whether you are applying for any person, including yourself, who is under the age of 21, who was born to unmarried parents, and for whom paternity (i.e., legal fatherhood) has not been established.
2. Check (✓) “Yes” or “No” to indicate whether you are applying for any person, including yourself, who is under the age of 21 and at least one of this person’s parents lives outside of the home.

If you checked (✓) “No” for both of these questions, skip to Section 11. You do not have to complete the rest of Section 10. If you checked (✓) “Yes” for either or both of these questions, you must complete the rest of Section 10.

3. Check (✓) “Yes” or “No” to indicate whether you are under the age of 21.

Read carefully the statement that follows Question 3 and contact your SSD if you do not understand it.

NAME OF INDIVIDUAL UNDER AGE 21: Print the first, middle, and last name of each person for whom you checked “Yes” for Question 1, 2, and/or 3.

NONCUSTODIAL PARENT OR PUTATIVE FATHER’S NAME AND ADDRESS, DATE OF BIRTH, and SOCIAL SECURITY NUMBER: If known, print the first, middle, and last name, address, date of birth, and Social Security number of the noncustodial parent or the putative father of each person for whom you checked “Yes” for Questions 1, 2, and/or 3. The “putative father” is the man who may be the child’s father, but who was not married to the child’s mother before the child was born and has not established that he is the father in a court proceeding or by an acknowledgment of paternity.

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SECTION 11: TAX FILING/DEPENDENT STATUS

Print the following information for each individual living in the household:

FIRST NAME, MIDDLE INITIAL, and LAST NAME: Print the first name, middle initial, and last name of each individual who lives in the household.

TAX STATUS: Check (✓) the appropriate tax filing status for each individual who lives in the household.

Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip these questions.

NAME OF TAX DEPENDENT: Print the first name, middle initial, and last name of any individual who does not live with you, but who you or anyone who lives with you claims as a tax dependent.

NAME OF TAX FILER: For each tax dependent listed, print the first name, middle initial, and last name of the individual living in the household who claims the tax dependent.

SECTION 12: ABSENT/DECEASED SPOUSE INFORMATION

NAME OF PERSON APPLYING: Print the name of any person applying who is/was married, but whose spouse does not live with them or is deceased.

NAME OF SPOUSE: Print the name of the spouse of any married/formerly married person applying whose spouse does not live with them or is deceased.

DATE OF SPOUSE'S BIRTH and DATE OF SPOUSE'S DEATH, IF APPLICABLE: Print the month, day, and year of birth, and death (if applicable), of the spouse of any married/formerly married person applying whose spouse does not live with them or is deceased.

SPOUSE'S SOCIAL SECURITY NUMBER: Print the Social Security number of the spouse of any married/formerly married person applying whose spouse does not live with them or is deceased.

SPOUSE'S ADDRESS, IF APPLICABLE: Print the street address, city, county, state, and zip code of the spouse of any married person applying whose spouse does not live with them. If unknown, print the spouse's last known address.

SECTION 13: ABSENT CHILD INFORMATION

NAME OF PERSON APPLYING: Print the name of any person applying who has a child under the age of 21 who does not live with them.

NAME OF ABSENT CHILD and DATE OF BIRTH: Print the name and month, day, and year of birth of any child under the age of 21 who does not live with a person applying.

ADDRESS OF CHILD: Print the street address, city, county, state, and zip code of any living child under the age of 21 who does not live with a person applying.

PATERNITY ESTABLISHED?: Check (✓) "Yes" or "No" to indicate whether paternity (i.e., legal fatherhood) has been established for any child under the age of 21 who does not live with a person applying.

DO YOU PAY CHILD SUPPORT?: Check (✓) "Yes" or "No" to indicate whether any person applying pays child support for a child under the age of 21 who does not live with them.

SECTION 14: TEEN PARENT INFORMATION

Only complete this section if you are applying for Public Assistance.

IS THERE A PARENT UNDER THE AGE OF 18 ("TEEN PARENT") IN THE HOUSEHOLD?: Check (✓) "Yes" or "No" to indicate whether any person applying is a parent under the age of 18.

NAME: Print the name of any person applying who is a parent under the age of 18.

DOES THE TEEN PARENT'S CHILD LIVE IN THE HOUSEHOLD?: Check (✓) "Yes" or "No" to indicate whether the child of any person under the age of 18 who is applying lives with you.

NAME OF TEEN PARENT'S CHILD: Print the name of the child of any person under the age of 18 who is applying.

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SECTION 15: INCOME INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU RECEIVES MONEY FROM and WHO: Check (✓) "YES" or "NO" for lines 1 through 27 to indicate whether you or anyone who lives with you receives money from any of the kinds of income listed, and for each "YES" answer, print the name(s) of the person(s) who receive(s) the money.

AMOUNT/VALUE & FREQUENCY: For each "YES" answer, print the dollar (\$) amount or value and how often this kind of income is received by each person who receives it. For instance, if you receive \$100 in unemployment insurance benefits every week, print "\$100 per week" or "\$100/wk."

SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS (STATE AND FEDERAL TOTAL): If you or anyone who lives with you gets New York State Supplement Program (SSP) benefits in addition to Supplemental Security Income (SSI) benefits, add these amounts together and enter them in the AMOUNT/VALUE & FREQUENCY column for SSI Benefits on line 2. If you or anyone who lives with you gets SSP benefits only, enter this amount in the AMOUNT/VALUE & FREQUENCY column for SSI Benefits on line 2.

FOSTER CARE PAYMENTS (RECEIVED): If you or anyone who lives with you gets foster care payments, enter this amount into the AMOUNT/VALUE & FREQUENCY column for Foster Care Payments on line 17. If you or anyone who lives with you gets foster care payments for the care of a foster child or adult and you are applying for Supplemental Nutrition Assistance Program (SNAP) benefits, you have two choices: You can choose to include the foster care child or adult and the foster care payments in your SNAP benefits household or you can choose not to include the foster care child or adult and the foster care payments in your SNAP benefits household. Ask your SSD which choice would give you more SNAP benefits.

CHILD SUPPORT PAYMENTS (RECEIVED): If you or anyone who lives with you gets child support payments, print the name of the person who pays the child support after "Received From" on line 18.

OTHER INCOME: Describe any other money received by you or anyone who lives with you, including who receives the money, how much they receive, and how often they receive it.

DEDUCTIONS, WHO, and AMOUNT/VALUE & FREQUENCY: Check (✓) "YES" or "NO" for lines 1 through 15 to indicate whether you or anyone who lives with you will claim any of the federal tax deductions listed on the current year's income tax return. For each "YES" answer, print the name(s) of the person(s) who will claim the deduction(s), and the amount or value and frequency of the expense(s) that will be claimed on the income tax return.

OTHER ADJUSTMENT: Describe any other federal tax deductions that you or anyone who lives with you will claim on the current year's income tax return, including who will claim the deduction(s), and the amount or value and frequency of the expense(s) that will be claimed on the income tax return.

SECTION 16: STEP-PARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

DOES THE STEP-PARENT OF ANY CHILDREN WHO LIVE WITH YOU HAVE ANY RESOURCES OR RECEIVE INCOME OF ANY KIND? and WHO: Check (✓) "YES" or "NO" to indicate whether anyone applying, including yourself, has a step-parent who does not live with you and who has financial resources or receives money from any source. (If the step-parent lives with you, the step-parent's resources/income should be included in Section 15, Income Information.) If "YES," print the name of the step-parent.

IS ANYONE IN YOUR HOUSEHOLD A NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS WHO WAS SPONSORED FOR ADMISSION INTO THE U.S. and WHO?: Check (✓) "YES" or "NO" to indicate whether you or anyone in your household is a non-citizen with satisfactory immigration status who was sponsored by someone in order to be admitted to the U.S. If "YES," print the name of the individual who was sponsored.

NAME OF SPONSOR, ADDRESS, and PHONE NO.: If "YES," print the name of the person who sponsored you or anyone in your household for admission to the U.S., the sponsor's address, and the sponsor's phone number.

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SECTION 17: EMPLOYMENT INFORMATION

Complete this section for yourself and for everyone who lives with you. If you are employed, you may still be eligible for assistance. For the purposes of this section, "working age" means 18 years of age or older, or 16 years of age or older for anyone who does not attend school.

I AM CURRENTLY: Check (✓) "employed," "self-employed," or "unemployed" to indicate whether you are working, and if so, whether you work for yourself or someone else.

GROSS INCOME: Print the amount you get paid before taxes on a weekly, biweekly, or monthly (not yearly) basis, if applicable. Include all wages, salary, overtime pay, commissions, and tips.

HOURS WORKED MONTHLY: Print the number of hours you work each month, if applicable.

PAID: Check (✓) "Weekly," "Bi-weekly," or "Monthly" to indicate how often you get paid, if applicable.

DAY OF THE WEEK PAID: Print the day of the week that you get paid, if applicable.

EMPLOYER'S NAME AND ADDRESS and PHONE NO.: Print your employer's name, address, and phone number, if applicable. Print "self," and your business address and phone number, if you are self-employed.

IS ANYONE ELSE WHO LIVES WITH YOU CURRENTLY EMPLOYED OR SELF-EMPLOYED and WHO: Check (✓) "employed" or "self-employed" if anyone who lives with you is working, and print his/her name.

Complete the **GROSS INCOME, HOURS WORKED MONTHLY, PAID, DAY OF THE WEEK PAID, EMPLOYER'S NAME AND ADDRESS, and PHONE NO.** for any person who lives with you and works, according to the directions above.

IS HEALTH INSURANCE AVAILABLE THROUGH YOUR EMPLOYER?: If you are employed, check (✓) "Yes" or "No" to indicate whether you have medical coverage available through your employer.

DOES ANYONE WHO LIVES WITH YOU HAVE HEALTH INSURANCE WITH AN EMPLOYER? and WHO: Check (✓) "Yes" or "No" to indicate whether anyone who lives with you has medical coverage through an employer, and if "Yes," print his/her name.

NAME OF INSURANCE COMPANY: Print the name of your health insurance company and/or the health insurance company of any person who lives with you, if applicable.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE CHILD OR DEPENDENT CARE EXPENSES DUE TO EMPLOYMENT? and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you has child care or dependent care (e.g., for an elderly parent) expenses as a result of being employed and print the name of the person with these expenses.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE OTHER EMPLOYMENT-RELATED EXPENSES? and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you has any employment-related expenses (e.g., transportation, uniforms), and if "Yes," print your/his/her name.

IF NOT EMPLOYED, WHEN WAS THE LAST TIME YOU OR ANYONE WHO LIVES WITH YOU WORKED?, WHO, WHEN, and WHERE: If you or anyone of working age who lives with you is unemployed, print your/his/her name(s), the date(s) you/he/she were last employed, and where you/he/she were last employed.

WHY DID YOU (OR THEY) STOP WORKING?: Print the reason(s) that you or anyone of working age who lives with you is unemployed.

DID YOU OR ANYONE LIVING WITH YOU FILE FOR UNEMPLOYMENT?, WHO, WHEN, and STATUS OF FILING: If you or anyone of working age who lives with you is unemployed, check (✓) "Yes" or "No" to indicate whether you/he/she have filed for unemployment. If "Yes," print your/his/her name, when you/he/she filed for unemployment, and the status of the filing.

ARE YOU OR IS ANYONE WHO LIVES WITH YOU PARTICIPATING IN A STRIKE? and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you is on strike (i.e., has stopped working in protest to an employer's decision or practices), and if "Yes," print your/his/her name.

WHEN THE STRIKE BEGAN: If you or anyone who lives with you is on strike, print the date that you/he/she went on strike.

ARE YOU OR IS ANYONE WHO LIVES WITH YOU A MIGRANT OR SEASONAL FARM WORKER? and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you travels to different farms for work or works on a farm only during the growing season, and if "Yes," print your/his/her name.

DO YOU OR ANY OTHER ADULT WHO LIVES WITH YOU HAVE ANY MEDICAL CONDITIONS THAT LIMIT THE ABILITY TO WORK OR THE TYPE OF WORK THAT CAN BE PERFORMED? and WHO: Check (✓) "Yes" or "No" to indicate whether you or anyone of working age who lives with you has any condition that keeps you/him/her from working full-time or from doing certain kinds of work, and if "Yes," print your/his/her name.

DESCRIBE LIMITATIONS: If you or anyone of working age who lives with you has any condition that keeps you/him/her from working full-time or from doing certain kinds of work, explain the ways in which you/he/she are limited.

COULD YOU ACCEPT A JOB TODAY? and IF NOT, WHY?: Check (✓) "Yes" or "No" to indicate whether you could take a job today if it was available, and if "No," explain why.

WHAT TYPE OF WORK WOULD YOU LIKE TO DO?: What kind of job would you enjoy doing?

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SECTION 18: EDUCATION/TRAINING

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION COMPLETED?: Check (✓) the description that best matches how much education you have completed.

IF SO, LAST GRADE COMPLETED?: If you did not finish high school, print the last grade that you completed.

DOES ANYONE ELSE IN THE HOUSEHOLD HAVE A HIGH SCHOOL DIPLOMA, GENERAL EQUIVALENCY DIPLOMA (GED) OR TEST ASSESSING SECONDARY COMPLETION (TASC™), OR HIGHER LEVEL OF EDUCATION?, WHO, DEGREE ATTAINED, and DATE COMPLETED: Check (✓) "Yes" or "No" to indicate whether anyone who lives with you has a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of

education. If "Yes," print the name of that person, the degree received, and the date it was received.

Complete the following questions for yourself and anyone who lives with you who is applying for or getting assistance:

IS OR HAS BEEN IN ANY TRAINING PROGRAM?, WHO, WHERE, PROGRAM, DATES ATTENDED, and DATES COMPLETED: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is applying for or getting assistance has participated in a job training program, and if "Yes," print the name of that person, where that person attended the training program, the name of the program or what kind of program it was, and the dates that person attended and completed the program.

IS 16 YEARS OF AGE OR OLDER AND IS ATTENDING SCHOOL OR COLLEGE?, WHO, and WHERE: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is applying for or getting assistance is 16 years of age or older and going to school or college, and if "Yes," print the name of that person and his/her school or college.

IS UNDER 16 YEARS OF AGE AND IS ATTENDING SCHOOL?, WHO, and SCHOOL: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is applying for or getting assistance is under 16 years of age, and if "Yes," print the name(s) of any such person(s) and his/her/their school(s).

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SECTION 19: RESOURCES INFORMATION

You do not have to fill out this section if you are applying only for Services, other than Foster Care and/or Child Care Assistance.

If you are applying only for Supplemental Nutrition Assistance Program benefits, you do not have to indicate whether you have life insurance.

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING: For lines 1 through 23, check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is applying for assistance has any of the financial resources listed.

WHO: For each "YES" answer, print the names(s) of the person(s) with the resource.

IF YES, AMOUNT/VALUE: For each "YES" answer, print the dollar (\$) amount or value of the resource. Be sure to list any joint holdings (i.e. resources belonging to two or more people, e.g., joint bank accounts). Anyone applying for Public Assistance or Medicaid must include the resources of any legally responsible relatives. These are people who are required by law to financially support you or anyone applying, such as a spouse or, if you are under the age of 21, any parents or step-parents who live with you or anyone applying.

HAS TITLE OR REGISTRATION TO A MOTOR VEHICLE(S) OR OTHER VEHICLE(S), YEAR, MAKE/MODEL, and OTHER: If your name or the name of anyone who lives with you who is applying is listed on the title for a car or other vehicle, print the year, make, and model for each vehicle on line 6. List resources, such as campers, snowmobiles, and boats, after "Other" on line 6.

HAS RESOURCES OTHER THAN THOSE LISTED ABOVE: It is very important to let your SSD know right away if you get or are expecting to get money from a lump sum. A lump sum is a one-time payment, such as an insurance settlement, inheritance, or award from a lawsuit or lottery winning. See LDSS-4148A, "Book 1: What You Should Know About Your Rights and Responsibilities," for more information about lump sums.

HAS ANYONE . . . EVER CREATED A TRUST IN THE PAST OR TRANSFERRED ANY ASSETS INTO A TRUST WITHIN THE PAST 60 MONTHS?: If you or your spouse transfer or give away any assets within the 36 months (60 months for transfers to a trust) prior to the first day of the month in which you receive nursing facility services and you have submitted an application for Medicaid, you may not be eligible to receive nursing facility services or home and community-based waived services under the Medicaid Program.

If you or anyone applying, or a spouse of you or anyone applying (even if the spouse is not applying or living in the household), has created a trust or put any money into a trust in the past five years, print when the trust was created or money was put into it on line 23.

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SECTION 20: MEDICAL INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING and IF YES, WHO: Check (✓) "YES" or "NO" to indicate whether any of the situations listed apply to you or anyone who lives with you who is applying for assistance, and if "YES," print the name of the person to whom each situation applies. Be sure to list all health and hospital/accident insurance that you have or that is available to anyone applying.

HAS PAID OR UNPAID MEDICAL BILLS WITHIN 3 MONTHS PRECEDING THE MONTH OF THIS APPLICATION: Medicaid may be able to pay for medical bills for care you were given during the three months before the month you apply for help. If you have already paid the bill, we may be able to pay you for the bill if we determine that you would have been eligible for Medicaid at the time. We may be able to pay you even if the doctor or other provider does not accept Medicaid, but we can only pay you the amount Medicaid would have paid and only if the bill was for services that Medicaid would have covered.

IS PREGNANT: If you or anyone who lives with you who is applying is pregnant, print the due date and the expected number of births on line 14.

HEALTH PLAN SELECTION: Complete this section for anyone applying for Medicaid. Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call the Managed Care Medicaid Choice Help Line at 1-800-505-5678.

NAME OF PLAN YOU ARE ENROLLING IN: Print the name of the health plan(s) in which anyone applying for Medicaid wishes to enroll. If you do not know which health plans are available to you, ask the SSD.

LAST NAME and FIRST NAME: Print the last name and first name of each person applying for Medicaid.

DATE OF BIRTH: Print the two-digit month, two-digit day, and two-digit year of the date of birth of each person applying for Medicaid.

SEX: Print "M" for "Male" or "F" for "Female" to indicate the sex of each person applying for Medicaid.

ID# (FROM MEDICAID CARD IF YOU HAVE ONE): If anyone applying for Medicaid has a Medicaid card, print the Medicaid card identification number here.

SOCIAL SECURITY #: Print the Social Security number of each person applying for Medicaid. This is optional if the person is pregnant.

PRIMARY CARE PROVIDER OR HEALTH CENTER (CHECK BOX IF CURRENT PROVIDER):

Print the name of the primary care provider (i.e., general practitioner or family doctor) or the health center anyone applying for Medicaid wishes to use. If this is the provider or center used by this person already, check (✓) the box. You must make sure that the provider or center accepts Medicaid before receiving medical care.

NAME AND ID # OF OB/GYN (CHECK BOX IF CURRENT PROVIDER):

If anyone applying for Medicaid needs obstetrician/gynecologist (OB/GYN) care and services, print the name of the OB/GYN the applicant wishes to use. If the applicant already uses this OB/GYN, check (✓) the box. You must make sure that the provider or center accepts Medicaid before receiving medical care.

You must make sure that any doctor or medical provider you see accepts Medicaid before you get medical care.

SECTION 21: SHELTER INFORMATION

You do not have to fill out this section if you are applying only for Services other than Foster Care and/or Child Care Assistance.

WHAT IS YOUR LANDLORD'S NAME, ADDRESS, and PHONE NUMBER?: If you have a landlord, print your landlord's name, address, and phone number.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE A RENT, MORTGAGE OR OTHER SHELTER

EXPENSE?: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays rent, a mortgage, or other shelter (e.g., room and board) expense, and if "YES," print the amount you/he/she pay(s) per month. If you have a mortgage payment, include the amount of property taxes and homeowner's insurance (including fire insurance).

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE A HEAT BILL SEPARATE FROM YOUR RENT

OR OTHER SHELTER EXPENSE?: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays for heat separately from your rent, mortgage, or other shelter expense, and if "YES," print the amount you/he/she pay(s) per month.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE THE FOLLOWING EXPENSES SEPARATE

FROM YOUR RENT OR OTHER SHELTER EXPENSE?: For lines 1 through 8, check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays for any of the expenses listed separately from your rent, mortgage, or other shelter expense, and if "YES," print the amount you/he/she pay(s) per month. For the questions on lines 9 through 11, check (✓) "YES" or "NO" to indicate whether you or anyone applying lives in any of these arrangements.

SECTION 22: OTHER EXPENSES**INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING and IF YES, AMOUNT:**

Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is applying makes any of the payments listed, or has any expenses not listed, on lines 1 through 6. Identify on line 6 any expenses not listed. For each "YES" answer, print the amount of the payment or expense and how often it is paid (e.g., \$100 per week or \$100/wk.)

DO YOU OR ANYONE WHO LIVES WITH YOU WHO IS APPLYING OWE AT LEAST FOUR MONTHS

OF SUPPORT FOR A CHILD UNDER AGE 21: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is applying owes four months or more of child support.

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SECTION 23: OTHER INFORMATION

DO YOU BUY OR PLAN TO BUY MEALS FROM A HOME DELIVERY OR COMMUNAL DINING SERVICE?: Check (✓) “YES” or “NO” to indicate whether you or anyone applying currently buys or plans to buy meals from a home delivery (e.g., Meals on Wheels) or communal dining (e.g., a cafeteria in the building where you live) service.

ARE YOU ABLE TO COOK OR PREPARE MEALS AT HOME?: Check (✓) “YES” or “NO” to indicate whether you have a place at home where you can cook.

For purposes of the questions on lines 10 through 12, “U.S. military” means the:

- U.S. Army
- U.S. Navy
- U.S. Coast Guard
- U.S. Marine Corps
- U.S. Air Force
- U.S. Merchant Marine during World War II

HAVE YOU OR ANYONE IN YOUR HOUSEHOLD EVER BEEN IN THE U.S. MILITARY? and WHO: Check (✓) “YES” or “NO” to indicate whether you or anyone who lives with you has ever been in any of the military branches listed above, and if “YES,” print his/her name.

HAS YOUR SPOUSE EVER BEEN IN THE U.S. MILITARY? Check (✓) “YES” or “NO” to indicate whether your spouse has ever been in any of the military branches listed above.

IS ANYONE IN YOUR HOUSEHOLD A DEPENDENT OF SOMEONE WHO IS OR WAS IN THE U.S. MILITARY? and WHO: Check (✓) “YES” or “NO” to indicate whether you or anyone who lives with you is financially dependent on someone who is or ever has been in any of the military branches listed above, and if “YES,” print the name of the dependent.

DO YOU OR DOES ANYONE WHO LIVES WITH YOU RECEIVE ASSISTANCE OR SERVICES NOW?; IF YES, WHO; and TYPE OF ASSISTANCE: Check (✓) “YES” or “NO” to indicate if you or anyone who lives with you now receives Public Assistance, Medicaid, Supplemental Nutrition Assistance Program (SNAP; formerly, “Food Stamp”) benefits, Child Care Assistance, or Services. If “YES,” print this person's name and the type of assistance received.

HAVE YOU OR ANYONE WHO LIVES WITH YOU RECEIVED ASSISTANCE OR SERVICES IN THE PAST?; IF YES, WHO; and TYPE OF ASSISTANCE: Check (✓) “YES” or “NO” to indicate if you or anyone who lives with you has ever received Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services in the past. If “YES,” print this person's name and the type of assistance received.

OTHER INFORMATION (CONT.): Check (✓) “YES” or “NO” to indicate whether the situations described in the next nine questions apply to you or anyone who lives with you, and if “YES,” print the name of the person to whom the situation applies. If you do not understand these questions, ask your SSD to explain. Please note that New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth.

PROPERTY TRANSFER STATUS: Check (✓) the “I have” box or “I have not” box to indicate whether you or anyone applying has sold, transferred, or given away any property in order to receive Public Assistance or SNAP benefits. Please note that New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth.

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NOTICES, ASSIGNMENTS, AUTHORIZATIONS, AND CONSENTS

Read **ALL** of the information in this section carefully or have someone read it to you. This section contains important information about your rights and responsibilities relative to receiving assistance, as well as penalties you may incur (e.g., a fine and/or jail) if you do not fulfill your responsibilities under this section. By signing and submitting an application, you indicate that you understand and agree to the statements in this section.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE: If you want someone to apply for Supplemental Nutrition Assistance Program (SNAP) benefits for you and/or you want someone who does not live with you to get the SNAP benefits for you and/or use them to buy food for you, print that person’s name, address, and phone number in the box. This person is your “Authorized Representative.” The Authorized Representative must sign and date the signature section at the end of the application. If your household does not live in an institution, a responsible adult member of your household must sign and date the application also, unless your household has otherwise designated the Authorized Representative to do so in writing.

RELEASE OF MEDICAL INFORMATION: Check (✓) “Do not disclose HIV/AIDS information,” “Do not disclose mental health information,” and/or “Do not disclose drug and alcohol information” if you do not agree to have this medical information about you and/or applying family members disclosed as permitted by law.

SIGNATURE SECTION: Read this section carefully or have someone read it to you. New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, Supplemental Nutrition Assistance Program benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth. **By signing and submitting an application, you indicate that you understand and agree to the statements in this section, and that all of the information you have provided on this application or will provide to the SSD in the future is complete and correct to the best of your knowledge.**

APPLICANT SIGNATURE and DATE SIGNED: Sign your name and print the date you signed the application, unless you have designated a Supplemental Nutrition Assistance Program (SNAP) Authorized Representative on the application and you live in an institution, in which case the Authorized Representative may sign and date the application. If you do not reside in an institution, both you and the Authorized Representative must sign and date the application, unless you have previously designated the SNAP Authorized Representative to do so in writing. If you have filled out the application for someone else, sign your name, not the name of the person for whom you applied, and print the date you signed.

SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE and DATE SIGNED: If you are married and applying for Public Assistance, Medicaid, Child Care Assistance, or Services, your spouse must sign and date the application. If you are married and applying just for Supplemental Nutrition Assistance Program benefits, only one spouse must sign and date the application. If you have a Protective Representative, that person must sign and date the application.

AUTHORIZED REPRESENTATIVE SIGNATURE: If you have designated a SNAP Authorized Representative on the application, that person must sign and date the application.

I CONSENT TO WITHDRAW MY APPLICATION FOR: Do not check any of the boxes, or sign or date this section, if you want to submit an application. Only mark this section if you want to withdraw your application for one or more programs. To withdraw your application for a program, check (✓) the box next to that program, and sign and date where indicated. Your application will be withdrawn only for the program(s) you check.

VOTER REGISTRATION FORM: The last two pages of this Application are a voter registration form. Using the form to register or declining to register to vote will not affect the decision made about your application for benefits and/or services, or the amount of assistance that you may receive. If you would like help filling out the voter registration form, ask your SSD.

Informational Purposes DOCUMENTATION REQUIREMENTS

This following list of eligibility factors and documentation requirements is solely for informational purposes. Your SSD will inform you which of the eligibility factors you will be required to prove. You may be asked to prove other eligibility factors not listed below. You may be able to provide documentation not listed below to prove these eligibility requirements. If you have any questions regarding documentation requirements, please contact your SSD.

Eligibility Factor	To prove this factor, provide: ✓↓ ONE of the following	OR	✓↓ TWO of the following (If you are applying for SNAP Benefits or Medicaid only, you need to bring only one form for each eligibility factor checked.)	
<input type="checkbox"/> Identity You must prove who you are.	Photo I.D. Driver's license U.S. passport Naturalization Certificate Hospital/Doctor's Records Adoption paper		Statement from another person Validated Social Security Number Birth/Baptismal Certificate	<input type="checkbox"/> Social Security Number (For Public Assistance, SNAP Benefits and Medicaid- only , you do not have to _____ provide proof of your Social Security Number (SSN) unless the SSN you give does not match with SSA'S records or cannot be verified by the agency.)
<input type="checkbox"/> Marital Status You must prove if you are married, divorced, separated, or widowed.	Marriage/Death certificates Separation agreement Divorce decree Social Security records VA records		Statement from clergy Census records Newspaper notice Statement from another person	<input type="checkbox"/> Citizenship or Current Non-Citizen Status - US citizens are eligible for Public Assistance, SNAP and Medicaid. Non-citizens must be in satisfactory immigration status in order to be eligible for Public Assistance, SNAP or Medicaid. Immigration status is not an eligibility factor for pregnant women or immigrant children applying for Child Health Plus B. Undocumented immigrants and temporary non-immigrants are eligible only for the treatment of an emergency medical condition.
<input type="checkbox"/> Residence You must prove where you live.	Statement from landlord Current rent receipt or lease Mortgage records		Statement from another person Current mail School records	<input type="checkbox"/> Earned Income From employer
<input type="checkbox"/> Household Composition/Size You must prove who is living with you.	Statement from non-relative Landlord School records		Statements from other persons	<input type="checkbox"/> From self-employment
<input type="checkbox"/> Age You must prove the age of each person applying for assistance, where appropriate.	Birth certificate Baptismal certificate Hospital records Adoption records Naturalization certificate Driver's license		Insurance policy Census records School records Statement from another person Physician statement Official correspondence from SSA	<input type="checkbox"/> Income from rent or room/board
<input type="checkbox"/> Absent Parent If the parent of any child in your home is not living with you, you must prove this	Death certificate Survivor's benefits Hospital records VA or military records Divorce papers Proof of remarriage		Newspaper notice Insurance company records Institutional records Agency case records and burial payment files Statement from another person	<input type="checkbox"/> Unearned Income Child support
<input type="checkbox"/> Absent Parent Information You must provide any information you have: name, address, Social Security Number, birth date, employment	Pay Stubs Tax returns Social Security or VA records Monetary determination letters ID. cards (health insurance) Driver's license or registration			<input type="checkbox"/> Unemployment Insurance benefits (UIB) <input type="checkbox"/> Social Security benefits (including SSI) Veteran's benefits

To prove this factor, provide one of the following:

Social Security Card
Official correspondence from SSA
A Social Security Number is not required for non-citizens who are seeking Medicaid for emergency treatment only or are Medicaid-only applicants who are pregnant.

Birth certificate
Baptismal certificate
Hospital records
U.S. passport
Military service records
Naturalization certificate
USCIS documentation
Evidence of continuous U.S. residence since prior to 1/1/72.

Current wage stubs
Pay envelopes
On letterhead, rate of pay per hour; hours worked per week; date of first pay, if new and employer's phone number
Contact with employer
Business records
Tax records
Records and related materials concerning self-employment earnings and expenses
Current income tax return
Current contribution check
Statement from roomer, boarder, tenant
Income tax records

Statement from Family Court
Statement from person paying support
Check stubs
Current award certificate
Current benefit check
Official correspondence with NYS Dept. of Labor
Current award certificate
Current benefit check
Official correspondence from SSA
Current award certificate
Current benefit check
Official correspondence from VA

Eligibility Factor	To prove this factor, provide one of the following:	Eligibility Factor	To prove this factor, provide one of the following:
<input type="checkbox"/> Unearned Income (con't) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Education grants and loans <input type="checkbox"/> Interest/dividends/royalties <input type="checkbox"/> Private pension/annuity <input type="checkbox"/> Other	Award Letter Check stub Statement from school Statement from bank Award letter Statement from bank or credit union Statement from broker/agent Current award letter Current benefit check Official correspondence from source of income	<input type="checkbox"/> Other _____ <input type="checkbox"/> Shelter Expenses You must prove how much it costs you to live where you do (You may need to provide separate documentation for each item of shelter expense.) Medicaid does not require documentation of shelter expenses. <input type="checkbox"/> Medical Bills	 Current rent receipt Current lease Mortgage book/records Property and school tax records Landlord statement Sewer and water bills Homeowner's insurance records Fuel bills Non-heating utility bills Telephone bills Copies of medical bills (paid and unpaid)
<input type="checkbox"/> Resources <input type="checkbox"/> Bank accounts: checking, savings, retirement (IRA and Keogh) <input type="checkbox"/> Stocks, bonds, certificates <input type="checkbox"/> Life Insurance <input type="checkbox"/> Burial trust or fund burial plot or funeral agreement <input type="checkbox"/> Income tax refund or earned income tax credit (EITC) <input type="checkbox"/> Real estate other than Residence <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Lump sum payment	Statement from household Statement from nursing home Current bank records Current credit union records Stock certificate Bonds Statement from financial institution Insurance policy Statement from insurance company Bank records Burial agreement Burial plot deed Statement from funeral director Tax Refund Statement from tax office Deed Statement from real estate broker Appraisal/estimate of current value by broker Registration (older models) Title of ownership Appraisal of current value by dealer Financing data Statement from source of payment	<input type="checkbox"/> Health Insurance If you or anyone applying has health insurance coverage (even if paid for by someone else), you must prove this. <input type="checkbox"/> Disabled/Incapacitated /Pregnant If you or anyone living with you is sick or pregnant, you must provide proof. <input type="checkbox"/> Unpaid Bills Rent, utility <input type="checkbox"/> Referral Drug/Alcohol Treatment Program <input type="checkbox"/> Employment Service <input type="checkbox"/> Other Expenses/ Dependent Care Cost You must provide proof if you pay court-ordered support, child care, recurring loans, or for services of a home health aide or attendant. <input type="checkbox"/> School Attendance You must prove who is in school <input type="checkbox"/> Other:	Insurance policy Insurance card Statement from provider of coverage Medicare card Statement from medical professional verifying pregnancy and expected date of birth Statement from medical professional Proof of SSA or SSI benefits for disability or blindness Copy of each bill showing amount owed, period of services and provider Statement from provider of Treatment Statement from employment service Court order Statement from day care center or other child care provider Statement from aide or attendant Cancelled checks or receipts School records (current report card) Statement from school/ or Higher Education Institution

CENTER/ OFFICE	INTERVIEW DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NUMBER	DISTRICT	CATEGORY	LANG	NUMBER REUSE INDICATOR
CASE NAME				EFFECTIVE DATE	DISPOSITION <input type="checkbox"/> RECERTIFICATION <input type="checkbox"/> CLOSE		REASON CODE		
ELIGIBILITY DETERMINED BY (WORKER):		DATE	ELIGIBILITY APPROVED BY (SUPERVISOR):		DATE	SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION		DATE	
DATE RECEIVED BY AGENCY		EMPLOYED BY: <input type="checkbox"/> SOCIAL SERVICES DISTRICT <input type="checkbox"/> PROVIDER AGENCY SPECIFY: _____							
PA AUTHORIZATION PERIOD			MA AUTHORIZATION PERIOD			SNAP AUTHORIZATION PERIOD			
FROM		TO	FROM		TO	FROM		TO	

NEW YORK STATE RECERTIFICATION FORM FOR CERTAIN BENEFITS AND SERVICES

If you are blind or seriously visually impaired and need this recertification form in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request a recertification form in an alternative format, see the instruction book (PUB-1313 Statewide), available at www.otda.ny.gov or <https://www.health.ny.gov/>.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? Yes No

If yes, check the type of format you would like: Large Print; Data CD;
 Audio CD; Braille, if you assert that none of the other alternative formats will be equally effective for you.

If you require another accommodation, please contact your social services district.

We are committed to assisting and supporting you in a professional and respectful manner. You are responsible for participating in activities, including work activities for Public Assistance and the Supplemental Nutrition Assistance Program, where required, so you can become self-sufficient. Whenever you see "Public Assistance" or "PA" on the recertification form, it means "Family Assistance" and/or "Safety Net Assistance." We call both programs "Public Assistance." These PA programs are meant to assist you only until you can fully support yourself and your family. **Please refer to the instruction book (PUB-1313 Statewide) and "What You Should Know" Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B, and LDSS-4148C) when completing this recertification form, and contact your social services district with any questions.**

When you see "MA" on the recertification form, it means "Medicaid." You may apply for MA using this recertification form only if you are also recertifying for Public Assistance or the Supplemental Nutrition Assistance Program at the same time. If you wish to only recertify for MA, you can go online at <https://nystateofhealth.ny.gov/> and/or call 1-855-355-5777 for more information or to recertify, or you may use the MA-only paper application - Form DOH-4220, which your worker can give you, or call MA help line at 1-800-541-2831. If you want to recertify only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH- 4220 MA application form.

SECTION 1 CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE RECERTIFYING FOR										<input type="checkbox"/> Public Assistance (PA) <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Medicaid (MA) and SNAP <input type="checkbox"/> Medicaid (MA) and PA										
SECTION 2										SECTION 5 DO ANY OF THESE APPLY TO YOU?										
WHAT IS YOUR PRIMARY LANGUAGE? <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER (specify) _____					DO YOU WANT TO RECEIVE NOTICES IN: <input type="checkbox"/> ENGLISH ONLY <input type="checkbox"/> ENGLISH AND SPANISH															
SECTION 3 RECIPIENT INFORMATION										PLEASE PRINT CLEARLY										
FIRST NAME			M.I.	LAST NAME			MARITAL STATUS		PHONE NUMBER () AREA CODE											
STREET ADDRESS				APT. NO.		CITY		COUNTY			STATE		ZIP CODE			<input type="checkbox"/> Pregnant 1				
IN CARE OF NAME (COMPLETE IF YOU RECEIVE YOUR MAIL IN CARE OF ANOTHER PERSON)										<input type="checkbox"/> Victim of Domestic Violence 2 <input type="checkbox"/> Need To Establish Paternity 3 <input type="checkbox"/> Need Child Support 4 <input type="checkbox"/> Drug/Alcohol Problem 5 <input type="checkbox"/> Fuel Or Utility Shutoff 6 <input type="checkbox"/> No Place To Stay/Homeless 7 <input type="checkbox"/> Fire Or Other Disaster 8 <input type="checkbox"/> Have No Income 9 <input type="checkbox"/> Serious Medical Problem 10 <input type="checkbox"/> Pending Eviction 11 <input type="checkbox"/> No Food 12 <input type="checkbox"/> Need Foster Care 13 <input type="checkbox"/> Need Child Care 14 <input type="checkbox"/> Problems with English 15 <input type="checkbox"/> Reasonable Accommodations 16 <input type="checkbox"/> Other _____ 17										
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)				APT. NO.		CITY		COUNTY			STATE		ZIP CODE							
HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?		YEARS	MONTHS	IS THIS A SHELTER? <input type="checkbox"/> YES <input type="checkbox"/> NO		ANOTHER PHONE WHERE YOU CAN BE REACHED		NAME			PHONE NUMBER () AREA CODE									
DIRECTIONS TO CURRENT ADDRESS																				
FORMER ADDRESS				APT. NO.		CITY		COUNTY			STATE		ZIP CODE							
IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK HERE <input type="checkbox"/>																				
AGENCY HELPING APPLICANT/CONTACT PERSON								PHONE NUMBER () AREA CODE												
DO YOU NEED THE MEDICAID PORTION OF THIS RECERTIFICATION FORM AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL? <input type="checkbox"/> YES <input type="checkbox"/> NO																				
LIST THE THINGS THAT HAVE CHANGED SINCE YOUR APPLICATION OR LAST RECERTIFICATION (such as moved, had a baby, income, etc.) _____																				
SECTION 4 – If You Are Reapplying For SNAP: You can file a recertification form the day you get it. In order to file a SNAP recertification, it must have, at minimum, your name, address (if you have one) and signature below. You must complete the recertification process, including signing the last page of the recertification and being interviewed. If eligible, you will get SNAP benefits back to the date you filed the recertification. You must be told, within 30 days of the date you turned in (filed) your recertification for SNAP benefits, if your recertification is approved or denied. If your household has little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources, you may be eligible to get SNAP benefits within five calendar days of the date you file. If you are a resident of an institution and are recertifying for both Supplemental Security Income (SSI) and SNAP benefits prior to leaving the institution, the filing date of the recertification is the date you leave the institution.																				
SNAP RECIPIENT/REPRESENTATIVE SIGNATURE								DATE SIGNED												
x																				

SECTION 6 – HOUSEHOLD INFORMATION – List everybody who lives with you, even if they are not recertifying with you. List yourself on the first line.

DOES THIS PERSON (INCLUDING MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU?

HIGHEST SCHOOL GRADE COMPLETED

SOCIAL SECURITY NUMBER OF RECERTIFYING HOUSEHOLD MEMBERS (See instruction book, PUB-1313 Statewide, or talk to your social services district)

(Middle Initial)				THIS PERSON IS RECERTIFYING FOR:			DATE OF BIRTH			SEX M OR F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER OF RECERTIFYING HOUSEHOLD MEMBERS (See instruction book, PUB-1313 Statewide, or talk to your social services district)	YES	NO
RI	LN	FIRST NAME	M.I.	LAST NAME	PA	SNAP	MA	Month	Day					
	01										SELF			
	02													
	03													
	04													
	05													
	06													
	07													
	08													

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAVE BEEN KNOWN

Line No.	ONC	FIRST NAME	M.I.	LAST NAME
Line No.	ONC	FIRST NAME	M.I.	LAST NAME

SECTION 7

HAS ANYONE MOVED **INTO** THE HOUSEHOLD IN THE PAST YEAR? YES NO
 IF YES, INCIDATE BELOW.

DID THEY EVER LIVE IN NEW YORK STATE BEFORE NOW? YES NO
 IF YES, INCIDATE BELOW.

HAS ANYONE MOVED **OUT** OF THE HOUSEHOLD IN THE LAST YEAR? YES NO
 IF YES, INCIDATE BELOW.

NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME	WHEN?
NAME	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME	WHEN?

IS ANYONE SANCTIONED? YES NO
 IF YES, WHO REASON END DATE

NON-APPLICANT INFORMATION

LN	FIRST NAME	LAST NAME	LEGALLY RESPONSIBLE		FOR WHOM?	CONTRIBUTION/ DEEMED INCOME	CHECK IF MEMBER OF SNAP HOUSEHOLD
			YES	NO			

NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS INFORMATION

INDIVIDUAL EDUCATION

CONSIDER

LN	NON-CITIZEN STATUS	STATUS ADJUSTED			DATE OF ENTRY/STATUS			APPLIED FOR CITIZENSHIP		SPONSORED		LN	DEGREE RECEIVED	LN	DEGREE RECEIVED
		YES	NO	MONTH	DAY	YEAR	YES	NO	YES	NO					
												01		05	
												02		06	
												03		07	
												04		08	

✓ RCA/RMA REFERRAL

Please read this entire page carefully before completing it. If you have questions, see the instruction book (PUB-1313 Statewide) or talk to your social services district.

SECTION 9 – CITIZENSHIP/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS	SECTION 10 – CERTIFICATION		
<p>LIST EVERYONE WHO IS RECERTIFYING OR WHO IS REQUIRED TO RECERTIFY.</p>	<p>Some social services programs require that you certify that you are a United States citizen, Native American or national of the U.S., or a non-citizen with satisfactory immigration status. Other programs do not.</p> <p>You MUST sign the Certification below only if you are a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status, and you are recertifying for:</p> <ul style="list-style-type: none"> Public Assistance (where there are children in the household or a member of the household is pregnant), or The Supplemental Nutrition Assistance Program, or Medicaid (<u>except</u> if the applicant is pregnant) <p>An adult household member or authorized representative may sign for all household members. Example: A parent without a satisfactory non-citizen status may sign for his/her child with a satisfactory non-citizen status.</p>		
	NEEDED	REFERRALS	COMPLETED
		Systematic Alien Verification for Entitlements (SAVE)	

<p>A recertification for SNAP must list all persons living in the SNAP household. A recertification for PA must list all children for whom you are recertifying, their brothers and sisters, and all parents of those children who live together. If you do not check whether a listed person is a United States citizen, national of the U.S. or an non-citizen with a satisfactory immigration status, or provide an U.S. Citizenship and Immigration Services (USCIS) number (Alien Registration Number) or a non-citizen number (if applicable), that person will not be given assistance and the remaining members of the household will receive reduced benefits. If you are a Native American, check citizen/national.</p>	<p>SIGN* AND DATE THE BOX BELOW FOR EACH APPLICANT.</p> <p>In the case of a recertifying non-citizen with a satisfactory immigration status, check the program(s) for which each recertifying non-citizen has satisfactory immigration status. (See the instruction book, Pub-1313 Statewide.)</p>
---	---

LN	FIRST NAME	MI	LAST NAME	Check either "CITIZEN / NATIONAL" or "NON-CITIZEN" for each person.	USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER (If Applicable)	CERTIFICATION	DATE	PA	S N A P	MA
01				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				
02				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				
03				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				
04				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				
05				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				
06				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				
07				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				
08				<input type="checkbox"/> CITIZEN/NATIONAL <input type="checkbox"/> NON-CITIZEN	A	Sign Name X				

By checking a box above and by signing the certification form in Section 10, I hereby certify, under penalty of perjury, that I, and/or the person(s) for whom I am signing, am a United States citizen, Native American or national of the United States, or a non-citizen with satisfactory immigration status.

I understand that signing the above Certification may result in information about recertifying members of my household being submitted to the United States Citizenship and Immigration Services for verification of non-citizen status, if applicable.

The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of citizenship status, and the administration or enforcement of the provisions of the Public Assistance, Supplemental Nutrition Assistance, and Medicaid.

*A person who wishes to sign the Recertification Form but cannot write may make an "X" on the line in front of a witness. The witness must sign below.

I witnessed the marks made in lines: _____ Signature of witness: _____ Date Signed: _____

SECTION 11 – INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT

If you are recertifying for Medicaid in addition to Public Assistance or the Supplemental Nutrition Assistance Program, you may have to help us obtain medical support for yourself and your recertifying children. Answer the following questions to determine if you need to complete this section. Include yourself, as appropriate:

1. Are you recertifying for an individual under the age of 21 who was born out of wedlock and for whom paternity (legal fatherhood) has not been established? Yes No
2. Are you recertifying for an individual under the age of 21 who has an absent father or mother (noncustodial parent)? Yes No

You do not need to complete this section if you answered “No” to both of these questions. Go to the next section.

You must complete this section if you answered “Yes” to either or both of these questions. Provide the names of all individuals under the age of 21 for whom you are recertifying and any information you currently have about those individuals’ noncustodial parents or putative (alleged) fathers.

3. Are you under the age of 21? Yes No

If you answered “Yes” to this question, provide the information for your noncustodial parent(s) or putative father(s).

As a condition of obtaining assistance, you are required to assign certain rights related to support, as described in the Notices, Assignments, Authorizations, and Consents section at the end of this recertification. You will be provided with the LDSS-4882 form, “Information About Child Support Services and Application/Referral for Child Support Services,” to complete and return to the Child Support Enforcement Unit. Except in situations of domestic violence or other good cause, as a condition of obtaining assistance you are required to cooperate with the Child Support Enforcement Unit to locate any noncustodial parent or putative father; establish paternity for each individual under the age of 21 born out of wedlock; and establish, modify, and/or enforce orders of support. You also will be provided with the LDSS-4279 form, “Notice of Responsibilities and Rights for Support,” which explains your responsibilities and your rights if you do not cooperate with the Child Support Enforcement Unit.

REQUESTED	DOCUMENTATION	IN FILE
	Acknowledgement of Paternity	
	Child Support Order	
	Good Cause Form (LDSS-4279)	
	IV-D Attestation (LDSS-4281)	
	Death Certificate	
	Divorce Decree	
	VA Benefits	
	Order of Filiation/Paternity	
	Birth Certificate	
NEEDED	REFERRALS	COMPLETED
	CTHP	
	CAP	
	Application/Referral for Child Support Services (LDSS-4882)	
	Paternity	
CONSIDER		
<input checked="" type="checkbox"/>	Health Insurance of Non-custodial Parent/Absent Spouse	<input checked="" type="checkbox"/> Child Health Plus
<input checked="" type="checkbox"/>	Petition to Family Court	<input checked="" type="checkbox"/> TASA
		<input checked="" type="checkbox"/> SSI/SSA

NAME OF INDIVIDUAL UNDER AGE 21	NONCUSTODIAL PARENT OR PUTATIVE FATHER'S NAME AND ADDRESS	NONCUSTODIAL PARENT OR PUTATIVE FATHER'S DATE OF BIRTH			NONCUSTODIAL PARENT OR PUTATIVE FATHER'S SOCIAL SECURITY NUMBER
		MONTH	DAY	YEAR	
A.					
B.					
C.					
D.					
E.					

SECTION 16 – INCOME INFORMATION:										
Indicate if you or anyone who lives with you receives money from:	YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY	INCOME			
							LN No.	SOURCE CODE	AMOUNT	PERIOD
Unemployment Insurance Benefits 1										
Supplemental Security Income (SSI) Benefits (State and Federal Total) 2										
Social Security Disability (SSD) Benefits 3										
Social Security Dependent Benefits 4										
Social Security Survivor's Benefits 5										
Social Security Retirement Benefits 6										
Railroad Retirement Benefits 7										
Retirement Benefits (Pensions) 8										
Dividends/Interest from Stocks, Bonds, Savings, etc. 9										
Workers' Compensation 10										
NYS Disability Benefits 11										
Veteran's Pension/Benefits/Aid and Attendance 12										
Public Assistance Grant 13										
GI Dependency Allotments 14										
Education Grants or Loans 15										
Contributions/Gifts (Received) 16										
Foster Care Payments (Received) 17										
Child Support Payments (Received) Received From: 18										
Spousal Support (Received) 19										
Private Disability Insurance - Health/Accident Insurance Policy Income 20										
No-Fault Insurance Benefits 21										
Union Benefits (including Strike Benefits) 22										
Loans, Other than Education (Received) 23										
Income from a Trust (including income you are currently entitled to receive, or were entitled to receive in the past, that has not been distributed) 24										
Training Allotments/Stipends 25										
Rental Income (Received) 26										
Boarders/Lodgers Income (Received) 27										
Other Income (Please Specify)										

CONSIDER	
<input checked="" type="checkbox"/>	Child Support Disregard/Pass-Through
<input type="checkbox"/>	Explained
<input type="checkbox"/>	Budgeted
<input checked="" type="checkbox"/>	SNAP Aged/Disabled Indicator
<input checked="" type="checkbox"/>	Disability Review
<input checked="" type="checkbox"/>	Reception and Placement Grant (SNAP Only)
<input checked="" type="checkbox"/>	Refugee Matching Grant
<input checked="" type="checkbox"/>	Change in Income from Last Budget

Deductions: Certain types of Medicaid budgeting allow applicants/recipients to reduce their countable income with deductions that they take on their federal taxes. These are specific expenses that the Internal Revenue Service (IRS) allows people to deduct to reduce their taxable income. Only record deductions here if you will claim them on the current year's tax return.		YES	NO	WHO	AMOUNT/VALUE & FREQUENCY	WHO	AMOUNT/VALUE & FREQUENCY
Educator expenses	1						
Individual Retirement Account (IRA) deduction	2						
Student loan interest deduction	3						
Tuition and fees	4						
Certain business expenses (reservists, artists, fee-based government officials)	5						
Health savings account deduction	6						
Job-related moving expenses	7						
Deductible part of self-employment (S/E) tax	8						
S/E, SIMPLE & qualified plans	9						
S/E health insurance deduction	10						
Penalty on early withdrawal of savings	11						
Alimony paid	12						
Domestic production activities deduction	13						
Additional adjustments added on line 36 (IRS Form 1040 only)	14						
Archer MSA deduction	15						
Other Adjustment (Please Specify)							

SECTION 17 – STEP-PARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

Answer all questions listed below.

	YES	NO	WHO?
Does the step-parent of any children who live with you have any resources or receive income of any kind?			
Is anyone in your household a non-citizen with satisfactory immigration status who was sponsored for admission into the U.S.?			

NAME OF SPONSOR: _____ PHONE NO.: _____

ADDRESS: _____

NEEDED	REFERRAL	COMPLETED
	UIB	

SECTION 18 – EMPLOYMENT INFORMATION

I am currently: employed self-employed unemployed

Gross Income \$ _____ Hours Worked Monthly _____

(Include wages, salary, overtime pay, commissions, and tips)

Paid: Weekly Bi-Weekly Monthly Day of the week paid: _____

Employer's Name and Address: _____ **1**

Phone No. _____

Is anyone else who lives with you currently: employed self-employed

Who: _____

Gross Income \$ _____ Hours Worked Monthly _____

Paid: Weekly Bi-Weekly Monthly Day of the week paid: _____ **2**

Employer's Name and Address: _____

Phone No. _____

Is health insurance available through your employer? Yes No

Does anyone who lives with you have health insurance with an employer? Yes No

Who: _____ **3**

Name of Insurance Company: _____

Do you or anyone who lives with you have a child or dependent care expenses due to employment? Yes No

Who: _____ **4**

Do you or anyone who lives with you have other employment-related expenses? Yes No

Who: _____ **5**

REQUESTED	DOCUMENTATION	IN FILE
	CINTRAK/RFI/IRCS	
	1099	
	Employment Verification	
	Income Tax Return	
	Self-Employment Worksheet	
	Wage Stubs	
	Work Registration Form	
	Dependent/Child Care Form/Statement	
	Approval of Informal Child Care Provider	

NEEDED	REFERRALS	COMPLETED
	CAP	
	Disability	
	Employment	
	TPHI/COBRA	
	UIB	
	Workers' Compensation	
	Drug/Alcohol	
	Domestic Violence	
	Refugee Cash Assistance	

CONSIDER
✓ Limited English Proficiency
✓ Earned Income Tax Credit (see PUB-4786)
✓ Explaining Periodic Reporting Requirements
✓ Net Loss of Cash Income
✓ P.A.S.S. Income Amount and Sources
✓ Employment Sanctions
✓ Temporary Employment
✓ Disability Review
✓ Individual Development Account (IDA)
✓ Voluntary Quit

SECTION 19 – EDUCATION/TRAINING

What is your highest level of education completed?
 ___ Less than high school diploma
 If so, last grade completed? _____
 ___ Completion of an Individualized Education Plan (IEP)
 ___ High school diploma or General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™)
 ___ Associate's Degree (2-year college degree) **1**
 ___ Bachelor's Degree (4-year college degree) or higher

Does anyone else in the household have a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education? Yes No
 If yes, who: _____
 Degree attained: _____ **2**
 Date completed: _____

Indicate if you or anyone who lives with you who is recertifying for or getting assistance:

Is or has been in any training program **in the last 12 months?** Yes No
 Who _____
 Where _____ **3**
 Program _____
 Dates attended _____
 Dates completed _____

Is 16 years of age or older and is attending school or college? Yes No
 Who _____ **4**
 Where _____

Is getting a Training Allowance? Yes No **5**
 Who _____ Amt. \$ _____

Is getting Educational Grants or Loans? Yes No **6**
 Who _____ Amt. \$ _____

Is under 16 years of age and is attending school? Yes No **7**

Who _____	Who _____
School _____	School _____
Who _____	Who _____
School _____	School _____

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Educational Grant Worksheet	
	Child Care Statement	

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

CONSIDER	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the SNAP student eligibility requirement?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone pay for child or dependent care to attend school or training?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a 16-19 year-old parent who does not have a high school or equivalency diploma and who is not attending school?	<input type="checkbox"/>	<input type="checkbox"/>
Is anyone in training?	<input type="checkbox"/>	<input type="checkbox"/>
Are any other supportive services appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any training related expenses?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 20 – RESOURCES INFORMATION									
Indicate if you or anyone who lives with you who is recertifying:	YES	NO	WHO	IF YES, AMOUNT/VALUE	WHO	IF YES, AMOUNT/VALUE	NEEDED	REFERRAL	COMPLETED
Has cash available	1			\$		\$		Legal	
Has a checking account(s)	2							Resource	
Has a savings account(s) or certificate(s) of deposit	3								
Has a credit union account(s)	4								
Has life insurance	5								
Has title or registration to a motor vehicle(s) or other vehicle(s): Year _____ Make/Model _____ Year _____ Make/Model _____ Other _____	6						LIFE INSURANCE		
							FACE AMOUNT		CASH VALUE
Has stocks, bonds, certificates or mutual funds	7								
Has savings bonds	8								
Has an IRA, Keogh, 401(k) or deferred compensation account(s)	9								
Has an irrevocable burial trust	10						REQUESTED	DOCUMENTATION	IN FILE
Has a burial fund	11							Resource Checklist	
Has a burial space	12							Market Value	
Has his/her own home	13							DMV Clearance	
Has real estate, including income-producing and non-income-producing property	14							Bank Statement	
Is eligible for an income tax refund	15							Assignment of Proceeds	
Has an annuity	16							Car/Vehicle Title	
Is the beneficiary of a trust	17							Car/Vehicle Registration (Older Models)	
Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources	18							Bank Clearance	
Has an "in trust" account(s)	19							RFI/OCA	
Has a safe deposit box(es)	20							1099	
Has resources other than those listed above	21								
Has anyone (including your spouse, even if not recertifying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months?	22								
Has anyone (including your spouse, even if not recertifying or living with you) ever created a trust in the past or transferred any assets to a trust within the past 60 months? If yes, when? _____	23								
VEHICLE INFORMATION									
YR.	MAKE	MODEL	OWNER'S NAME	AMOUNT OWED	NADA VALUE	EXEMPT		LIEN HOLDER	ACCOUNT NO.
						YES*	NO		
				\$	\$				
				\$	\$				
*IF EXEMPT, WHY?									

CONSIDER

- ✓ Children's Resources
- ✓ Lump Sum
- ✓ Boats, Campers, Snowmobiles
- ✓ Individual Development Account (IDA)
- ✓ Exempt Vehicles
- ✓ EIC
- ✓ Change in Resources from Last Budget

SECTION 21 – MEDICAL INFORMATION				REQUESTED	DOCUMENTATION	IN FILE
Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES, WHO		Pregnancy Statement	
Has any medical bills or medically-related expenses 1					Med/Psych Statement	
Is on Medicaid with a spend-down 2					Drug/Alcohol Screening (LDSS-4571)	
Has health or hospital/accident insurance (including insurance from employer) 3				POLICY NO.:	Drug/Alcohol Statement	
Has health insurance available through an employer 4				AMOUNT:	Paid or Unpaid Medical Bills	
Has Medicare (red, white, and blue card) 5				FREQUENCY OF PAYMENT:	SSI Application Verification (PA ONLY)	
Has a health attendant/home health aide 6				INSURANCE COMPANY NAME:	CONSIDER	
Is blind, sick or disabled 7				WHO IS COVERED:	<ul style="list-style-type: none"> ✓ AD/SSI Related ✓ SNAP Aged/Disabled Indicator ✓ SNAP Medical Deduction ✓ TPHI Reimbursement ✓ Buy-In Eligibility ✓ Kreiger (LDSS-3664) ✓ Domestic Violence ✓ SSI Referral ✓ Earned Income Credit ✓ Change in Resources 	
Is a child with a developmental disability 8				EFFECTIVE DATE:		
Is in a hospital, nursing home or other medical institution 9				Is the answer to question 7 in this section consistent with Section 18 asking if the applicant or any other adult who lives in the household have any medical conditions that limit their ability to work or the type of work that they can perform?		
Has paid or unpaid medical bills within 3 months preceding the month of this recertification 10				NEEDED	REFERRALS	COMPLETED
Is or was drug or alcohol dependent 11					SSI (D-CAP)	
Needs home care/personal care 12					Disability Interview (LDSS-1151)	
Is on SSI or has ever applied for SSI 13					Medical Report (LDSS-486, 486t)	
Is pregnant If pregnant, due date: _____ Expected number of births: _____ 14					Disability Report	
Receives treatment from a drug abuse or alcohol treatment program 15					AD	
Has not been able to work for at least 12 months because of a disability or illness 16					TPHI	
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months 17					ACCES-VR	
Has been in a car accident or work-related accident in the past two years 18					CTHP	
Has had a government agency (public program) besides Medicaid or Medicare pay any of your medical bills If yes, what agency _____ 19					Family Planning	
Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of Medicaid? 20					SSA (RSDI)	
					Veteran's Benefits	
					Veteran's Counseling	
					Child Health Plus	
					COBRA Eligibility	
					Nurse's Aide Service	
					Home Care	
					NYSOH	
					MA-Only (DOH-4220)	
					SSI-Related/Chronic Care (DOH-4220 with Supplement A)	
					LDSS-4526 or local equivalent	

RETROACTIVE MEDICAID	WHO	DATE	RECURRING MEDICAL EXPENSES	WHO	AMOUNT \$		

MEDICAL BILLS: YES NO **TPHI:** YES NO

HEALTH PLAN SELECTION

Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call 1-800-505-5678.

Name of Plan You Are Enrolling In	Last Name	First Name	Date Of Birth mm/dd/yy	Sex M/F	ID# (from Medicaid Card if you have one)	Social Security # (optional if pregnant)	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID# of OB/GYN (check box if current provider)
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

SECTION 22 – SHELTER

WHAT IS YOUR LANDLORD'S NAME?

WHAT IS YOUR LANDLORD'S ADDRESS?

WHAT IS YOUR LANDLORD'S PHONE NUMBER?
 () _____

	YES	NO	IF YES, AMOUNT
Do you or anyone who lives with you have a rent, mortgage or other shelter expense?			\$
Do you or anyone who lives with you have a heat bill separate from your rent or other shelter expense?			\$

SHELTER COSTS	MONTHLY ACTUAL COST
A. Room and Board	
B. Rent	
C. Trailer Lot Rent	
D. Mortgage Payment	
1. Principal	
2. Interest	
3. Property Tax (including School Tax)	
4. Homeowner's Insurance (incl. Fire Insurance)	
5. Taxes Included in Mortgage (Escrow Payment)	
6. Assessments (Sewer, etc.)	
E. Total Mortgage Payment (Line 1-6)	
TOTAL (Lines A - E)	

REQUESTED	DOCUMENTATION	IN FILE
	Landlord Statement	
	Rent Receipt	
	Tenant of Record	
	Customer of Record	
	Voluntary Restrict	
	Mandatory Restrict	
	Subsidized Housing	
	Mortgage/Title Search	
	Section 8 Lease or Statement from Section 8 Office	
	Property Lien	
	Shelter/Utility Repayment Agreement	

- CONSIDER**
- ✓ Utility and/or Fuel Restrict
 - ✓ Utility Guarantee
 - ✓ HEAP
 - ✓ Subsidized Housing May Show Total Rent, NOT Client Amount
 - ✓ Foster Care-Related Additional Allowances
 - ✓ SNAP Household Composition Rules
 - ✓ SNAP Aged/Disabled Indicator
 - ✓ Real Property Tax Credit
 - ✓ AIDS/HIV Emergency Shelter Allowance
 - ✓ Property Lien
 - ✓ If Shelter Expenses/Living Quarters Are Shared by More than One Household

SECTION 22 – SHELTER (CONT.)			
Do you or anyone who lives with you have the following expenses separate from your rent or other shelter expense?	YES	NO	IF YES, AMOUNT
Electricity (for needs other than heat; example: lights, cooking, hot water, etc.) 1			\$
Natural Gas (for needs other than heat; example: cooking, hot water, etc.) 2			\$
Water 3			\$
Air Conditioning 4			\$
Propane (for needs other than heat) 5			\$
Sewer 6			\$
Trash 7			\$
Other Utilities and Expenses 8 Specify _____			\$
Do you live in public housing? 9			
Do you live in Section 8, HUD, or other subsidized housing? 10			
Do you live in a drug/alcohol treatment facility? 11			

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	ACCOUNT NUMBER	IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD)	WHO IS THE TENANT OF RECORD?
A. Heat*					
B. Electricity (for cooking, lights, hot water)					
C. Gas (for cooking, hot water)					
D. Liquid Propane Gas					
E. Other Utilities or Expenses					
F. Air Conditioning					
G. Utility Installation Fees					
H. Sewer					
I. Trash					
J. Water					

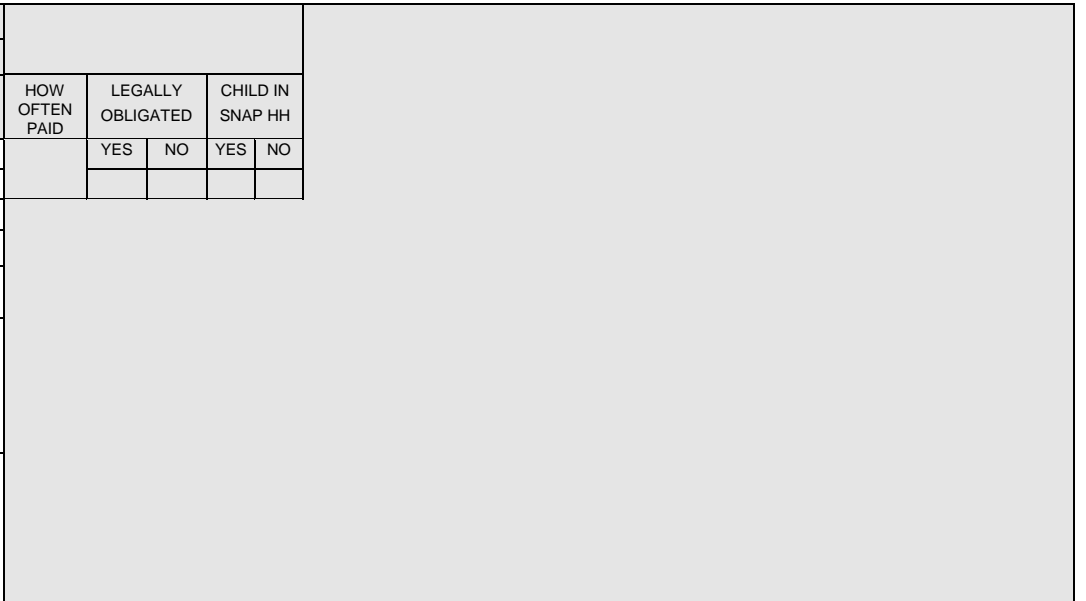
***Check Primary Heat Type:**

- Natural Gas Oil PSC Electric Coal
 Kerosene Propane Municipal Electric Wood
 Other _____

ADDITIONAL INFORMATION

SECTION 23 – OTHER EXPENSES

Indicate if you or anyone who lives with you who is recertifying:	YES	NO	IF YES, AMOUNT	HOW OFTEN PAID	LEGALLY OBLIGATED		CHILD IN SNAP HH	
					YES	NO	YES	NO
Pays child support 1			\$					
Pays spousal support 2			\$					
Pays for child care 3			\$					
Pays for dependent care 4			\$					
Pays tuition, fees, or other educational expenses 5			\$					
Has additional expenses (Example: car payment, car insurance payment, credit card payments, other loan payments, etc.) Specify: _____ 6			\$					
Do you or anyone who lives with you who is recertifying owe at least four months of support for a child under the age of 21? 7	<input type="checkbox"/> YES		<input type="checkbox"/> NO					



SECTION 24 – OTHER INFORMATION			
Do you buy or plan to buy meals from a home delivery or communal dining service? 8	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Are you able to cook or prepare meals at home? 9	<input type="checkbox"/> YES	<input type="checkbox"/> NO	VETERAN STATUS
Have you or anyone in your household ever been in the U.S. military? Who? _____ 10	<input type="checkbox"/> YES	<input type="checkbox"/> NO	VETERAN CODE
Has your spouse ever been in the U.S. military? 11	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? _____ 12	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Indicate if you or anyone who lives with you who is recertifying:	YES	NO	WHO
Have you or anyone who lives with you who is recertifying moved into this county from another New York State county within the past two months?			
Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Public Assistance and/or the Supplemental Nutrition Assistance Program (SNAP) because of fraud/an Intentional Program Violation?			
Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?			
Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive Public Assistance in two or more states?			
Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP Benefits in any state after September 22, 1996?			
Have you or any member of your household been convicted of buying or selling SNAP Benefits for a combined amount of over \$500 or more after September 22, 1996?			
Have you or any member of your household been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs?			
Are you or any member of your household fleeing to avoid prosecution, custody or confinement after conviction of a felony or attempted felony and actively being pursued by law enforcement?			
Are you or any member of your household violating probation or parole according to a court order?			
PROPERTY TRANSFER STATUS			
I have <input type="checkbox"/> I have not <input type="checkbox"/> sold, transferred or given away any of my property to anyone to get Public Assistance or SNAP Benefits.			

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ SNAP Dependent Care Deductions
	UIB		✓ District of Fiscal Responsibility (SSL 62.5)

REQUESTED	DOCUMENTATION	IN FILE
	Child/Dependent Care Statement	
	Recoupments	
	Outstanding Overpayment	
	Pending Disqualification	

IF TOTAL EXPENSES (INCLUDING EXPENSES NOT USED IN THE BUDGET DETERMINATION) EXCEED INCOME (INCLUDING PA GRANT), EXPLORE HOW THE HOUSEHOLD IS MEETING ITS OBLIGATIONS.

Actual Expenses	\$		CONSIDER
			✓ Actual Expenses, including: shelter, fuel/utility costs, telephone costs, etc.
			✓ Actual Shelter
			✓ Actual Fuel/Utility Costs
			✓ Telephone Expenses
Actual Income	\$		✓ Car Expenses
			✓ Furniture/Appliance Rental
			✓ Cable TV
= Difference	\$		✓ Tuition
			✓ Out-of-Pocket Medical Expenses

Does Client Receive Contribution Towards Difference Yes No

If Yes, From Whom? _____

Based on the information contained in this recertification, make sure you reconsider the category. For PA, especially, consider the following:

- Eligible Child Status
- Essential Persons Status
- Family Assistance Extensions

Category is _____

Documented by _____

NOTES/COMMENTS

NOTICES, ASSIGNMENTS, AUTHORIZATIONS, and CONSENTS

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS – The collection of Social Security Numbers (SSNs) is authorized for each household member with respect to the Supplemental Nutrition Assistance Program (SNAP), pursuant to the Food and Nutrition Act of 2008 (as amended). Anyone applying for SNAP must provide an SSN in order to receive benefits. If you or anyone applying does not have an SSN, that person must apply for an SSN with the Social Security Administration (visit www.SSA.gov or call 1-800-772-1213).

With respect to all other programs for which this recertification form requires an SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: Section 205(c) of the Social Security Act (42 U.S. Code 405), Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) and Section 7(a)(2) of the Privacy Act of 1974. See the instruction book (PUB-1313 Statewide) or talk to your social services district if you have questions.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. The information will be used to check identity, to verify earned and unearned income, to determine if absent parents can receive health insurance coverage for applicants or recipients, to determine if applicants or recipients can obtain child or spousal support, and to determine if applicants or recipients can receive money or other help. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. Besides using the information you give us in this way, the state will use the information to prepare statistics about all of the people receiving benefits from the Home Energy Assistance Program (HEAP) (see below).

This information may be disclosed to other state and federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. Information collected with respect to applicants for and recipients of Family Assistance and Safety Net Assistance, including SSNs, may be used to assist in the formation of jury pools. If a SNAP claim arises against your household, the information on this recertification, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

SSNs of ineligible household members will also be used and disclosed in the manner above.

Besides using the information you give us in this way, the State also uses the information to prepare statistics about all the people receiving benefits from HEAP. The information is used for quality control by the State to make sure social services districts are doing the best job they can. It is used to verify your energy supplier and to make certain payments to such vendors.

NONDISCRIMINATION NOTICE – This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

The United States Department of Agriculture (USDA) also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a Supplemental Nutrition Assistance Program (SNAP) complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) Fax: (202) 690-7442; or
- (3) Email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201, or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

CONSENT FOR INVESTIGATION – I agree to any investigation to verify or confirm the information I have given in connection with my request for Public Assistance (PA), Medicaid, Supplemental Nutrition Assistance Program (SNAP) Benefits, Home Energy Assistance Program Benefits, Services or Child Care Assistance. If additional information is requested, I will provide it. I will also cooperate fully with state and federal personnel in any PA and/or SNAP Quality Control Review.

If I am recertifying for SNAP, I understand that the social services district will request and use information available through the Income and Eligibility Verification System to investigate my recertification, and may verify this information through collateral contacts if discrepancies are found. I also understand that such information may affect my eligibility for SNAP and/or the level of SNAP Benefits I receive.

CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE INFORMATION – I authorize the New York State Department of Labor (DOL) to release any confidential information maintained by DOL for Unemployment Insurance (UI) purposes to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with state and local agency employees working in social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of, Public Assistance, Medicaid, Supplemental Nutrition Assistance Program Benefits, Home Energy Assistance Program Benefits or Child Care Assistance, applied for in this application/recertification and for investigations to determine whether I received benefits to which I was not entitled. OTDA may also share the information with the New York State Office of Children and Family Services (OCFS) and the New York State Department of Health (DOH). OCFS will use the information to monitor the Child Care Assistance program.

RELEASE OF INFORMATION TO SERVICE PROVIDERS – I give permission to the social services district and New York State to share information regarding Public Assistance or Supplemental Nutrition Assistance Program benefits that I or any member of my household for whom I can legally give authorization have received, for purposes of verifying my eligibility for services and payment related to program administration provided by a State or local contractor. Such services may include, but are not limited to, job placement or training services provided to help me or members of my household obtain and retain employment.

CHANGE REPORTING – I agree to inform the agency **promptly** of any change in my needs, residency/address, living arrangements, household size, income, employment, property/resources, dependent care costs, health insurance, non-citizen with satisfactory immigration status/citizenship status, able-bodied adult without dependents (ABAWD) status, pregnancy status or living arrangements, to the best of my knowledge or belief.

If I am applying for Child Care Assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my home, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

PENALTIES – Federal and state laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you recertify for Public Assistance, Medicaid, Supplemental Nutrition Assistance Program, Services or Child Care Assistance (“Assistance, Benefits or Services”) or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your recertification or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have recertified to obtain or continue to receive Assistance, Benefits or Services. If you are an authorized representative, such Assistance, Benefits or Services must be used for the other person and not for yourself. Federal and state laws provide that any transfer of assets for less than fair market value made by an individual or an individual’s spouse, within 60 months prior to the first of the month in which the individual is both in receipt of nursing facility services and has submitted an application for Medicaid, may render the individual ineligible for nursing facility services or home and community-based waived services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM DISQUALIFICATION PENALTIES – Any information you provide in connection with your application for the Supplemental Nutrition Assistance Program (SNAP) will be subject to verification by federal, state and local officials. If any information is incorrect, you may be denied SNAP Benefits. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to \$250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable federal and state laws. Anyone who is violating a condition of probation or parole, or anyone who is fleeing to avoid prosecution, custody or confinement of a felony and is actively being pursued by law enforcement, is not eligible to receive SNAP Benefits.

You may be found ineligible for SNAP or found to have committed an Intentional Program Violation (IPV) if you make a false or misleading statement, or misrepresent, conceal or withhold facts, in order to qualify for benefits or receive more benefits; purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or commit or attempt to commit any act that constitutes a violation of federal or state law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking SNAP Benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system. Additionally, the following is not allowed and you may be disqualified from receiving SNAP Benefits and/or be subject to penalties for actions that include:

- Using SNAP benefits to buy non-food items, such as alcohol or cigarettes;
- Using SNAP benefits to pay for food previously purchased on credit;
- Allowing someone else to use your EBT card in exchange for cash, firearms, ammunition or explosives, or drugs, or to purchase food for individuals who are not members of your SNAP household; or
- Using or having in your possession EBT cards that do not belong to you, without the card owner’s consent.

Individuals found to have committed an IPV either through an administrative disqualification hearing or by a federal, State or local court, or have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution shall be ineligible to participate in SNAP for a period of:

- 12 months for the first SNAP IPV;
 - 24 months for the second SNAP IPV;
 - 24 months for the first SNAP IPV that is based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor’s prescription is required); or
 - 120 months if the individual is found to have made a fraudulent statement about who he/she is or where he/she lives in order to get multiple SNAP Benefits simultaneously, unless permanently disqualified for a third SNAP IPV.
- Additionally, a court may bar an individual from participating in SNAP for an additional 18 months.

An individual can be permanently disqualified from receiving SNAP Benefits for:

- The first SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of firearms, ammunition or explosives;
- The first SNAP IPV based on a court conviction for trafficking SNAP Benefits for a combined amount of \$500 or more (trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices);
- The second SNAP IPV based on a court finding that the individual used or received SNAP Benefits in a transaction involving the sale of a controlled substance (illegal drugs or certain drugs for which a doctor's prescription is required); or
- A third SNAP IPV.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – Your household must report child care and utility expenses in order to get a Supplemental Nutrition Assistance Program (SNAP) deduction for these expenses. Your household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a SNAP deduction for these expenses. Failure to report/verify the above expenses will be seen as a statement by your household that you do not want to receive a deduction for these unreported/unverified expenses. A deduction for these expenses may make you eligible for SNAP or may increase your SNAP benefits. You may report/verify these expenses at any time in the future. The deduction would then be applied to the calculation of SNAP benefits in future months, in accordance with the rules for change reporting (see Change Reporting, above).

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to recertify for Supplemental Nutrition Assistance Program (SNAP) Benefits for you. You can also authorize someone outside your household to get SNAP Benefits for you or to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may authorize someone by printing the person's name, address, and phone number immediately below, and having them sign in the signature section at the end of this recertification. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, both the Authorized Representative and a responsible adult member of the household must sign and date the signature section at the end of this recertification, unless the SNAP household has otherwise designated the Authorized Representative to do so in writing.

NAME, ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE (PLEASE PRINT):

STANDARD UTILITY ALLOWANCE – I understand that Public Assistance and Supplemental Nutrition Assistance Program (SNAP) recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). I also understand that if I have not received a HEAP benefit of greater than \$20 in the current month or previous 12 months, or a similar energy assistance benefit, I must pay for heating or air conditioning separately from my rent in order to receive the heating/cooling standard utility allowance (i.e., a deduction) for SNAP. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

RELEASE OF MEDICAL INFORMATION – I consent to the release of any medical information about me and any members of my family for whom I can give consent by my primary care provider, any other health care provider or the New York State Department of Health (DOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to DOH and other authorized federal, state, and local agencies for purposes of administration of Medicaid; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I authorize the release of any health-related information about me and any members of my family for whom I can legally give authorization related to the provision of assistance and services and my ability to participate in work activities, including employment, to the New York State Office of Temporary and Disability Assistance (OTDA), the New York State Office of Children and Family Services or the local social services district, as reasonably necessary for the provision of Public Assistance benefits; for services, including child welfare services; for determining appropriate work activity assignments; for determining the need to apply and for making application for Supplemental Security Income Benefits; for establishing appropriate treatment plans for restoring employability; and for determining eligibility for exemptions from the State sixty-month time limit on cash assistance receipt. If I am required to apply for benefits administered by the Social Security Administration, the

information specified above may be shared with the Social Security Administration. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law, unless a box is checked below. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information. I understand that my ability to consent to the release of information relating to any minor children for whom I may give consent is limited by the extent to which I can obtain information regarding treatment, diagnosis and procedures on their behalf.

Do not disclose HIV/AIDS information Do not disclose drug and alcohol information
 Do not disclose mental health information

RELEASE OF EDUCATIONAL RECORDS – I give permission to the New York State Department of Health and the social services district to:1) obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming Medicaid reimbursement for health-related educational services; and 2) provide the appropriate federal government agency access to this information for the sole purpose of audit.

RELEASE OF INFORMATION FOR THE EARLY INTERVENTION PROGRAM – If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the social services district and New York State to share my child's Medicaid eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medicaid.

CHILD/TEEN HEALTH PROGRAM – I understand that if my child is on Medicaid, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the social services district.

MEDICARE – I authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

MEDICAID – You have a right as part of your Medicaid **application**, or within two years from the date of your **application**, to request reimbursement of expenses you paid for covered medical care, services and supplies received during the three-month period prior to the month of your **application**. After the date of your application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

ASSIGNMENT OF INSURANCE/OTHER BENEFITS AND DIRECT PAYMENT – For Public Assistance and Medicaid, I agree to file any claims for health or accident insurance benefits, and to pursue any personal injury claims or any other resources to which I may be entitled, and do hereby assign any such resources to the social services district to whom this recertification is made. In addition, I will assist in making any assigned benefits available to the social services district to whom this recertification is made.

I authorize payments owed to me or members of my household for health or accident insurance benefits to be made directly to the appropriate social services district for medical and other health services furnished while we are eligible for Medicaid.

MEDICAID RECOVERIES – Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. MA paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. MA may also recover the cost of services and premiums incorrectly paid.

I understand that effective April 1, 2014, if I get Medicaid through New York State of Health:

- No lien will be placed on my real property prior to my death.
- Recovery from assets in my estate upon my death is limited to the amount Medicaid paid for the cost of nursing home care, home and community-based services, and related hospital and prescription drug services received on or after my 55th birthday.

PUBLIC ASSISTANCE RECOVERIES – Public Assistance (PA) you receive for yourself and for persons for whom you are legally responsible to support is recoverable from property or money you possess or may acquire. You may be required, as a condition of receiving PA, to execute a deed or mortgage of real property you own. Your tax refunds and portions of lottery winnings may be taken to repay your debt for PA.

AUTHORIZATION TO REPAY PUBLIC ASSISTANCE BENEFITS FROM RETROACTIVE SUPPLEMENTAL SECURITY INCOME – I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of Supplemental Security Income (SSI); i.e. my retroactive SSI payment) to reimburse the local social services district (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for SSI. SSA will not reimburse the SSD for PA that was paid using any federal funds.

I will be bound by this authorization only if the State gives notice to SSA that I and an SSD representative have signed it. The State must give notice within 30 calendar days of matching my SSI record with my State record. SSA will not accept it after 30 calendar days. Instead, SSA will send me my retroactive SSI payment under SSA rules.

Only my first payment of SSI can be used. If my first payment is larger than the amount owed to the SSD, SSA will send the rest to me under its rules.

SSA can reimburse the SSD in two situations:

- (1) It will repay the SSD if I apply for SSI and SSA finds me eligible.
- (2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

SSA will only reimburse the SSD for PA it paid me during the time I am waiting for an SSA determination of eligibility. This is called “interim assistance.” The period begins: 1) with the first month I become eligible for payment of SSI benefits; or 2) on the first day I am reinstated after my SSI was suspended or terminated. The period includes the month SSI payments actually begin. If the SSD cannot stop my last PA payment, the period ends the next month.

No later than 10 days after SSA reimburses the SSD, the SSD must send me a notice telling me the amount of interim assistance paid. The notice will also tell me that SSA will send me a letter telling me how any remaining SSI money owed to me will be sent by SSA and that, if I do not agree with a state decision, how I can appeal the decision to the state.

Under its rules, SSA may use the date I sign this authorization as the date I first become eligible for SSI. It will do this only if I apply for SSI within the next 60 days.

This authorization applies to any SSI application or appeal I now have pending before SSA. This authorization terminates if my SSI case is completely decided. It terminates when SSA first pays me. The State and I can also agree to terminate the authorization. I must sign a new authorization consistent with NYS rules if I reapply for SSI after this authorization terminates, or if I file a new SSI claim while I have an SSI application or appeal pending.

I will be given an opportunity for a fair hearing if I disagree with a decision the SSD made about reimbursement.

I received a copy of the pamphlet called “What You should Know About Social Services Programs.” I understand what it says about interim assistance.

SUPPORT – Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or Title IV-E foster care operates as an assignment to the State and the social services district of any rights to support from any other person that the applicant or recipient may have in his or her own right or on behalf of any other family member for whom the applicant or recipient is applying for, or receiving, assistance (Social Services Law, Sections 158 and 348). This assignment is limited in certain situations. Other sections of this recertification contain additional assignments.

ASSIGNMENT OF SUPPORT RIGHTS – I assign to the state and social services district any rights I have to support from persons having legal responsibility for my support and any rights I have to support on behalf of any family member for whom I am applying for or receiving assistance. Where applying for or receiving Family Assistance or Safety Net Assistance, my assignment of support rights is limited to support which accrues during the period that I and/or any family member receives assistance. However, any support rights that I assigned to the state on behalf of myself or any family member prior to October 1, 2009, continue to be assigned to the state.

HOME ENERGY ASSISTANCE PROGRAM – I understand that by signing this application/certification, I consent to any investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this recertification to be used in referrals to available weatherization assistance programs and my utility company’s low income programs.

I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the New York State Office of Temporary and Disability Assistance, the local social services district and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program performance measurement.

SEXUAL ASSAULT INFORMATION – If you are a victim of sexual assault, you have the right to request referral information from the social services district. If you request referral information, the social services district must provide you with the addresses and phone numbers of any: 1) local hospitals offering sexual assault forensic examiner services certified by the NYS Department of Health; 2) local rape crisis centers; and 3) local advocacy, counseling, and hotline services appropriate for victims of sexual assault. In addition, the social services district must provide you with the NYS Hotline for Sexual Assault and Domestic Violence numbers: (800) 942-6906 and (800) 818-0656 (TTY).

CERTIFICATION FOR CHILD CARE ASSISTANCE – If I am applying for Child Care Assistance, I certify that my family’s income does not exceed 85 percent of the State median income for a family of the same size, and my family resources do not exceed \$1,000,000.

I have read and understand the notices above. I understand and agree to the assignments, authorizations and consents above. I swear and/or affirm under the penalties of perjury that the information I have given or will give to the social services district is complete and correct.			
APPLICANT SIGNATURE x	DATE SIGNED	SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE x	DATE SIGNED
AUTHORIZED REPRESENTATIVE SIGNATURE x	DATE SIGNED		

I REQUEST THAT MY CASE BE CLOSED FOR:

- Public Assistance** **Supplemental Nutrition Assistance Benefits** **Medical Assistance**

I understand that I may reapply at any time.

Give Reason: _____

Signature x _____

Date _____



NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

- YES** If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below
- NO** because I choose not to register **OR**
- I am already registered at my current address **OR**
- I asked for and received a mail registration form

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Signature _____

Date _____ / ____ / ____

Please Print Name _____

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料: 若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদি আপনি এই ফর্মটি ইংরেজীতে পেতে চান তাহলে 1-800-367-8683 নম্বরে ফোন করুন

Rev. 2/2015

VOTER REGISTRATION APPLICATION (instructions on back)

Yes, I need an application for an Absentee Ballot

Please print or type in blue or black ink

Yes, I would like to be an Election Day worker

1	Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If you answered NO, do not complete this form</small>	2	Will you be 18 years old on or before election day? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If you answered NO, do not complete this form unless you will be 18 by the end of the year</small>	For Board Use Only	
3	Last Name _____		First Name _____		Middle Initial _____ Suffix _____
4	Address where you live (do not give P.O. box) _____		Apt. No. _____	City/Town/Village _____	Zip Code _____ County _____
5	Address where you get your mail (if different than above) _____		P.O. Box, Star Route, etc. _____	Post Office _____	Zip Code _____
6	Date of Birth _____	7	Sex <input type="checkbox"/> M <input type="checkbox"/> F	8	Telephone (optional) _____ Email (optional) _____
10	The last year you voted _____	Your address was (give house number, street and city) _____		9	ID Number (Check the applicable box and provide your number) <input type="checkbox"/> New York State DMV number — — — — — <input type="checkbox"/> Last four digits of your Social Security number — — — — <input type="checkbox"/> I do not have a New York State DMV or Social Security number
	In county/state _____	Under the name (if different from your name now) _____			
11	Political Party I wish to enroll in a political party <input type="checkbox"/> Democratic party <input type="checkbox"/> Independence party <input type="checkbox"/> Republican party <input type="checkbox"/> Women's Equality party <input type="checkbox"/> Conservative party <input type="checkbox"/> Reform party <input type="checkbox"/> Green party <input type="checkbox"/> Other _____ <input type="checkbox"/> Working Families party I do not wish to enroll in a political party <input type="checkbox"/> No party			12	Affidavit: I swear or affirm that <ul style="list-style-type: none"> I am a citizen of the United States. I will have lived in the county, city or village for at least 30 days before the election. I will meet all requirements to register to vote in New York State. This is my signature or mark on the line below. The above information is true, I understand that if it is not true, I can be convicted and fined up to \$5,000 and/or jailed for up to four years.
	Signature or Mark in ink _____				Date _____ / ____ / ____

(Optional) Register to donate your organs and tissues

Last Name _____		
First Name _____	Middle Initial _____	Suffix _____
Address _____		
Apt Number _____	City/Town/Village _____	Zip Code _____
Birth Date _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Eye Color _____	Height _____	Ft. _____ In. _____

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.



Signature _____

Date _____ / ____ / ____

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections

40 North Pearl St, Suite 5

Albany, NY 12207-2729

Telephone: 1-800-469-6872;

TDD/TTY users contact the New York State Relay at 711;

or visit our web site - www.elections.ny.gov

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state party rules allow otherwise.



INSTRUCTIONS FOR COMPLETING THE NEW YORK STATE RECERTIFICATION FORM FOR:

- **PUBLIC ASSISTANCE**
- **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM**
- **MEDICAID AND SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM**
- **MEDICAID AND PUBLIC ASSISTANCE**

If you are blind or seriously visually impaired and need an application/recertification form or these instructions in an alternative format, you may request them from your social services district (SSD). The following alternative formats are available:

- Large print;
- Data format (a screen reader-accessible electronic file);
- Audio format (an audio transcription of the instructions or application/recertification questions); and
- Braille, if you assert that none of the alternative formats above will be equally effective for you.

Applications/recertification forms and instructions are also available for download in large print, data format and audio format from www.otda.ny.gov or www.health.ny.gov. Please note that applications/recertification forms are available in audio format and Braille solely for informational purposes. In order to recertify, you must submit a recertification form in written, non-alternative format.

If you have any disabilities that prevent you from completing this recertification form and/or from waiting to be interviewed, please notify your SSD. The SSD will make every effort to provide a reasonable accommodation to address your needs.

If you require another accommodation or need other help completing this recertification form, please contact your SSD. We are committed to assisting and supporting you in a professional and respectful manner.

TIPS FOR COMPLETING THE RECERTIFICATION FORM

Whenever you see “Public Assistance” or “PA” on the recertification form, it means “Family Assistance” and/or “Safety Net Assistance.” We call both programs “Public Assistance.” PA and the other programs for which you can recertify using this recertification form were created to give temporary help to those in need. Certain programs limit how long you can get help, so it is important for you to achieve self-sufficiency as soon as you can. The social services district (SSD) is there to help you with achieving self-sufficiency. In order to do so, we must know who you are and what you need. This is why you must fill out a recertification form.

As a part of the recertification process, the SSD will ask you to provide and verify information about yourself and other individuals for whom you are recertifying. A listing of documentation requirements, which can be found at the end of these instructions, shows the kinds of information you may need to provide and the kinds of documents that can verify this information. For instance, in order to prove who you are, you can supply photograph identification, a driver’s license, a United States passport, a naturalization certificate, hospital or doctor’s records, or adoption papers. In addition, the SSD may interview you as part of the recertification process. The SSD may combine interviews for multiple programs where possible.

The recertification form and these instructions are numbered by section to help you. Please keep the following in mind when filling out the recertification form:

- **PLEASE PRINT CLEARLY.**
- **DO NOT WRITE IN THE SHADED AREAS.**
- **BE SURE TO COMPLETE EACH SECTION RELEVANT TO THE PERSON(S) FOR WHOM YOU ARE RECERTIFYING.**
- **ALWAYS USE LEGAL NAMES, UNLESS OTHERWISE INSTRUCTED.**
- **IF YOU ARE RECERTIFYING AS SOMEONE'S REPRESENTATIVE, PLEASE PROVIDE INFORMATION ABOUT THAT PERSON, NOT YOURSELF. MAKE SURE THAT BOTH YOU AND THE PERSON YOU ARE REPRESENTING SIGN THE LAST PAGE OF THE RECERTIFICATION FORM.**
- **IF YOU ARE UNSURE ABOUT HOW TO COMPLETE ANY PART OF THIS RECERTIFICATION FORM, ASK YOUR SSD FOR HELP.**

In addition to the LDSS-3174: "New York State Recertification Form for Certain Benefits and Services," make sure you have copies of the following informational booklets, available from the SSD or www.otda.ny.gov:

- **LDSS-4148A: "Book 1: What You Should Know About Your Rights and Responsibilities"**
- **LDSS-4148B: "Book 2: What You Should Know About Social Services Programs"**
- **Supplement to Book 1, LDSS-4148A and Book 2, LDSS-4148B: "Important Changes in the Medicaid Program"**
- **LDSS-4148C: "Book 3: What You Should Know if You Have an Emergency"**

PAGE 1 OF THE RECERTIFICATION FORM

If you are blind or seriously visually impaired, you may choose to receive notices regarding the programs for which you are recertifying for in an alternative format.. Alternative formats are available in large print, data CD, audio CD, or Braille, if you assert that none of the other alternative formats will be equally effective for you.

IF YOU ARE BLIND OR SERIOUSLY VISUALLY IMPAIRED, WOULD YOU LIKE TO RECEIVE WRITTEN NOTICES IN AN ALTERNATIVE FORMAT? If you are blind or seriously visually impaired, check (✓) "Yes" or "No" to indicate whether you would like to receive written notices regarding the program(s) for which you recertify in an alternative format.

IF YES, CHECK THE TYPE OF FORMAT YOU WOULD LIKE: If you are blind or seriously visually impaired and would like to receive notices regarding the program(s) for which you recertify in an alternative format, check (✓) the type of format you prefer: large print, data CD, audio CD, or Braille. Braille is available as an alternative format if you assert that none of the other alternative formats will be as effective for you as Braille.

If you require another accommodation or need other help completing this recertification form, please contact your SSD.

PAGE 2 OF THE RECERTIFICATION FORM

SECTION 1: CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER ARE RECERTIFYING FOR

Check (✓) the box for each program that you or any household member wants to recertify for.

Medicaid includes the Medicaid, Medicaid Buy-In for Working People with Disabilities, and Family Planning Benefit programs. When you see "MA" on the recertification form, it means "Medicaid," which was previously called "Medical Assistance." You may recertify for MA using this recertification form only if you are also recertifying for Public Assistance (PA) or the Supplemental Nutrition Assistance Program (SNAP) at the same time. If you want to recertify for Medicaid and SNAP, check (✓) the "Medicaid (MA) and SNAP" box. If you want to recertify for Medicaid and PA, check (✓) the "Medicaid (MA) and PA" box.

If you wish to only recertify for MA, you can go online at <https://nystateofhealth.ny.gov/> or call 1-855-355-5777 for more information or to recertify. You may also use the MA-only paper application - Form DOH-4220, which your worker can give you or call the MA help line at 1-800-541-2831. If you want to recertify only for the Medicare Savings Program (MSP), you must apply with Form DOH-4328, which your worker can provide to you. If you have an immediate need for personal care services, you should apply for MA separately using the DOH-4220 MA application form.

SECTION 2

WHAT IS YOUR PRIMARY LANGUAGE?: Check (✓) the "English," "Spanish," or "Other" box to indicate the language you use most often. If you check (✓) the "Other" box, print your preferred language.

DO YOU WANT TO RECEIVE NOTICES IN: You will receive notices regarding the programs for which you recertify. Check (✓) the "English Only" or "English and Spanish" box to indicate the language(s) in which you would like to receive these notices.

SECTION 3: APPLICANT INFORMATION

NAME: Print your name, including your first name, middle initial (M.I.), and last name.

MARITAL STATUS: Print whether you are now single, married, widowed, legally separated or divorced. If you have ever been married print the appropriate status, do not print "single."

PHONE NUMBER: Print the phone number at which you can be reached most easily. Include your area code.

RESIDENTIAL ADDRESS: Street Address: Print the house or building number, street, avenue, road, etc., where you live.

Apt. No.: Print the number of your apartment, if applicable.

City: Print the name of the city you live in.

County: Print the name of the county you live in.

State: Print the name of the state you live in.

Zip Code: Print the zip code for your address.

IN CARE OF NAME: If someone else receives your mail for you, print that person's name.

MAILING ADDRESS: If you get your mail somewhere other than where you live, print the street address (and apartment number, if applicable) or post office box, city, county, state, and zip code of this location.

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?: Print the number of years and/or months that you have lived at your current address.

IS THIS A SHELTER?: Check (✓) "YES" or "NO" to indicate whether the place you are living is a shelter.

ANOTHER PHONE WHERE YOU CAN BE REACHED: Print another phone number where you can be reached and, if applicable, the name of the person to whom the number belongs. Include the area code.

DIRECTIONS TO CURRENT ADDRESS: Print directions on how to find your home. Use commonly known landmarks.

FORMER ADDRESS: Print the address where you lived before you moved to your present address.

IF YOU ARE CURRENTLY WITHOUT A HOME, CHECK HERE: If you do not have anywhere to live/do not have an address, check (✓) this box.

AGENCY HELPING APPLICANT/CONTACT PERSON: If someone is helping you to recertify, print the name of that person, their agency, if any, and the person's phone number.

DO YOU NEED THE MEDICAID PORTION OF THIS RECERTIFICATION FORM AND THE POTENTIAL RECEIPT OF ANY MEDICAID COVERAGE TO BE KEPT CONFIDENTIAL?: Check (✓) "YES" or "NO" to indicate on the recertification form and/or tell your worker whether you need your recertification and/or correspondence related to the receipt of any Medicaid coverage to be kept confidential.

LIST THE THINGS THAT HAVE CHANGED SINCE YOUR APPLICATION OR LAST RECERTIFICATION: List any changes that have occurred since your last application or recertification, such as a change in address, new baby, change in income, loss of a job, etc.

SECTION 4: IF YOU ARE REAPPLYING FOR SNAP

Read the statement in Section 4 of the recertification, and sign and date underneath the statement if it applies to you or anyone for whom you are recertifying. Please contact the SSD if you have questions about this section.

SECTION 5: DO ANY OF THESE APPLY TO YOU?

Check (✓) each situation that applies to you or someone for whom you are recertifying.

PAGE 3 OF THE RECERTIFICATION FORM**SECTION 6: HOUSEHOLD INFORMATION**

NAME: Print the first name, middle initial (M.I.), and last name of everyone who lives with you, even if they are not recertifying. List yourself first.

THIS PERSON IS RECERTIFYING FOR: Check (✓) the type(s) of assistance each person is recertifying for: PA for Public Assistance, SNAP for the Supplemental Nutrition Assistance Program, MA for Medicaid.

DATE OF BIRTH: Print the date of birth of each person who is recertifying.

SEX: Print "M" for male or "F" for female for each person who is recertifying.

RELATIONSHIP TO YOU: For each person, print their relationship to you (for example: spouse, son, foster child, friend, roommate, boarder, etc.).

SOCIAL SECURITY NUMBER OF RECERTIFYING HOUSEHOLD MEMBERS: Print the Social Security number of each person who is recertifying unless that person is:

- A pregnant woman who is recertifying only for Medicaid;

HIGHEST SCHOOL GRADE COMPLETED: Enter the highest school grade (1 through 12) completed for each person who is recertifying. If more than 12 years, enter 13.

DOES THIS PERSON (INCLUDING MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU?: It is important to check (✓) "YES" or "NO" to this question for every person who lives with you, whether or not they are recertifying. Sometimes, people who buy food and prepare meals separately may get more SNAP benefits.

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAVE BEEN KNOWN: Print any maiden names, names from a previous marriage, or other names used by anyone listed in this section. Include first name, middle initial (M.I.), and last name.

SECTION 7: CHANGE IN HOUSEHOLD MEMBERS

Complete this section if anyone has moved into or out of your household during the past year.

PAGE 4 OF THE RECERTIFICATION FORM**SECTION 8: RACE/ETHNICITY**

Complete this section for each person recertifying. Enter "Y" for "YES" or "N" for "NO" in the column labeled "H" to indicate whether the person is Hispanic and/or Latino. Enter "Y" for "YES" or "N" for "NO" in each of the race columns to indicate each person's racial background:

- H = Hispanic or Latino

- I = Native American or Alaskan Native
- A = Asian
- B = Black or African American
- P = Native Hawaiian or Pacific Islander
- W = White
- U = Unknown

Providing this information is voluntary. It will not affect the eligibility of the persons recertifying or the level of benefits received. The reason for requesting this information is to ensure that program benefits are distributed without regard to race, color, or national origin.

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SECTION 9: CITIZENSHIP/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS

If you or anyone in your household is recertifying for the Supplemental Nutrition Assistance Program (SNAP), you must list everyone in the household, even if they are not recertifying for SNAP. You must also list any siblings and parents who live with any children recertifying for Public Assistance (PA). If you do not complete this section for a person who is recertifying, that person may not receive assistance.

NAME: Print the first name, middle initial (MI), and last name of each person who is recertifying or who must be listed.

CHECK EITHER “CITIZEN/NATIONAL” OR “NON-CITIZEN” FOR EACH PERSON: Next to each person’s name, check (✓) either the “CITIZEN/NATIONAL” box to indicate that the person is a U.S. citizen, Native American, or national, or “NON-CITIZEN” box to indicate that the person is not a U.S. citizen, Native American, or national.

USCIS NUMBER (ALIEN REGISTRATION NUMBER) OR NON-CITIZEN NUMBER: Enter the person’s U.S. Citizenship and Immigration Services (USCIS) number or non-citizen number, if applicable.

SECTION 10: CERTIFICATION

Read carefully the statements at the bottom of this section, then sign and date the certification attesting to the citizenship or non-citizen with satisfactory immigration status of each person who is recertifying for any of the following programs. If anyone recertifying is not a U.S. citizen, Native American, or national, check (✓) the programs for which that person is recertifying and has non-citizen with satisfactory immigration status:

- Public Assistance (PA);
- Supplemental Nutrition Assistance Program (SNAP); or
- Medicaid (MA), unless the person recertifying is pregnant.

“Satisfactory non-citizen status” means a non-citizen status that does not make the person ineligible for benefits from a given program. Please note that different programs have different non-citizen status requirements. LDSS-4148B, “Book 2: What You Should Know About Social Services Programs,” contains more information about satisfactory non-citizen statuses. You may also contact your SSD for more information.

Any adult household member or authorized representative may sign the certification for all recertifying household members. For example, a parent without citizenship or satisfactory non-citizen status may sign the certification for a child with citizenship or satisfactory non-citizen status. If a recertifying household member is under age 18 (or is age 18 or older but unable to sign his/her own name due to a medical impairment or disability), a household member who is age 18 or older must sign for him/her.

When signing for another household member, sign your own name. For example, Mary Doe, when signing for infant Johnny Doe, should sign "Mary Doe."

Checking a box and signing the certification means that you certify, under penalty of perjury, that you and/or the persons for whom you are signing, are a U.S. citizen, Native American, national, or non-citizen with satisfactory immigration status, for each program for which you/they are recertifying. If you do not check one of the boxes or provide a U.S. Citizenship and Immigration Services (USCIS) number for a non-citizen who is recertifying, that person may not receive assistance.

You should not sign the certification for yourself or any other person who is not a U.S. citizen, Native American, or national, or who does not have non-citizen with satisfactory immigration status. Non-citizens without satisfactory immigration status are not eligible for PA, SNAP benefits, or Medicaid (except Medicaid for a pregnant person or treatment of an emergency medical condition). Such persons also may be ineligible for certain Services (such as child or adult preventive/protective services).

We may confirm the non-citizen status of any or all household members recertifying for PA, SNAP benefits, or Medicaid by submitting the information you give us to the USCIS. Information received from USCIS may affect your household's eligibility and level of benefits.

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SECTION 11: INFORMATION REGARDING REFERRAL TO THE CHILD SUPPORT ENFORCEMENT UNIT

You do not need to fill out this section if you are recertifying only for Medicaid and you are pregnant, gave birth within the past sixty days, or are recertifying for children under 21 only.

1. Check (✓) "Yes" or "No" to indicate whether you are recertifying for any person, including yourself, who is under the age of 21, who was born to unmarried parents, and for whom paternity (i.e., legal fatherhood) has not been established.
2. Check (✓) "Yes" or "No" to indicate whether you are recertifying for any person, including yourself, who is under the age of 21 and at least one of this person's parents lives outside of the home.

If you checked (✓) "No" for both of these questions, skip to Section 12. You do not have to complete the rest of Section 11. If you checked (✓) "Yes" for either or both of these questions, you must complete the rest of Section 11.

3. Check (✓) "Yes" or "No" to indicate whether you are under the age of 21.

Read carefully the statement that follows Question 3 and contact your SSD if you do not understand it.

NAME OF INDIVIDUAL UNDER AGE 21: Print the first, middle, and last name of each person for whom you checked "Yes" for Question 1, 2, and/or 3.

NONCUSTODIAL PARENT OR PUTATIVE FATHER'S NAME AND ADDRESS, DATE OF BIRTH, and SOCIAL SECURITY NUMBER: If known, print the first, middle, and last name; address; date of birth; and Social Security number of the noncustodial parent or the putative father of each person for whom you checked "Yes" for Questions 1, 2, and/or 3. The "putative father" is the man who may be the child's father, but who was not married to the child's mother before the child was born and has not established that he is the father in a court proceeding or by an acknowledgment of paternity.

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SECTION 12: TAX FILING/DEPENDENT STATUS

Print the following information for each individual living in the household:

FIRST NAME, MIDDLE INITIAL, and LAST NAME: Print the first name, middle initial, and last name of each individual who lives in the household.

TAX STATUS: Check (✓) the appropriate tax filing status for each individual who lives in the household.

Please list any tax dependents who do not live with you and are claimed by you or anyone in your household. If you do not file taxes, you can skip these questions.

NAME OF TAX DEPENDENT: Print the first name, middle initial, and last name of any individual who does not live with you, but who you or anyone who lives with you claims as a tax dependent.

NAME OF TAX FILER: For each tax dependent listed, print the first name, middle initial, and last name of the individual living in the household who claims the tax dependent.

SECTION 13: ABSENT/DECEASED SPOUSE INFORMATION

NAME OF PERSON RECERTIFYING: Print the name of any person recertifying who is/was married, but whose spouse does not live with them or is deceased.

NAME OF SPOUSE: Print the name of the spouse of any married/formerly married person recertifying whose spouse does not live with them or is deceased.

DATE OF SPOUSE'S BIRTH and DATE OF SPOUSE'S DEATH, IF APPLICABLE: Print the month, day, and year of birth, and death (if applicable), of the spouse of any married/formerly married person recertifying whose spouse does not live with them or is deceased.

SPOUSE'S SOCIAL SECURITY NUMBER: Print the Social Security number of the spouse of any married/formerly married person recertifying whose spouse does not live with them or is deceased.

SPOUSE'S ADDRESS, IF APPLICABLE: Print the street address, city, county, state, and zip code of the spouse of any married person recertifying whose spouse does not live with them. If unknown, print the spouse's last known address.

SECTION 14: ABSENT CHILD INFORMATION

NAME OF PERSON RECERTIFYING: Print the name of any person recertifying who has a child under the age of 21 who does not live with them.

NAME OF ABSENT CHILD and DATE OF BIRTH: Print the name, and month, day, and year of birth, of any child under the age of 21 who does not live with a person recertifying.

ADDRESS OF CHILD: Print the street address, city, county, state, and zip code of any living child under the age of 21 who does not live with a person recertifying.

PATERNITY ESTABLISHED?: Check (✓) "Yes" or "No" to indicate whether paternity (i.e., legal fatherhood) has been established for any child under the age of 21 who does not live with a person recertifying.

DO YOU PAY CHILD SUPPORT?: Check (✓) "Yes" or "No" to indicate whether any person recertifying pays child support for a child under the age of 21 who does not live with them.

SECTION 15: TEEN PARENT INFORMATION

Only complete this section if you are recertifying for Public Assistance.

IS THERE A PARENT UNDER THE AGE OF 18 (“TEEN PARENT”) IN THE HOUSEHOLD?: Check (✓) “Yes” or “No” to indicate whether any person recertifying is a parent under the age of 18.

NAME: Print the name of any person recertifying who is a parent under the age of 18.

DOES THE TEEN PARENT’S CHILD LIVE IN THE HOUSEHOLD?: Check (✓) “Yes” or “No” to indicate whether the child of any person under the age of 18 who is recertifying lives with you.

NAME OF TEEN PARENT’S CHILD: Print the name of the child of any person under the age of 18 who is recertifying.

PAGES 8 AND 9 OF THE RECERTIFICATION FORM**SECTION 16: INCOME INFORMATION**

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU RECEIVES MONEY FROM and WHO: Check (✓) “YES” or “NO” for lines 1 through 27 to indicate whether you or anyone who lives with you receives money from any of the kinds of income listed, and for each “YES” answer, print the name(s) of the person(s) who receive(s) the money.

AMOUNT/VALUE & FREQUENCY: For each “YES” answer, print the dollar (\$) amount or value and how often this kind of income is received by each person who receives it. For instance, if you receive \$100 in unemployment insurance benefits every week, print “\$100 per week” or “\$100/wk.”

SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS (STATE AND FEDERAL TOTAL): If you or anyone who lives with you gets New York State Supplement Program (SSP) benefits in addition to Supplemental Security Income (SSI) benefits, add these amounts together and enter them in the AMOUNT/VALUE & FREQUENCY column for SSI Benefits on line 2. If you or anyone who lives with you gets SSP benefits only, enter this amount in the AMOUNT/VALUE & FREQUENCY column for SSI Benefits on line 2.

FOSTER CARE PAYMENTS (RECEIVED): If you or anyone who lives with you gets foster care payments, enter this amount into the AMOUNT/VALUE & FREQUENCY column for Foster Care Payments on line 17. If you or anyone who lives with you gets foster care payments for the care of a foster child or adult and you are recertifying for Supplemental Nutrition Assistance Program (SNAP) benefits, you have two choices: You can choose to include the foster care child or adult and the foster care payments in your SNAP benefits household or you can choose not to include the foster care child or adult and the foster care payments in your SNAP benefits household. Ask your SSD which choice would give you more SNAP benefits.

CHILD SUPPORT PAYMENTS (RECEIVED): If you or anyone who lives with you gets child support payments, print the name of the person who pays the child support after “Received From” on line 18.

OTHER INCOME: Describe any other money received by you or anyone who lives with you, including who receives the money, how much they receive, and how often they receive it.

DEDUCTIONS, WHO, and AMOUNT/VALUE & FREQUENCY: Check (✓) “YES” or “NO” for lines 1 through 15 to indicate whether you or anyone who lives with you will claim any of the federal tax deductions listed on the current year’s income tax return. For each “YES” answer, print the name(s) of the person(s) who will claim the deduction(s), and the amount or value and frequency of the expense(s)

that will be claimed on the income tax return.

OTHER ADJUSTMENT: Describe any other federal tax deductions that you or anyone who lives with you will claim on the current year's income tax return, including who will claim the deduction(s), and the amount or value and frequency of the expense(s) that will be claimed on the income tax return.

SECTION 17: STEP-PARENT/NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS SPONSOR INFORMATION

DOES THE STEP-PARENT OF ANY CHILDREN WHO LIVE WITH YOU HAVE ANY RESOURCES OR RECEIVE INCOME OF ANY KIND and WHO?: Check (✓) "YES" or "NO" to indicate whether anyone recertifying, including yourself, has a step-parent who does not live with you and who has financial resources or receives money from any source. (If the step-parent lives with you, the step-parent's resources/income should be included in Section 16, Income Information.) If "YES," print the name of the step-parent.

IS ANYONE IN YOUR HOUSEHOLD A NON-CITIZEN WITH SATISFACTORY IMMIGRATION STATUS WHO WAS SPONSORED FOR ADMISSION INTO THE U.S. and WHO?: Check (✓) "YES" or "NO" to indicate whether you or anyone in your household is a non-citizen with satisfactory immigration status who was sponsored by someone in order to be admitted to the U.S. If "YES", print the name of the non-citizen with satisfactory immigration status.

NAME OF SPONSOR, ADDRESS, and PHONE NO.: If you checked "YES" above, print the name of the person who sponsored you or anyone in your household for admission to the U.S., the sponsor's address, and the sponsor's phone number.

PAGES 10 AND 11 OF THE RECERTIFICATION FORM

SECTION 18: EMPLOYMENT INFORMATION

Complete this section for yourself and for everyone who lives with you. If you are employed, you may still be eligible for assistance. For the purposes of this section, "working age" means 18 years of age or older, or 16 years of age or older for anyone who does not attend school.

I AM CURRENTLY: Check (✓) "employed," "self-employed," or "unemployed" to indicate whether you are working, and if so, whether you work for yourself or someone else.

GROSS INCOME: Print the amount you get paid before taxes on a weekly, biweekly, or monthly (not yearly) basis, if applicable. Include all wages, salary, overtime pay, commissions, and tips.

HOURS WORKED MONTHLY: Print the number of hours you work each month, if applicable.

PAID: Check (✓) "Weekly," "Bi-weekly," or "Monthly" to indicate how often you get paid, if applicable.

DAY OF THE WEEK PAID: Print the day of the week that you get paid, if applicable.

EMPLOYER'S NAME AND ADDRESS and PHONE NO.: Print your employer's name, address, and phone number, if applicable. Print "self," and your business address and phone number, if you are self-employed.

IS ANYONE ELSE WHO LIVES WITH YOU CURRENTLY EMPLOYED OR SELF-EMPLOYED and WHO?: Check (✓) "employed" or "self-employed" if anyone who lives with you is working, and print his/her name.

GROSS INCOME, HOURS WORKED MONTHLY, PAID, DAY OF THE WEEK PAID, EMPLOYER'S NAME AND ADDRESS, and PHONE NO.: Complete for any person who lives with you and works, according to the directions above.

IS HEALTH INSURANCE AVAILABLE THROUGH YOUR EMPLOYER?: If you are employed, check (✓) "Yes" or "No" to indicate whether you have medical coverage available through your employer.

DOES ANYONE WHO LIVES WITH YOU HAVE HEALTH INSURANCE WITH AN EMPLOYER and WHO?: Check (✓) "Yes" or "No" to indicate whether anyone who lives with you has medical coverage through an employer, and if "Yes," print his/her name.

NAME OF INSURANCE COMPANY: Print the name of your health insurance company and/or the health insurance company of any person who lives with you, if applicable.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE CHILD OR DEPENDENT CARE EXPENSES DUE TO EMPLOYMENT and WHO?: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you has child care or dependent care (e.g., for an elderly parent) expenses as a result of being employed and print the name of the person with these expenses.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE OTHER EMPLOYMENT-RELATED EXPENSES and WHO?: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you has any employment-related expenses (e.g., transportation, uniforms), and if "Yes," print your/his/her name.

IF NOT EMPLOYED, WHEN WAS THE LAST TIME YOU OR ANYONE WHO LIVES WITH YOU WORKED, WHO, WHEN, and WHERE?: If you or anyone of working age who lives with you is unemployed, print your/his/her name(s), the date(s) you/he/she were last employed, and where you/he/she were last employed.

WHY DID YOU (OR THEY) STOP WORKING?: Print the reason(s) that you or anyone of working age who lives with you is unemployed.

DID YOU OR ANYONE LIVING WITH YOU FILE FOR UNEMPLOYMENT, WHO, WHEN, and STATUS OF FILING?: If you or anyone of working age who lives with you is unemployed, check (✓) "Yes" or "No" to indicate whether you/he/she have filed for unemployment. If "Yes," print your/his/her name, when you/he/she filed for unemployment, and the status of the filing.

ARE YOU OR IS ANYONE WHO LIVES WITH YOU PARTICIPATING IN A STRIKE and WHO?: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you is on strike (i.e., has stopped working in protest to an employer's decision or practices), and if "Yes," print your/his/her name.

WHEN THE STRIKE BEGAN: If you or anyone who lives with you is on strike, print the date that you/he/she went on strike.

ARE YOU OR IS ANYONE WHO LIVES WITH YOU A MIGRANT OR SEASONAL FARM WORKER and WHO?: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you travels to different farms for work or works on a farm only during the growing season, and if "Yes," print your/his/her name.

DO YOU OR ANY OTHER ADULT WHO LIVES WITH YOU HAVE ANY MEDICAL CONDITIONS THAT LIMIT THE ABILITY TO WORK OR THE TYPE OF WORK THAT CAN BE PERFORMED and WHO?: Check (✓) "Yes" or "No" to indicate whether you or anyone of working age who lives with you has any condition that keeps you/him/her from working full-time or from doing certain kinds of work, and if "Yes," print your/his/her name.

DESCRIBE LIMITATIONS: If you or anyone of working age who lives with you has any condition that keeps you/him/her from working full-time or from doing certain kinds of work, explain the ways in which you/he/she are limited.

COULD YOU ACCEPT A JOB TODAY, and IF NOT, WHY?: Check (✓) "Yes" or "No" to indicate whether you could take a job today if it was available, and if "No," explain why.

WHAT TYPE OF WORK WOULD YOU LIKE TO DO?: What kind of job would you enjoy doing?

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SECTION 19: EDUCATION/TRAINING

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION COMPLETED?: Check (✓) the description that best matches how much education you have completed.

IF SO, LAST GRADE COMPLETED?: If you did not finish high school, print the last grade that you completed.

DOES ANYONE ELSE IN THE HOUSEHOLD HAVE A HIGH SCHOOL DIPLOMA, GENERAL EQUIVALENCY DIPLOMA (GED) OR TEST ASSESSING SECONDARY COMPLETION (TASC™), OR HIGHER LEVEL OF EDUCATION, WHO, DEGREE ATTAINED, and DATE COMPLETED?: Check (✓) "Yes" or "No" to indicate whether anyone who lives with you has a high school diploma, General Equivalency Diploma (GED) or Test Assessing Secondary Completion (TASC™), or higher level of education. If "Yes," print the name of that person, the degree received, and the date it was received.

Complete the following questions for yourself and anyone who lives with you who is recertifying for or getting assistance.

IS OR HAS BEEN IN ANY TRAINING PROGRAM IN THE LAST 12 MONTHS, WHO, WHERE, PROGRAM, DATES ATTENDED, and DATES COMPLETED?: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is recertifying for or getting assistance has participated in a job training program in the last 12 months, and if "Yes," print the name of that person, where that person attended the training program, the name of the program or what kind of program it was, and the dates that person attended and completed the program.

IS 16 YEARS OF AGE OR OLDER AND IS ATTENDING SCHOOL OR COLLEGE, WHO, and WHERE?: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is recertifying for or getting assistance is 16 years of age or older and going to school or college, and if "Yes," print the name of that person and his/her school or college.

IS GETTING A TRAINING ALLOWANCE, WHO, and AMOUNT? Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is recertifying for or getting assistance is receiving a training allowance. If "Yes", print the name of that person(s) and the amount of money received.

IS GETTING EDUCATIONAL GRANTS OR LOANS, WHO, and AMOUNT? Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is recertifying for or getting assistance is getting educational grants or loans. If "Yes", print the name of that person(s) and the amount of money received.

IS UNDER 16 YEARS OF AGE AND IS ATTENDING SCHOOL, WHO, and SCHOOL?: Check (✓) "Yes" or "No" to indicate whether you or anyone who lives with you who is recertifying for or getting assistance is under 16 years of age, and if "Yes," print the name(s) of any such person(s) and his/her/their school(s).

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SECTION 20: RESOURCES INFORMATION

If you are recertifying only for Supplemental Nutrition Assistance Program benefits, you do not have to indicate whether you have life insurance.

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING: For lines 1 through 23, check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is recertifying for assistance has any of the financial resources listed.

WHO: For each "YES" answer, print the names(s) of the person(s) with the resource.

IF YES, AMOUNT/VALUE: For each "YES" answer, print the dollar (\$) amount or value of the resource. Be sure to list any joint holdings (resources belonging to two or more people, such as joint bank accounts). Anyone recertifying for Public Assistance or Medicaid must include the resources of any legally responsible relatives. These are people who are required by law to financially support you or anyone recertifying, such as a spouse or, if you are under the age of 21, any parents or step-parents who live with you or anyone recertifying.

HAS TITLE OR REGISTRATION TO A MOTOR VEHICLE(S) OR OTHER VEHICLE(S), YEAR, MAKE/MODEL, and OTHER: If your name or the name of anyone who lives with you who is recertifying is listed on the title for a car or other vehicle, print the year, make, and model for each vehicle on line 6. List resources, such as campers, snowmobiles, and boats, after "Other" on line 6.

HAS RESOURCES OTHER THAN THOSE LISTED ABOVE: It is very important to let your SSD know right away if you get or are expecting to get money from a lump sum. A lump sum is a one-time payment, such as an insurance settlement, inheritance, or award from a lawsuit or lottery winning. See LDSS-4148A, "Book 1: What You Should Know About Your Rights and Responsibilities," for more information about lump sums.

HAS ANYONE . . . EVER CREATED A TRUST IN THE PAST OR TRANSFERRED ANY ASSETS INTO A TRUST WITHIN THE PAST 60 MONTHS?: If you or your spouse transfer or give away any assets within the 36 months (60 months for transfers to a trust) prior to the first day of the month in which you receive nursing facility services and you have submitted an application for Medicaid, you may not be eligible to receive nursing facility services or home and community-based waived services under the Medicaid Program.

If you or anyone applying, or a spouse of you or anyone applying (even if the spouse is not applying or living in the household), has created a trust or put any money into a trust in the past five years, print when the trust was created or money was put into it on line 23.

PAGES 14 THROUGH 16 OF THE RECERTIFICATION FORM

SECTION 21: MEDICAL INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING and IF YES, WHO?: Check (✓) "YES" or "NO" to indicate whether any of the situations listed apply to you or anyone who lives with you who is recertifying for assistance, and if "YES," print the name of the person to whom each situation applies. Be sure to list all health and hospital/accident insurance that you have or that is available to anyone recertifying.

HAS PAID OR UNPAID MEDICAL BILLS WITHIN 3 MONTHS PRECEDING THE MONTH OF THIS RECERTIFICATION: Medicaid may be able to pay for medical bills for care you were given during the

three months before the month you apply for help. If you have already paid the bill, we may be able to pay you for the bill if we determine that you would have been eligible for Medicaid at the time. We may be able to pay you even if the doctor or other provider does not accept Medicaid, but we can only pay you the amount Medicaid would have paid and only if the bill was for services that Medicaid would have covered.

IS PREGNANT: If you or anyone who lives with you who is recertifying is pregnant, print the due date and the expected number of children that will be born on line 14.

HEALTH PLAN SELECTION: Complete this section for anyone recertifying for Medicaid. Most people enrolled in Medicaid are required to join a managed care health plan unless they are in an exempt category. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker or call the Managed Care Medicaid Choice Help Line at 1-800-505-5678.

NAME OF PLAN YOU ARE ENROLLING IN: Print the name of the health plan(s) in which anyone recertifying for Medicaid wishes to enroll. If you do not know which health plans are available to you, ask the SSD.

LAST NAME and FIRST NAME: Print the last name and first name of each person recertifying for Medicaid.

DATE OF BIRTH: Print the two-digit month, two-digit day, and two-digit year of the date of birth of each person recertifying for Medicaid.

SEX: Print "M" for "Male" or "F" for "Female" to indicate the sex of each person recertifying for Medicaid.

ID# (FROM MEDICAID CARD IF YOU HAVE ONE): When recertifying for Medicaid, print the Medicaid card identification number here.

SOCIAL SECURITY #: Print the Social Security number of each person recertifying for Medicaid. This is optional if the person is pregnant.

PRIMARY CARE PROVIDER OR HEALTH CENTER (CHECK BOX IF CURRENT PROVIDER): Print the name of the primary care provider (i.e., general practitioner or family doctor) or the health center anyone recertifying for Medicaid wishes to use. If this is the provider or center used by this person already, check (✓) the box. You must make sure that the provider or center accepts Medicaid before receiving medical care.

NAME AND ID # OF OB/GYN (CHECK BOX IF CURRENT PROVIDER): If anyone recertifying for Medicaid needs obstetrician/gynecologist (OB/GYN) care and services, print the name of the OB/GYN the applicant wishes to use. If the applicant already uses this OB/GYN, check (✓) the box. You must make sure that the provider or center accepts Medicaid before receiving medical care.

You must make sure that any doctor or medical provider you see accepts Medicaid before you get medical care.

SECTION 22: SHELTER INFORMATION

WHAT IS YOUR LANDLORD'S NAME, ADDRESS, and PHONE NUMBER?: If you have a landlord, print your landlord's name, address, and phone number.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE A RENT, MORTGAGE OR OTHER SHELTER EXPENSE?: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays rent, a mortgage, or other shelter (e.g., room and board) expense, and if "YES," print the amount you/he/she pay(s) per month. If you have a mortgage payment, include the amount of property taxes and

homeowner's insurance (including fire insurance).

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE A HEAT BILL SEPARATE FROM YOUR RENT OR OTHER SHELTER EXPENSE?: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays for heat separately from your rent, mortgage, or other shelter expense, and if "YES," print the amount you/he/she pay(s) per month.

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE THE FOLLOWING EXPENSES SEPARATE FROM YOUR RENT OR OTHER SHELTER EXPENSE?: For lines 1 through 8, check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you pays for any of the expenses listed separately from your rent, mortgage, or other shelter expense, and if "YES," print the amount you/he/she pay(s) per month. For the questions on lines 9 through 11, check (✓) "YES" or "NO" to indicate whether you or anyone recertifying lives in any of these arrangements.

SECTION 23: OTHER EXPENSES

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING and IF YES, AMOUNT: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is recertifying makes any of the payments listed, or has any expenses not listed, on lines 1 through 6. Identify on line 6 any expenses not listed. For each "YES" answer, print the amount of the payment or expense and how often it is paid (e.g., \$100 per week or \$100/wk.)

DO YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING OWE AT LEAST FOUR MONTHS OF SUPPORT FOR A CHILD UNDER AGE 21: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you who is recertifying owes four months or more of child support.

PAGE 17 OF THE RECERTIFICATION FORM

SECTION 24: OTHER INFORMATION

DO YOU BUY OR PLAN TO BUY MEALS FROM A HOME DELIVERY OR COMMUNAL DINING SERVICE?: Check (✓) "YES" or "NO" to indicate whether you or anyone recertifying currently buys or plans to buy meals from a home delivery (e.g., Meals on Wheels) or communal dining (e.g., a cafeteria in the building where you live) service.

ARE YOU ABLE TO COOK OR PREPARE MEALS AT HOME?: Check (✓) "YES" or "NO" to indicate whether you have a place at home where you can cook.

For purposes of the questions on lines 10 through 12, "U.S. military" means the:

- U.S. Army
- U.S. Navy
- U.S. Coast Guard
- U.S. Marine Corps
- U.S. Air Force
- U.S. Merchant Marine during World War II

HAVE YOU OR ANYONE IN YOUR HOUSEHOLD EVER BEEN IN THE U.S. MILITARY and WHO?: Check (✓) "YES" or "NO" to indicate whether you or anyone who lives with you has ever been in any of the military branches listed above, and if "YES," print his/her name.

HAS YOUR SPOUSE EVER BEEN IN THE U.S. MILITARY? Check (✓) "YES" or "NO" to indicate whether your spouse has ever been in any of the military branches listed above.

IS ANYONE IN YOUR HOUSEHOLD A DEPENDENT OF SOMEONE WHO IS OR WAS IN THE U.S. MILITARY and WHO?: Check (✓) “YES” or “NO” to indicate whether you or anyone who lives with you is financially dependent on someone who is or ever has been in any of the military branches listed above, and if “YES,” print the name of the dependent.

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING and WHO: Check (✓) “YES” or “NO” to indicate whether the situations described in the next nine questions apply to you or anyone who lives with you, and if “YES,” print the name of the person to whom the situation applies. If you do not understand these questions, ask your SSD to explain. Please note that New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth.

PROPERTY TRANSFER STATUS: Check (✓) the “I have” box or “I have not” box to indicate whether you or anyone recertifying has sold, transferred, or given away any property in order to receive Public Assistance or SNAP benefits. Please note that New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, SNAP benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth.

PAGES 18 THROUGH 26 OF THE RECERTIFICATION FORM

NOTICES, ASSIGNMENTS, AUTHORIZATIONS, AND CONSENTS

Read ALL of the information in this section carefully or have someone read it to you. This section contains important information about your rights and responsibilities relative to receiving assistance, as well as penalties you may incur (e.g., a fine and/or jail) if you do not fulfill your responsibilities under this section. By signing and submitting a recertification form, you indicate that you understand and agree to the statements in this section.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM AUTHORIZED REPRESENTATIVE: If you want someone to recertify for Supplemental Nutrition Assistance Program (SNAP) benefits for you and/or you want someone who does not live with you to get the SNAP benefits for you and/or use them to buy food for you, print that person’s name, address, and phone number in the box. This person is your “Authorized Representative.” The Authorized Representative must sign and date the signature section at the end of the recertification form. If your household does not live in an institution, a responsible adult member of your household must sign and date the recertification form also, unless your household has otherwise designated the Authorized Representative to do so in writing.

RELEASE OF MEDICAL INFORMATION: Check (✓) “Do not disclose HIV/AIDS information,” “Do not disclose mental health information,” and/or “Do not disclose drug and alcohol information” if you do not agree to have this medical information about you and/or recertifying family members disclosed as permitted by law.

SIGNATURE SECTION: Read this section carefully or have someone read it to you. New York State law provides for a fine or jail, or both, for a person found guilty of obtaining Public Assistance, Medicaid, Supplemental Nutrition Assistance Program benefits, Child Care Assistance, or Services by hiding the facts or not telling the truth. **By signing and submitting a recertification form, you indicate that you understand and agree to the statements in this section, and that all of the information you have provided on this recertification form or will provide to the SSD in the future is complete and correct to the best of your knowledge.**

APPLICANT SIGNATURE and DATE SIGNED: Sign your name and print the date you signed the recertification form, unless you have designated a Supplemental Nutrition Assistance Program (SNAP) Authorized Representative on the recertification form and you live in an institution, in which case the Authorized Representative may sign and date the recertification form. If you do not reside in an institution, both you and the Authorized Representative must sign and date the recertification form,

unless you have previously designated the SNAP Authorized Representative to do so in writing. If you have filled out the recertification form for someone else, sign your name, not the name of the person for whom you represent, and print the date you signed.

SPOUSE OR PROTECTIVE REPRESENTATIVE SIGNATURE and DATE SIGNED: If you are married and recertifying for Public Assistance or Medicaid, your spouse must sign and date the recertification form. If you are married and recertifying just for Supplemental Nutrition Assistance Program benefits, only one spouse must sign and date the recertification form. If you have a Protective Representative, that person must sign and date the recertification form.

AUTHORIZED REPRESENTATIVE SIGNATURE and DATE SIGNED: If you have designated a SNAP Authorized Representative on the recertification form, that person must sign and date the recertification form.

I REQUEST MY CASE BE CLOSED FOR: Do not check any of the boxes, or sign or date this section, if you want to submit a recertification. Only mark this section if you want to close your case for one or more programs. To request to close your case, check (✓) the box next to that program, and sign and date where indicated. Please provide a reason for the request.

VOTER REGISTRATION FORM: The last two pages of this recertification form are a voter registration form. Using the form to register or declining to register to vote will not affect the decision made about your recertification for benefits, or the amount of assistance that you may receive. If you would like help filling out the voter registration form, ask your SSD.

Informational Purposes DOCUMENTATION REQUIREMENTS

This following list of eligibility factors and documentation requirements is solely for informational purposes. Your SSD will inform you which of the eligibility factors you will be required to prove. You may be asked to prove other eligibility factors not listed below. You may be able to provide documentation not listed below to prove these eligibility requirements. If you have any questions regarding documentation requirements, please contact your SSD.

Eligibility Factor	To prove this factor, provide: ✓↓ ONE of the following	OR	✓↓ TWO of the following (If you are applying for SNAP Benefits or Medicaid only, you need to bring only one form for each eligibility factor checked.)	
<input type="checkbox"/> Identity You must prove who you are.	Photo I.D. Driver's license U.S. passport Naturalization Certificate Hospital/Doctor's Records Adoption paper		Statement from another person Validated Social Security Number Birth/Baptismal Certificate	<input type="checkbox"/> Social Security Number (For Public Assistance, SNAP Benefits and Medicaid- only , you do not have to _____ provide proof of your Social Security Number (SSN) unless the SSN you give does not match with SSA'S records or cannot be verified by the agency.)
<input type="checkbox"/> Marital Status You must prove if you are married, divorced, separated, or widowed.	Marriage/Death certificates Separation agreement Divorce decree Social Security records VA records		Statement from clergy Census records Newspaper notice Statement from another person	<input type="checkbox"/> Citizenship or Current Non-Citizen Status - US citizens are eligible for Public Assistance, SNAP and Medicaid. Non-citizens must be in satisfactory immigration status in order to be eligible for Public Assistance, SNAP or Medicaid. Immigration status is not an eligibility factor for pregnant women or immigrant children applying for Child Health Plus B. Undocumented immigrants and temporary non-immigrants are eligible only for the treatment of an emergency medical condition.
<input type="checkbox"/> Residence You must prove where you live.	Statement from landlord Current rent receipt or lease Mortgage records		Statement from another person Current mail School records	<input type="checkbox"/> Earned Income From employer
<input type="checkbox"/> Household Composition/Size You must prove who is living with you.	Statement from non-relative Landlord School records		Statements from other persons	<input type="checkbox"/> From self-employment
<input type="checkbox"/> Age You must prove the age of each person applying for assistance, where appropriate.	Birth certificate Baptismal certificate Hospital records Adoption records Naturalization certificate Driver's license		Insurance policy Census records School records Statement from another person Physician statement Official correspondence from SSA	<input type="checkbox"/> Income from rent or room/board
<input type="checkbox"/> Absent Parent If the parent of any child in your home is not living with you, you must prove this	Death certificate Survivor's benefits Hospital records VA or military records Divorce papers Proof of remarriage		Newspaper notice Insurance company records Institutional records Agency case records and burial payment files Statement from another person	<input type="checkbox"/> Unearned Income Child support
<input type="checkbox"/> Absent Parent Information You must provide any information you have: name, address, Social Security Number, birth date, employment	Pay Stubs Tax returns Social Security or VA records Monetary determination letters ID. cards (health insurance) Driver's license or registration			<input type="checkbox"/> Unemployment Insurance benefits (UIB) <input type="checkbox"/> Social Security benefits (including SSI) Veteran's benefits

To prove this factor, provide one of the following:

Social Security Card
Official correspondence from SSA
A Social Security Number is not required for non-citizens who are seeking Medicaid for emergency treatment only or are Medicaid-only applicants who are pregnant.

Birth certificate
Baptismal certificate
Hospital records
U.S. passport
Military service records
Naturalization certificate
USCIS documentation
Evidence of continuous U.S. residence since prior to 1/1/72.

Current wage stubs
Pay envelopes
On letterhead, rate of pay per hour; hours worked per week; date of first pay, if new and employer's phone number
Contact with employer
Business records
Tax records
Records and related materials concerning self-employment earnings and expenses
Current income tax return

Current contribution check
Statement from roomer, boarder, tenant
Income tax records

Statement from Family Court
Statement from person paying support
Check stubs
Current award certificate
Current benefit check
Official correspondence with NYS Dept. of Labor
Current award certificate
Current benefit check
Official correspondence from SSA
Current award certificate
Current benefit check
Official correspondence from VA

Eligibility Factor	To prove this factor, provide one of the following:	Eligibility Factor	To prove this factor, provide one of the following:
<input type="checkbox"/> Unearned Income (con't) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Education grants and loans <input type="checkbox"/> Interest/dividends/royalties <input type="checkbox"/> Private pension/annuity <input type="checkbox"/> Other	Award Letter Check stub Statement from school Statement from bank Award letter Statement from bank or credit union Statement from broker/agent Current award letter Current benefit check Official correspondence from source of income	<input type="checkbox"/> Other _____ <input type="checkbox"/> Shelter Expenses You must prove how much it costs you to live where you do (You may need to provide separate documentation for each item of shelter expense.) Medicaid does not require documentation of shelter expenses. <input type="checkbox"/> Medical Bills	 Current rent receipt Current lease Mortgage book/records Property and school tax records Landlord statement Sewer and water bills Homeowner's insurance records Fuel bills Non-heating utility bills Telephone bills Copies of medical bills (paid and unpaid)
<input type="checkbox"/> Resources <input type="checkbox"/> Bank accounts: checking, savings, retirement (IRA and Keogh) <input type="checkbox"/> Stocks, bonds, certificates <input type="checkbox"/> Life Insurance <input type="checkbox"/> Burial trust or fund burial plot or funeral agreement <input type="checkbox"/> Income tax refund or earned income tax credit (EITC) <input type="checkbox"/> Real estate other than Residence <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Lump sum payment	Statement from household Statement from nursing home Current bank records Current credit union records Stock certificate Bonds Statement from financial institution Insurance policy Statement from insurance company Bank records Burial agreement Burial plot deed Statement from funeral director Tax Refund Statement from tax office Deed Statement from real estate broker Appraisal/estimate of current value by broker Registration (older models) Title of ownership Appraisal of current value by dealer Financing data Statement from source of payment	<input type="checkbox"/> Health Insurance If you or anyone applying has health insurance coverage (even if paid for by someone else), you must prove this. <input type="checkbox"/> Disabled/Incapacitated /Pregnant If you or anyone living with you is sick or pregnant, you must provide proof. <input type="checkbox"/> Unpaid Bills Rent, utility <input type="checkbox"/> Referral Drug/Alcohol Treatment Program <input type="checkbox"/> Employment Service <input type="checkbox"/> Other Expenses/ Dependent Care Cost You must provide proof if you pay court-ordered support, child care, recurring loans, or for services of a home health aide or attendant. <input type="checkbox"/> School Attendance You must prove who is in school <input type="checkbox"/> Other:	Insurance policy Insurance card Statement from provider of coverage Medicare card Statement from medical professional verifying pregnancy and expected date of birth Statement from medical professional Proof of SSA or SSI benefits for disability or blindness Copy of each bill showing amount owed, period of services and provider Statement from provider of Treatment Statement from employment service Court order Statement from day care center or other child care provider Statement from aide or attendant Cancelled checks or receipts School records (current report card) Statement from school/ or Higher Education Institution



Book 1

What You Should Know About Your Rights and Responsibilities

When Applying For or Receiving Benefits

If you are blind or seriously visually impaired and need an application or these instructions in an alternative format, you may request them from your social services district. The following alternative formats are available:

- Large print;
- Data format (a screen-reader accessible electronic file);
- Audio format (an audio transcription of the instructions or application questions); and
- Braille, if you assert that none of the other alternative formats will be equally effective for you.

Applications and instructions are also available for download in large print, data format and audio format from www.otda.ny.gov or www.health.ny.gov. Please note that applications are available in audio format and Braille solely for informational purposes. In order to apply, you must submit an application in written, non-alternative format. If you require another accommodation, please contact your social services district.

Also See

BOOK 2 (LDSS-4148B)

“What You Should Know About
Social Services Programs”

and

BOOK 3 (LDSS-4148C)

“What You Should Know If
You Have an Emergency”

SAVE THIS BOOK FOR FUTURE USE

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PLEASE NOTE:

This book tells you about many of your rights and responsibilities when you are applying for or getting social services benefits or care.

It is intended to give you a general understanding of rights and responsibilities contained in State and federal laws, rules and regulations. Please ask your worker for further information if you have specific questions.

INTRODUCTION

This book (**LDSS-4148A**: “What You Should Know About Your Rights and Responsibilities”) is one of three that answers most questions about the assistance we can give you. This book tells you about your rights and responsibilities when you apply for and when you receive benefits.

The second book (**LDSS- 4148B**: “What You Should Know About Social Services Programs”) gives specific information about each program, and the third book (**LDSS-4148C**: “What You Should Know If You Have An Emergency”) tells you what to do if you have an emergency.

Throughout these books we call the public assistance programs “Temporary Assistance”. (Officially they are called “Family Assistance” and “Safety Net Assistance”.) The reason for the word “Temporary” is to stress that these programs are meant to assist you only until you can fully support yourself and your family.

These books also refer to Medical Assistance. Medical Assistance includes Child Health Plus A coverage for children, Medicaid coverage for adults, Family Health Plus, Medicaid Buy-In Program for Working People with Disabilities, Medicare Savings Program, and the Family Planning Benefits Program.

These books also refer to Services. Services include such things as child care, foster care, child welfare, adoption, and others.

YOUR RIGHTS

1. APPLICATION RIGHTS

You have the right to:

- Be told about the programs and help you can get.
- Be told what you need to do to get these programs.
- Apply for these programs.
- Get an Application when you ask for one.
- Turn in (file) the Application the same day you get it (for Temporary Assistance and Food Stamp Benefits).

NOTE: A Food Stamp Benefits Application must be accepted if you have filled in at least your name, address (if you have one) and signature. This is important because the amount of your Food Stamp Benefits is figured from the day you turn in your Food Stamp Benefits Application. You could get more Food Stamp Benefits if you turn in your application the same day you get it. Please note, however, that you will have to fill out the rest of the application to see if you can get Food Stamp Benefits.

- Mail in your application if you are applying only for child care services.
- Have an interview.
 - For Medical Assistance (Medicaid/Child Health Plus A/Family Health Plus/ Medicaid Buy-In program for Working People with Disabilities/ Medicare Savings program/Family Planning Benefit program) there is no specific time frame within which you or your representative must be interviewed. However, you must be interviewed before eligibility can be established.
 - For Temporary Assistance, this interview should be within seven working days.
 - For Food Stamp Benefits, the interview must be scheduled timely in order to ensure a determination of eligibility and benefit issuance within 30 days of application filing.
 - For Food Stamp Benefits, you have the right to request that the in-office interview be waived in hardship situations. Hardship generally includes, but is not limited to, illness, transportation difficulties, care of a household member, hardship due to residency in a rural area, prolonged severe weather, or work or training hours that prevent you from coming in during the social services district's office hours. The in-office interview will be waived, at your request, if all the adult members of your household are elderly or disabled with no earned income. The agency may waive the in-office interview in favor of a telephone interview or scheduled home visit. In-person interviews may be scheduled in advance at any mutually acceptable location including a household's residence.

If an applicant is unable to attend the interview, he or she can designate **in writing** an authorized representative, someone who is not a member of the household, to attend the interview for the household. He or she can be a friend, a relative, or anyone else the applicant chooses. This person must have the necessary documentation and be able to give the local department of social services (LDSS) the information it needs to determine eligibility. The selection of an authorized representative is the choice of the household. If an applicant wants someone to act as an authorized representative, both the applicant and the authorized representative must sign the application.

When the application is for Medical Assistance only, the application may be completed and signed by anyone the applicant authorizes to represent him/her in the application process. This representative may attend the interview for the applicant.

NOTE: If you are applying for Temporary Assistance, and you tell us today that you have an emergency, we must interview you today about your emergency. We must also tell you in writing today about our decision on your emergency. If you are applying for Food Stamp Benefits, and you are eligible for expedited processing, your interview and the notice of our decision will be no later than five calendar days after the day you filed your application.

- Bring someone to your interview to interpret for you. If you need an interpreter, the agency will arrange for one. You cannot be denied access to services because you are not fluent in English. Hearing or speech impaired applicants/recipients may consider utilizing TTY/TTD relay systems to gain access to services.
- Have the same access to social services programs, if you have a disability, as someone who does not have a disability.

- Be told, within 30 days of the date you turned in (filed) your Application for Family Assistance and Food Stamp Benefits, if your Application is approved or denied; be told within 45 days of the date you turned in (filed) your Application for **Safety Net Assistance**, if your Application is approved or denied.
- Have a decision made to approve or deny your application for Services within 30 days of the date you turned in (filed) your application, and have written notice of that decision sent to you within 15 days after the decision is made. However, a decision to approve or deny protective services for adults must be made at the time a protective service for adults assessment services plan is completed.
- Be notified if you are eligible for Medical Assistance or if your application is denied when your application for Medical Assistance, including your interview, is completed. The time frame for you to be notified varies:
 - Pregnant women and young children must be told within 30 days of filing the Application;
 - If a person's eligibility is dependent on disability status, the person must be told of the eligibility decision within 90 days of filing the Application; and
 - All other persons must be told within 45 days of filing the Application.
- Get a written notice telling you if your Application is approved or denied:
 - If your Application is approved, this notice will tell you what benefits you will get;
 - If your Application is denied, this notice will tell you why and what you should do if you disagree or do not understand this decision.

NOTE: If your application for Temporary Assistance is approved and you are an adult with no children, your category of Temporary Assistance will generally be Safety Net Assistance. Some families with children will receive Safety Net Assistance.

People in Safety Net Assistance cases will not get recurring Temporary Assistance for any period prior to 45 days from the date of application. People in the Safety Net Assistance Category may be able to get help to meet emergencies during the 45 day period that they cannot get recurring benefits. (See LDSS-4148C: "What You Should Know If You Have An Emergency".)

People in the Safety Net Assistance category who are eligible for Food Stamp Benefits do not have to wait any longer for those benefits than any other applicant.

2. NONDISCRIMINATION RIGHTS

Discrimination by the New York State Office of Temporary and Disability Assistance (OTDA), by the New York State Department of Health, by the New York State Office of Children and Family Services or by your local department of social services based on race, religion, ethnic background, marital status, disability, sex, national origin, political belief or age is illegal.

If you think you have been discriminated against in a **Temporary Assistance** program, **which includes Family Assistance and Safety Net Assistance**, or that your case has been handled improperly due to some type of discrimination, you can complain by calling or writing to the:

**Bureau of Equal Opportunity Development (BEOD)
New York State Office of Temporary and Disability Assistance
40 North Pearl Street 13A
Albany, New York 12243-0001
(518) 473-8555**

BEOD will refer the complaint to the local department of social services for investigation, and send a copy of the transmittal letter to the complainant. When a complaint has been referred by OTDA to a local department of social services a report must be submitted within 20 days of the date of such request and shall cover fully all matters pertaining to the complaint, as required by 18 NYCRR Part 356.3(e.). If the time limit cannot be met, an interim report should be sent. OTDA may provide feedback to the local department of social services concerning any matters covered in the report pertaining to the complaint, and may undertake further review of the complaint, in consultation with the local department of social services if determined necessary.

If you think you have been discriminated against in the **Food Stamp Benefits** program, you can also complain by writing to the:

**USDA
Director, Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Avenue, S.W.
Washington, D.C. 20250-9410
(Voice and TDD: (202) 720-5964)**

Your discrimination complaint will be investigated, and you will be told in writing of the findings.
If you think you have been discriminated against on the basis of disability, you can also complain by writing to:

Disability Rights Section
P.O. Box 66738
Washington, D. C. 20035-6738
or

Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 506-F
Washington, D.C. 20201
or

call the Office for Civil Rights at 1-800-368-1019 (voice) or 1-800-537-7697(TDD)

Your discrimination complaint will be investigated, and you will be told in writing of the findings.

If you feel you have been discriminated against in the **Medical Assistance** program, you can call or write to one of the regional offices of the New York State Division of Human Rights, which can be found in the Government pages of the telephone book.

If you feel you have been discriminated against in **Temporary Assistance, Food Stamp Benefits** and their related employment programs, **Medical Assistance, Services** or **Child Care**, you can contact the New York State Division of Human Rights in Albany.

You can also call or write to one of the regional offices of the New York State Division of Human Rights, which can be found in the Government pages of the telephone book. Some cities and counties in New York State also have human rights commissions that investigate discrimination complaints. Check your telephone book for a listing.

3. PERSONAL PRIVACY RIGHTS

The New York State Personal Privacy Protection Law and the federal Privacy Act require the New York State Office of Temporary and Disability Assistance, the New York State Office of Children and Family Services and the New York State Department of Health to tell you what it does with the information, including social security numbers, that you give the State (or, in certain instances, to your local department of social services) about you and your family. The Privacy Act statement is on your application form.

This information, including your social security number, is used to find out which programs can help you, and is also used to find out how much money and other help you can get. Following are some other uses for the information:

- Upon request of a law enforcement officer in certain circumstances, a local department of social services must provide the address of Temporary Assistance and Food Stamp Benefits recipients.
- In some cases, information you supply is used to form jury pools.
- In some cases, information is shared with the United States Citizenship and Immigration Services (USCIS) (in the Department of Homeland Security). **Note:** Medical Assistance will not give the information you provided concerning your immigration/citizenship status to the United States Citizenship and Immigration Services (USCIS).
- Information is used for child support purposes.
- Information is shared with other states and agencies that provide similar assistance, in order to prevent duplication and fraud.

Whenever you are asked for information, you must give it so that it can be used to see if you can get money or other help. The parts of law that oblige New York State Office of Temporary and Disability Assistance, New York State Department of Health and local departments of social services to get information about you and to verify this information are Sections 21, 132, 134-a and 366-a of the Social Services Law and Section 1137 of the Federal Social Security Act.

To make sure you are getting the money or other help that you and your family are legally allowed to get, other people may be asked to confirm and add to the information you have already given us. For example:

- To find out if you are or were working, and, if so, how much money you made, your name and social security number are sent to the New York State Department of Taxation and Finance, and also to known employers. In some cases your name and social security number may be sent to government agencies in other states to find out if you worked or got money or other help in those states.

NOTE: If you are applying for or getting Temporary Assistance or Medical Assistance, we may give your children's social security numbers to their non-custodial parent in order to enroll the children in their noncustodial parent's health insurance coverage and, if necessary, to begin child support enforcement services. If you are applying for Medical Assistance only, we may pursue the noncustodial parent of your children for medical support only.

- The Unemployment Insurance Division in New York State and similar offices in other states are asked if you are or were getting unemployment benefits.
- Banks may be asked to see if you have a bank account(s), or confirm that you have one and how much money is in your account(s).
- Schools may be asked to confirm that your children go there.
- The New York State Department of Motor Vehicles may be asked if you own a car.
- The Social Security Administration is asked for employment information and to see if you get pension or disability benefits.
- The Departments of Defense and Veterans Affairs are asked if you are eligible for and/or in receipt of compensation and/or pension benefits.
- The Internal Revenue Services may be asked about federal tax information (1099) if you are applying for or in receipt of Temporary Assistance, to determine your income or resources.

Personal privacy rights also apply to all Medical Assistance and Services applicants and participants.

All of the information you provide on a Medical Assistance application will remain confidential. The only people who will see the information are the enrollment facilitators and the State or local agencies, and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with your application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

You may use a confidential mailing address if you do not want information concerning your eligibility for the Family Planning Benefit Program (FPBP) to go to your regular address. If you need to keep your family planning information confidential from your health insurance provider, tell your worker.

Besides using the information you give us in this way, the New York State Office of Temporary and Disability Assistance (OTDA) also uses the information for program planning and management and to make sure local departments of social services are doing the best job they can ("**quality control**"). This information is kept by the Deputy Commissioner, Division of Information Technology (DoIT), Office of Temporary and Disability Assistance, 40 North Pearl Street, Albany, N. Y. 12243-0001

The New York State Office of Temporary and Disability Assistance (OTDA) is also doing research to learn whether our programs are effective in helping Temporary Assistance applicants and recipients find and keep jobs. This research is very important. It helps us improve services that affect thousands of Temporary Assistance clients like you.

In order to carry out this research, it is necessary to track the wages of samples of Temporary Assistance applicants and recipients for up to 10 years using the State's Wage Reporting System. This wage information is used only for research purposes. **It does not affect your eligibility for Temporary Assistance in any way.** All the wage information collected for the research is kept strictly confidential. Only the people doing the research see the wage information and they do not have access to the names of individual applicants and participants. If you are included in the research, you will never be named in any report and no information about your wages will ever be given out. If you object to the use of your wage reporting records, you can request that they be excluded from the research by writing to:

**New York State Office of Temporary and Disability Assistance
Office of Program Evaluation
40 North Pearl Street
Albany, New York 12243**

4. YOUR RIGHT TO LOOK AT YOUR RECORDS

Once you apply for money or other help, **two** kinds of records are kept about your case. Usually, you have the right to look at these records.

You may **not** be able to look at all of your records. For example, you may not be able to look at all or part of child support, adoption, foster care, child protective and preventive records. Your worker can explain these rules to you.

CASE RECORD -The **first** type of record is called your **case record** and contains all the papers about your case, **and** is accessible through your local department of social services. Your case record may include your application, copies of birth certificates, pay stubs, notes taken by your worker during your interviews and any other information about your case.

Usually, you have the right to look at your case record during working hours. However, you must ask your local department of social services ahead of time in order to do this. You can ask for copies of the papers that are in your case record, but you may have to pay for copying these papers. If the papers will be used at or are needed for a Fair Hearing, copies of them must be given to you for free.

COMPUTER RECORDS –The **second** type of record is kept on computer systems maintained by the New York State Office of Temporary and Disability Assistance, (OTDA) the New York State Department of Health (DOH), or the New York State Office of Children and Family Services (OCFS). The information about your case is put in these State computer systems by your local department of social services and/or by voluntary authorized agencies that provided services to you and your family. In most cases, you also have the right to see your computer records kept by the State. In general, you should make your inquiry to the local department of social services to which you applied, or that is providing services to you and/or your family. Consult with your worker where to direct your request.

For copies of your specific Medicaid Protected Health information, a written request must be sent to:

**Claim Detail Unit
NYS Department of Health
Office of Medicaid Management
99 Washington Ave
7th floor, Suite 729
Albany, NY 12210**

When you write for copies of your computer records, the Personal Privacy Protection Law requires that New York State agencies, within five working days of when they get your letter, must:

- send you your records; **or**
- tell you why they will not give you your records; **or**
- tell you they have your request and they will determine if you are allowed to get your records.

5. CONFERENCES and FAIR HEARINGS

If you think any decision about your case is wrong, or you do not understand any decision, talk to your worker right away. If you still disagree or do not understand, you have the right to a **Conference** and a **Fair Hearing**.

CONFERENCE - A Conference is when you meet with someone other than the person who made the decision about your case. At the Conference this person will review that decision. Sometimes a Conference is the fastest way to solve any problems you may have. We encourage you to ask for one **even if you have requested a Fair Hearing**. However, Conferences are voluntary, and you can request a Fair Hearing even if you do not request a Conference. To ask for a Conference, call or write your local department of social services.

A CONFERENCE IS NOT A FAIR HEARING. If you are told that your case is being closed, or that the money or other help you are getting will be less, and the problem is not settled through a Conference, you must ask for a **Fair Hearing** to keep the money or other help you are getting from being stopped or reduced.

NOTE: A request for a Conference is not a request for a Fair Hearing. If you want a Fair Hearing, you must request one.

Fair Hearing - A Fair Hearing is a chance for you to tell an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance why you think the decision about your case was wrong. The State will then issue a written decision which will state whether the local department of social services decision was right or wrong. The written decision may order the local department of social services to correct your case.

Some Reasons Why You Might Ask For A Fair Hearing

- You agreed to withdraw your application but you feel you were given incorrect or incomplete information about your eligibility for the covered program or service.
- Your Application for Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services, Child Care or Home Energy Assistance Program (HEAP) is denied, and you do not agree with this decision.
- You applied for Temporary Assistance, Food Stamp Benefits, Services or HEAP and more than 30 days have passed. You have not been told yet if your Application has been approved or denied. For some adults applying for Temporary Assistance, the decision may take up to 45 days.

- You believe that your Temporary Assistance, Medical Assistance, Services, Child Care or HEAP are inadequate.
- You applied for Medical Assistance and have not received a notice telling you if your Application has been approved or denied.
 - If you are pregnant or applying for a young child, you should get a notice within 30 days.
 - If you are applying as a disabled person, your eligibility determination may take 90 days.
 - Everyone else is notified within 45 days.
- You are told that you are able to work or to participate in an employment activity (employable), and you do not agree with this.
- You think the amount of your Temporary Assistance or Food Stamp Benefits or Child Care Benefits is wrong.
- You are getting Medical Assistance or Child Care benefits, but you have to pay part of the cost. You think your share is too much.
- Medical Assistance is paying for a service and you have been told that your service is being reduced or discontinued. You do not agree with this.
- You have applied for a Medical Assistance waiver program and have been denied. You do not agree with this.
- You have been told that, due to your abuse of Medical Assistance, you must get your medical care from one main provider (Recipient Restriction Program). You do not agree with this decision. **(See "Your Responsibilities," Section 14, "Responsibilities Regarding The Use Of Medical Assistance Providers".)**
- You are getting Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services or Child Care and you have been told that your case is being closed. You do not agree with this decision.
- You asked for removed cash Electronic Benefit Transfer (EBT) benefits to be reissued to you, and they were not reissued.
- You asked for an adjustment (correction) of your Food Stamp Benefit EBT account and your request was denied.
- Your Food Stamp Benefit EBT account was reduced to correct an EBT system error, and you do not agree with this action.
- Your local department of social services uses part of your Temporary Assistance to pay directly for your bills such as heat, rent, utilities (restricted payments). You do not agree with this.
- You ask for more assistance or services for a special need and you are told you cannot get it. You do not agree with this.
- You are getting Temporary Assistance or Food Stamp Benefits, Services or Child Care benefits each month and you are told that you will be getting less. You do not agree with this.
- You are told you received an overpayment for child care services, Temporary Assistance or Food Stamp Benefits and you are told you will have to pay the overpayment. You do not agree that there is an overpayment or you do not agree with the amount of the overpayment.

At a Fair Hearing you will have a chance to explain why you think the decision is wrong.

TIME LIMITS TO ASK FOR A FAIR HEARING - If you want to ask for a Fair Hearing for Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services or Child Care, call **right away** because **there are time limits**. If you wait too long, you may not be able to get a Fair Hearing.

<p>NOTE: If your situation is very serious, the New York State Office of Temporary and Disability Assistance will set up a Fair Hearing for you as soon as possible. When you call or write for a Fair Hearing, be sure to explain that your situation is very serious.</p>
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If you do get a notice about your case and you want to ask for a Fair Hearing, the notice will tell you how much time you have to ask for the Fair Hearing. **Be sure to read all of the notice carefully.**

If your notice tells you that your **Temporary Assistance, Medical Assistance, Services or Child Care** has been denied, will be stopped or will be reduced, you may ask for a Fair Hearing within **60** days from the date of the notice.

If your notice tells you that your **Food Stamp Benefits** have been denied, will be stopped or will be reduced, you may ask for a Fair Hearing within **90** days from the date of the notice. You may ask for a Fair Hearing if you think you are not getting enough Food Stamp Benefits at anytime within the certification period.

If you do not get a notice about your case, and your money or other help is denied, stopped or reduced you can also ask for a Fair Hearing.

HOW TO ASK FOR A FAIR HEARING

If you do get a notice about your case and you want to ask for a Fair Hearing, the notice will tell you how. **Be sure to read all of the notice carefully.**

If you get a notice telling you that your money or other help will be stopped or reduced, and you ask for a Fair Hearing before the **effective date** on your notice, your money or other help will, in most instances, stay the same ("**aid continuing**") until the Fair Hearing decision is made. If the notice was not sent before the effective date, and you ask for a Fair Hearing within **10** days of the **postmark date** of the notice, you also have the right to have your money or other help stay the same ("**aid continuing**") until the Fair Hearing decision is made.

However, if you do get "**aid continuing**" and you lose the Fair Hearing, you will have to pay back any Temporary Assistance, Food Stamp Benefits, Medical Assistance and/or Child Care benefits that you received as "aid continuing" while waiting for the Fair Hearing decision.

If you **do not** want the money or other help you have been getting to stay the same until the Fair Hearing decision is made, you must tell this to the New York State Office of Temporary and Disability Assistance when you call or write for a Fair Hearing.

If you do not get a notice about your case, and your money or other help is stopped or reduced, you can still ask for a Fair Hearing. At the same time that you ask for a Fair Hearing, you can ask that your money or other help be restored ("**aid continuing**").

However, if you do get "**aid continuing**" and you lose the Fair Hearing, you will have to pay back any Temporary Assistance, Food Stamp Benefits, Medical Assistance and/or Child Care benefits that you received as "aid continuing" while waiting for the Fair Hearing decision.

WHAT YOU SHOULD DO FOR A FAIR HEARING

The New York State Office of Temporary and Disability Assistance will send you a notice, which tells you when and where the Fair Hearing will be held.

To help you get ready for the Fair Hearing, you have the right to look at your case record and get free copies of the forms and papers which will be given to the Administrative Law Judge at the Fair Hearing. You can also get free copies of any other papers in your case record which you think you may need for the Fair Hearing. Usually, you can get these papers before the hearing or at the hearing at the latest. If you ask for any papers, and the local department of social services does not give them to you before or at the hearing, you should tell the Administrative Law Judge about it. ("**See Your Rights,**" **Section 4, "Your Right To Look At Your Records"**.)

You can bring a lawyer, a relative or a friend to the Fair Hearing to help you explain why you think a decision about your case is wrong. If you cannot go to the Fair Hearing, you can send someone else in your place. If you are sending someone who is not a lawyer to the Fair Hearing, you should give this person a letter to give to the Administrative Law Judge. This letter should tell the Judge that this person is taking your place.

To help you explain at the Fair Hearing why you think the decision is wrong, you should also bring any witnesses who can help you and any information you have such as:

- **Pay stubs**
- **Leases**
- **Bills**
- **Doctor's Statements**
- **Receipts**

Someone from your local department of social services will also be at the Fair Hearing to explain the decision about your case. You or your representative will be able to question this person and present your side of the case. You or your representative will also be able to question any witnesses who you bring to help you.

If you think you need a lawyer to help you with your Fair Hearing, you may be able to get a lawyer at no cost to you by calling your local Legal Aid or Legal Services Office. For the names of other lawyers, call your local Bar Association.

NOTE: If you ask, you will be able to get back the money you had to pay for public transportation, child care and other necessary expenses to go to the fair hearing. If no public transportation is available, you may be able to get back the money you had to pay for another type of transportation. If you are unable to use public transportation because of a medical problem, you may be able to get back the money you had to pay for another type of transportation. However, you may be asked to provide medical verification.

LDSS-4148A (Rev. 07/16)

If you live anywhere in New York State, you may request a Fair Hearing by telephone, fax, online, or by writing to the address below.

Telephone: Statewide toll free request number is 800-342-3334. Please have the notice, if any, with you when you call.

Fax: your Fair Hearing Request to: 518- 473-6735

Online: Complete online request form at <http://www.otda.state.ny.us.us/oah/forms.asp>

In writing: For notices, fill in the supplied space and send a copy of the notice, or write to:

**NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
P.O. Box 1930
Albany, New York 12201-1930**

Please keep a copy of any notice for yourself

If your request involves any issues about health benefits or services provided under your Managed Care Plan or Managed Long Term Care you can write to:

**NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023**

Fax: your copy of the notice, or your Written Request to (518) 473-6735

You may also make your request in person by walking into the offices listed below.

Walk-In Bring a copy of the notice, or ask for a hearing on a matter not based on a notice, to:

**Office of Temporary & Disability Assistance
Office of Administrative Hearings
14 Boerum Place
Brooklyn, New York**

or

330 W. 34th Street, 3rd Fl., New York, New York

or

**NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Fair Hearings
P.O. Box 1930
Albany, NY 12201-1930**

<p>NOTE: For New York City emergency fair hearings only – Call (800) 205-0110. Do not use this telephone number for anything except emergencies. Requests that do not involve emergencies will not be taken at this number.</p>
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6. TEMPORARY ASSISTANCE EMPLOYMENT RIGHTS

For Temporary Assistance

As a Temporary Assistance recipient, you may be expected to look for work and to participate in activities that will help you get and keep a job. If you do not have a high school diploma or equivalent, such as a GED diploma, you may be eligible and may be required to participate in an education activity to improve your basic skills and/or obtain a high school equivalency diploma. You will likely also be expected to participate in employment, work experience or other activities along with the education activity. Let your worker know if you are interested in participating in an education activity.

If you believe you will not be able to comply with some or all the employment requirements because of domestic violence, you may be eligible for a temporary waiver of these requirements. To request a waiver, you must complete the Domestic Violence Screening Form or notify your worker that you want to see a domestic violence liaison for an assessment.

If you have a physical or mental health impairment that substantially limits one or more major life activities, have a record of such impairment or are regarded as having such impairment, you may have rights under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990. Physical or mental health impairments include, for example, learning disabilities, mental retardation, depression, mobility impairments, and hearing or vision impairments. Having a disability will not

disqualify you from receiving Temporary Assistance.

The local department of social services will ask you if there is anything, including a physical or mental health impairment, that might affect your ability to participate in work activities, including employment. You are not required to tell the local department of social services if you have a disability if you do not want to, however, you may then be required to participate in work activities, including employment, without an accommodation for your disability. Any health information you provide to the local department of social services will be kept confidential and will be used to determine if you need services and reasonable accommodations to help you participate in work activities. Reasonable accommodations may include, for example, reduced or changed work hours to allow for disability related appointments, accessible work sites for those with mobility impairments, and specialized programs. If your disability is adequately documented, the local department of social services will assign you to work activities that are consistent with your limitations.

If you do not agree with your work activity assignment or you think you are unable to perform the assignment due to health related limitations, including if you do not think the local department of social services adequately accommodated your disability, you may request a conciliation conference. A conciliation conference is a meeting with staff from your local department of social services to talk about why you disagree with your work activity assignment. A person who is not directly responsible for your case will be present at the conference. This person will try to resolve any problems. If you request a conciliation conference, you are still expected to continue to comply with your work activity assignment. You may also request a fair hearing to tell an Administrative Law Judge why you do not agree with your assignment. If you are assigned to an employment or training program provided by a religious organization, you have the right to receive services of similar value from a different provider.

If your local department of social services assigns you to a work activity assignment and you do not do what you are required to do, you may be offered the opportunity to request a conciliation conference. A conciliation conference is a meeting with staff from your local department of social services to explain why you did not participate. If the local department of social services decides you had good cause for not participating when you were required to, you may not be sanctioned. If you do not agree with your local department of social services that you did not have good cause for not participating, or if you do not request a conciliation conference when you are offered one, and your local department of social services sanctions you, you may also request a Fair Hearing to tell an Administrative Law Judge why you did not participate.

You should inform the local department of social services if you need help with expenses, such as child care or transportation in order to participate in work activities, including employment. If you indicate that you need help with any employment or work activity related expenses, the local department of social services will inform you how to access any available services and provide reimbursement to cover the costs of expenses that the district determines are necessary for you to participate in work activities. If you are unable to locate necessary child care for a child who is under thirteen years of age, the local department of social services will help you locate child care.

For Food Stamp Benefits

If you do not agree that you are able to work, you should notify the local department of social services that you believe you should be exempt from participation in work activities. You will be notified by the local department of social services determination regarding your claim. If the local department of social services disagrees with you, you may request a fair hearing to tell an Administrative Law Judge why you think you are not able to work.

If you are required to participate in food stamp work activities, you may be able to get help paying for certain work-related expenses. You also may be able to receive assistance with child care costs.

You should inform the local department of social services if you need help getting child care or paying for work-related expenses such as transportation. If you are unable to locate necessary child care for a child who is under thirteen years of age, the local department of social services will help you locate child care.

For Medical Assistance

Medical Assistance has no employment requirements. However, to be eligible for the Medicaid Buy-In Program for Working People with Disabilities, an individual must be engaged in work.

7. RIGHTS OF CHILDREN AND FATHERS WHEN PATERNITY IS ESTABLISHED IN COURT

When a court has established who is the father of a child, the father and the child each may have rights, as explained below:

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| <p>A. The child may have the right to:</p> <ul style="list-style-type: none">• Disability benefits if the father becomes disabled• Death benefits if the father dies• An inheritance when the father dies• Child support payments until the age of 21 | <p>B. The father may have the right to:</p> <ul style="list-style-type: none">• Get custody of the child• Visit with the child• Take part in any foster care, adoption or other permanency planning for the child• Inherit from the child |
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8. RIGHTS REGARDING PATERNITY AND CHILD SUPPORT LEGAL ACTIONS AND REPRESENTATION

You have the right to be told about any paternity or child support court actions involving you or your child, including the right to be informed of the time, date and place of such court actions. You have the right, and may be required to, appear in court at the time of any paternity or child support action involving you or your child.

If any paternity or child support actions are brought in court, your local department of social services will have a lawyer or other representative who will **only** try to prove your child's paternity. This lawyer or representative only represents the local department of social services and **not** you personally. This lawyer or representative **will not** handle any custody, visitation or other legal issues not related to child support.

Any information you give this lawyer or representative **may not** stay private. Any information indicating welfare fraud may be reported.

If you think you need a lawyer to help you, you may be able to get a lawyer at no cost to you by calling your local Legal Aid or Legal Services office. For the names of other lawyers, call your local Bar Association.

If you believe compliance with paternity establishment or child support enforcement will place you or your children at risk due to domestic violence, you may be eligible for a temporary waiver from some or all child support activities. To obtain a waiver, you must complete the Domestic Violence Screening Form or notify your worker that you want to see a domestic violence liaison for an assessment.

9. RIGHTS REGARDING CHILD CARE

You have the **right to receive information** about how to locate a child care provider. This information could be provided in a number of ways.

- Your worker can give you the name and telephone number of a Child Care Resource and Referral Program or other similar program which can help you find a child care provider; **or**
- Your worker can give you a list with the name, address and telephone numbers of child care providers.
- You have the **right to choose** the child care provider for your child. This could be a provider who is licensed or registered or it could be a relative, a friend of the family or a trusted neighbor. If you choose someone who is not licensed or registered they will need to complete a child care enrollment form to see if they are eligible for payment.

You have the right to choose child care in lieu of Temporary Assistance (TA). You may decide that instead of receiving TA, what you really need is help paying for child care. Families who are applying for or are receiving TA and need child care in order to work, may be eligible for a child care guarantee for working families. Eligibility for this child care guarantee does **not** have a 60-month time limit. You can continue to receive child care benefits for as long as you are eligible.

You are eligible for this guarantee if you are applying for TA and choose child care instead of TA or if you are receiving TA and ask that your TA case be closed, and:

- your income is within TA limits;
- you are working the number of hours required by TA;
- you need child care for a child under age 13 so you can work;
- you are using an eligible child care provider; and

If you are eligible for TA and decide that all you really need is child care, your worker can tell you how to apply for the child care guarantee. If you are already receiving TA and are otherwise eligible for the program, you will need to close your TA case in order to get the child care guarantee. If you change your mind and decide you need Temporary Assistance, you can apply at any time.

If you chose to receive child care assistance instead of receiving TA and child care, you will have to pay part of your child care costs. This is called your family share or fee. The amount that you pay depends on your income. Additionally, if your provider charges more than the market rate, you will need to pay the amount that your child care provider charges above the market rate.

You may still be eligible to get Food Stamp benefits even if you request to change your application for Temporary Assistance to a request for child care assistance or to close your TA case. If you change your application or close your TA case to get child care assistance then you will receive a separate eligibility determination for Food Stamp benefits.

If you applied for Medical Assistance at the same time you applied for Temporary Assistance and Food Stamps, and you choose to receive child care assistance only, your application will be referred to the Medical Assistance program for a separate determination. If you are currently receiving Temporary Assistance and request that your case be closed, your Medical Assistance will continue unless you request that it be closed or your circumstances have changed so that you are no longer eligible for Medical Assistance. You should talk to your Medical Assistance worker, if you are requesting that your case be closed due to increased earnings. You may still be eligible for Medical Assistance or you maybe eligible for Transitional Medical Assistance.

You have the **right to request a fair hearing** if you have been denied child care benefits, your benefits have been reduced or discontinued or you have been charged with an overpayment.

For Temporary Assistance Recipients:

Your **Temporary Assistance cannot be reduced or ended** because you are not participating in work activities **if** the reason you are not participating is because **you don't have appropriate, accessible, affordable and suitable child care for a child under the age of 13.**

If you are unable to find a child care provider on your own, your worker must provide you with **two choices** of child care providers. At least one of these choices must be a child care provider who is licensed or registered with the State of New York or with New York City Department of Health and Mental Hygiene.

You have the **right to be excused from your work activity** if you have a child under 13 years of age and you are unable to find a child care provider that is **appropriate, accessible, affordable and suitable**. However, the time you are excused from your work activity will still count toward your 60-month limit of federally funded and cash Temporary Assistance.

- **Appropriate** means the provider is open for the hours and days needed for you to participate in your work activity, and is willing to care for your child(ren) including any special needs your child has.
- **Accessible** means that you are able to get to the provider by driving your own car or by public transportation and the provider is located within a **reasonable distance** from your home and work. Your worker must tell you what is considered a reasonable distance for your community.
- **Suitable** means the physical or mental condition of a legally exempt (informal) provider or the physical condition of the legally exempt home would not be detrimental to the health or safety of your children.
- **Affordable** means you have enough money to pay your share of the child care cost, if you are required to pay a share of the costs.

You have the **right to request a fair hearing to appeal the decision to reduce or end your Temporary Assistance** if you feel your worker made the wrong decision regarding your refusal to comply with your work activities due to a lack of child care.

10. RIGHTS REGARDING SUPPORT PASS-THROUGH AND EXCESS SUPPORT PAYMENTS - TEMPORARY ASSISTANCE

When you apply for Temporary Assistance, which includes Family Assistance and Safety Net Assistance, and, for as long as you receive Temporary Assistance, you assign to you local department of social services **all** of your rights to receive support payments on your own behalf and any rights to support on behalf of any family member for whom you are applying for, or receiving, Temporary Assistance.

Effective October 1, 2009, when you apply for Temporary Assistance, and, for as long as you receive Temporary Assistance, you assign to your local department of social services your rights to receive support payments on your own behalf and any rights to support on behalf of any family member for whom you are applying for or receiving assistance, but it is **limited** to the amount of support that accrues while you or the family member receive Temporary Assistance.

Support Pass-Through: A portion of any assigned child support collections for the current court-ordered obligation, when paid timely, will be given to you in addition to the monthly Temporary Assistance grant. The portion of the child support payment given to you is called a "pass-through payment." The pass-through payment is the lesser of an amount up to the first \$100 of current support collected each month or the amount collected toward the monthly court-ordered obligation. Effective January 1, 2010, the \$100 pass-through payment will continue where there is one individual under the age of 21 active in the Temporary Assistance case. Where there are two or more individuals under the age of 21 active in the same Temporary Assistance case, the pass-through payment will increase to the lesser of an amount up to the first \$200 of current support collected each month or the amount collected toward the monthly court-ordered obligation. This pass-through payment is not counted against your Temporary Assistance grant, but may reduce your Food Stamp Benefits.

When your local department of social services receives current support for you, you will be sent a Monthly Report of Support Received. This monthly report tells you whether or not you will receive a pass-through payment, how much, and why. You should compare this report to your benefits receipts for that month.

You will get the pass-through payment the month after your local department of social services receives current support payments for you. The pass-through payment is paid once a month.

A support payment is "current" if it is paid in the month when it is due. A support payment might be paid on time by the noncustodial parent but received late by your local department of social services. This might happen if an employer is taking the support money out of the noncustodial parent's paycheck but sending it in late. Current support also might be received late if the noncustodial parent is making the support payment in another county or state and that office sends the payment in late. As long as the noncustodial parent pays the support in the month when it is due, and your local department of social services receives the support, you will be paid a pass-through payment for that month.

Excess Support Payment: Assigned child support collections received will be paid to the State and to the local department of social services for reimbursement of up to the total amount of Temporary Assistance that has been paid to you. You are entitled to receive any support collected that **exceeds** the total amount of Temporary Assistance paid to you, in addition to any pass-through payment that you are entitled to receive.

Desk Review: If you feel that you may be entitled to a pass-through payment or excess support, you may call **1-888-208-4485** to obtain a form for requesting a Desk Review of your payments. You should request a Desk Review soon after you believe a mistake has been made because a First-Level Desk Review only covers payments for the calendar year of your request and the year before the year of your request. After you send in the completed form and documentation, the local department of social services will review your case and issue you a written response within 45 calendar days of the date that your written request is received, or under certain circumstances, within 75 calendar days. As part of this Desk Review, you will be able to give information to the desk review staff who will review the appropriate records and any information you provide to make a determination as to whether you are owed any child support. You may ask for help getting information to prove that you are owed more money.

If after the First-Level Desk Review has been completed you are not satisfied with the determination, you may ask for a Second-Level Desk Review by completing the Second-Level Desk Review Form provided with your First-Level Desk Review determination. You must request a Second-Level Desk Review within 20 days of the date of the First-Level Desk Review determination. The Second-Level Desk Review is a review conducted by the New York State Office of Temporary and Disability Assistance (OTDA) of the First-Level determination and of any additional but previously unavailable documentation that you provide. The NYS OTDA will conduct the review and will provide you with their determination within 30 calendar days of the date of your request. If you have any questions about this process or need an additional copy of the Second-Level Desk Review request form, you may call 1-888-208-4485.

11. YOUR RIGHT TO ASK FOR RESTRICTED PAYMENT FOR TEMPORARY ASSISTANCE

If you are applying for or are getting Temporary Assistance from the Family Assistance program, you have the right to ask your local department of social services to "**restrict**" all or part of your Temporary Assistance grant to pay your bills such as heat, rent or utilities directly. To "**restrict**" your Temporary Assistance means that a part of your Temporary Assistance will be paid to someone else for you.

For example, if you ask your local department of social services to restrict your rent, your rent money will be sent right to your landlord every month instead of being given to you in your Temporary Assistance cash benefit. To ask that your Temporary Assistance be restricted, ask for a "Request For Voluntary Restricted Payments" form, fill it out and return it to your local department of social services.

You can stop a voluntary restriction by writing to your local department of social services. The voluntary restriction must be stopped within 30 days of when the local department of social services gets your written request. However, the local department of social services may decide to restrict all or part of your grant for administrative ease.

If you request that your grant be restricted to pay for your heat and/or domestic energy bills, your heating allowance and/or budget billing amount for your domestic energy will be restricted from your grant. At least once a year the local department of social services will compare your energy bill(s) to the amount(s) restricted from your grant. If the total amount billed is less than the amount restricted from your grant, the local department of social services may pay you the difference in cash. If the amount billed is more than the amount restricted from your grant, the difference will be recouped from your future Temporary Assistance grants.

Your local department of social services may refuse to restrict your payment when your Temporary Assistance grant is less than the bill you owe.

You can ask about restricted payments even if your Temporary Assistance does not come from the Family Assistance program.

12. YOUR RIGHTS IF YOU ARE SUSPECTED OF FRAUD

If you find out that you are being investigated because your worker thinks you did not tell the truth about your case, you should talk to a lawyer. If you are charged with welfare fraud in criminal court, the court will, if you are eligible, assign a lawyer to represent you at no cost.

13. YOUR RIGHT TO REGISTER TO VOTE

Any person who wishes to register to vote, regardless of whether they are applying for assistance, can obtain Voter Registration form and assistance in filling out that Voter Registration Form at a government office accepting applications for benefits described in this book. That office will also accept a completed Voter Registration Form and forward it to the local board of elections. For further information, you can contact the New York State Board of Elections at 1-800-FORVOTE (367-8683).

14. YOUR RIGHTS REGARDING FAITH BASED SERVICE PROVIDERS

If any of the services and benefits provided are delivered through a religious organization, you have the right to receive services of similar value from a different provider.

YOUR RESPONSIBILITIES

1. GENERAL RESPONSIBILITIES

If you are applying for, or getting Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services, Child Care benefits or other help, you must:

- answer all questions completely and honestly. False answers may result in penalties, including civil or criminal penalties;
- be interviewed. If you miss an interview without telling your worker why, your application may be denied or your case may be closed. If you miss an interview and want to reschedule one, it is your responsibility to tell your worker.
 - For Food Stamp Benefits, reschedule a missed interview before the 30th day after the date you applied to avoid losing Food Stamp Benefits.
 - For child care benefits, if you are applying only for child care benefits you can apply by mail. If your worker cannot determine your eligibility based on what you mailed in, you may be asked to come for an interview.
 - For Medical Assistance, a personal interview is conducted with you or your representative. You may be interviewed by a facilitated enroller, if you are not applying for long term care.
- give your worker the papers and the information needed to find out if you can get help. If you cannot get these papers and information, your worker must try to help you;
- If you are able to work, and are applying for Temporary Assistance, you must accept any job offered to you that you are able to do, even if it would pay you less than Temporary Assistance does. Temporary Assistance will pay you a supplemental grant if you need it.
- If you are a non-legally responsible caretaker relative applying for Temporary Assistance for minor children and not receiving Temporary Assistance yourself, you must provide certain personal information that the federal government requires us to collect and report.
- If minor children applying for or receiving Temporary Assistance have non-applying or non-recipient brothers or sisters who are also minor children living in the same household, you must provide certain information on the non-applying or non-recipient children that the federal government requires us to collect and report.
- You must apply for and pursue any benefit that would reduce and/or eliminate your need for Temporary Assistance.

2. RESPONSIBILITY TO PROVIDE TRUTHFUL AND ACCURATE INFORMATION

When you are applying for or getting help, or when you are a non-legally responsible caretaker relative applying for or getting Temporary Assistance for minor children and not applying for or getting help yourself, you will be asked to provide proof of certain things such as those listed in "**Your Responsibilities**", **Section 3**, "**Responsibility To Provide Proof**".

If you are applying for or getting Temporary Assistance or Food Stamp Benefits, and you or someone else in your case has been found guilty of lying about or concealing money, property or resources, you may lose your Temporary Assistance or Food Stamp Benefits. This is called an **Intentional Program Violation (IPV)**.

If you are found to have committed an IPV by a court or a State Administrative Hearing, you will be "disqualified". This means that you cannot get Temporary Assistance or Food Stamp Benefits for a certain period of time. The length of time will depend on whether you get Temporary Assistance or Food Stamp Benefits and whether you have been found guilty of an IPV before and the monetary amount of the violation.

Besides losing your assistance, if you are found to have committed an IPV, you will have to pay back to your local department of social services the money or Food Stamps Benefits you should not have gotten.

You will either have to pay back the money or Food Stamp Benefits or when you begin to get your benefits again, they will be reduced until what you owe is paid back. If you live with other people and the other people continue to get benefits while you are disqualified, the other people might also get less benefits.

If you are disqualified from getting Temporary Assistance, your Food Stamp Benefits eligibility will be reviewed to determine if you are eligible for continued Food Stamp Benefits. Your Medical Assistance eligibility may be reviewed to determine if you are eligible for continued Medical Assistance.

If you are convicted in a federal or State court of having made a fraudulent statement or representation about your place of residence in order to receive Temporary Assistance or Food Stamp Benefits from two or more states at the same time, you will be ineligible for ten years.

If you did not provide truthful and accurate information when applying for or getting child care benefits, you will have to pay back any benefits that you were not eligible for. If you are convicted of fraud, additional penalties may apply.

If you receive child care assistance or received child care assistance and your case is closed, and you have been convicted of, or voluntarily admit to, fraudulently receiving child care assistance, you will have your child care services suspended or terminated and will not be eligible for subsequent child care services for a period of time determined by the time periods established for Intentional Program Violations listed below.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES FOR TEMPORARY ASSISTANCE:

If you have committed a Temporary Assistance IPV, you will not be able to get Temporary Assistance as follows:

- 6 months Disqualification if this is
- your first IPV, and
 - the IPV is less than \$1,000
- 12 Months Disqualification if this is
 - your second IPV, or
 - the IPV is between \$1,000 and \$3,900
- 18 Months Disqualification if this is
 - your third IPV, or
 - the IPV is greater than \$3,900
- 5 year Disqualification if this is your fourth or subsequent offense

Anyone who makes a false statement about who he/she is or where he/she resides in order to receive multiple Temporary Assistance benefits will not be able to get Temporary Assistance for ten years.

Anyone who is fleeing to avoid prosecution, custody or confinement for a felony, or who is violating a condition of probation or parole, is not eligible to receive Temporary Assistance.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES FOR MEDICAL ASSISTANCE:

Medical Assistance does not have its own IPVs. Single individuals and childless couples who are disqualified from Temporary Assistance because of an IPV are also ineligible for Medicaid. All other applicants/recipients who are disqualified for a TA IPV will have their Medical Assistance eligibility determined separately.

INTENTIONAL PROGRAM VIOLATION (IPV) PENALTIES FOR FOOD STAMP PROGRAM:

If you have committed a Food Stamp Benefits Program IPV, you will not be able to get Food Stamp Benefits as follows:

- One year disqualification if this is
 - the first IPV
- Two years Disqualification if this is
 - the second IPV
- Permanent disqualification if this
 - is the third IPV.
- A court can also, in certain instances, bar an individual from receiving Food Stamp Benefits for an additional 18 months.

Anyone found guilty in a court of law of selling or getting **firearms, ammunition or explosives** in exchange for Food Stamp Benefits will never be able to get Food Stamp Benefits again.

Anyone found guilty in a court of law of buying or selling **controlled substances** (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for Food Stamp Benefits will not be able to get Food Stamp Benefits for 2 years for the first

offense and permanently for the second offense.

Anyone found guilty in a court of law of trafficking in Food Stamp Benefits worth \$500 or more will never be able to get Food Stamp Benefits again. Trafficking includes the illegal use, transfer, acquisition, alteration, or possession of Food Stamp Benefits, authorization cards, or access devices.

Anyone who makes a false statement about who he/she is or where he/she resides in order to receive multiple Food Stamp Benefits will not be able to get Food Stamp Benefits for ten years.

Anyone who is fleeing to avoid prosecution, custody or confinement for a felony, or who is violating a condition of probation or parole, is not eligible to receive Food Stamp Benefits.

3. RESPONSIBILITY TO PROVIDE PROOF

When you are applying for or getting help, you will be asked to provide proof of certain things such as those listed below. Your worker will tell you which of these things you **must** prove. Not all of these things are required for every program. You may have to prove some things for one program and not for another. If you bring proof with you when you first come in to apply for assistance, you may be able to get help sooner.

If you drop documentation off at your local department of social services, you should ask for a receipt to prove what documentation you left. The receipt should have your name, the specific documentation that you dropped off, the time, date, district name and the name of the social services worker who provided the receipt.

If you cannot get the proof you need, ask your worker to help you. If the local department of social services already has proof of the things that do not change, such as your social security number, you do not need to prove them again.

Note: Listed are the most common documents used; the list is not complete. There are other documents that can be used.

WHAT YOU MAY BE ASKED TO PROVE

SOME EXAMPLES OF HOW TO PROVE IT

- | | |
|--|---|
| • Who you are | Photo ID, driver's license, U.S. passport |
| • Age of each applying household member | Birth or baptismal certificate, hospital records, driver's license |
| • Where you live | Current rent receipt, mortgage records, statement from non-relative landlord |
| • Shelter Expenses | Current rent receipt, current lease, mortgage records, property and school tax records, sewer and water bills, fuel bills, utility bills, telephone bills |
| • Social Security Numbers | Social Security Card or proof that you have applied for social security numbers for everyone in your household who is applying for help. |

NOTE: ***For Temporary Assistance, Food Stamp Benefits and Medical Assistance Program***, if we ask you for your social security number, you must provide us with the number if you have one. If we can not verify your number with the Social Security Administration, you will have to provide proof of your social security number. If you do not have a social security number, you must apply for one in order to receive benefits.

For Services Program, some Services, such as foster care, child protective, child preventive, and counseling, are funded by a variety of funding sources, many of which require that a social security number be provided. While applicants for some Services are not required to provide a social security number, these Services may be unavailable to you if you do not furnish a social security number. We are therefore requesting a social security number of all applicants for these Services, in order to help them get all the benefits for which they may qualify.

- | | |
|--|--|
| • Citizenship or Immigration Status | Birth certificate, U. S. passport, military service records, naturalization certificate, and United States Citizenship and Immigration Services documentation. |
|--|--|

NOTE: *For the Food Stamp Benefits Program*, citizenship must be documented only if questionable.

The local department of social services district must report the name and address and other identifying information known of any alien who has been determined by the Immigration and Naturalization Service or the Executive Office of Immigration Review, such as in a Final Order of Deportation, to be unlawfully in the United States. This information may be shared with the Department of Homeland Security. This does not apply for Medical Assistance.

For Services Program, some Services are available only to persons with a proper immigration status. We are therefore requesting the Immigration status of all applicants in order to determine the Services for which applicants may qualify.

For Child Care Benefits, you must prove that any child who is receiving child care benefits is legally residing in the United States.

NOTE: *For the Medical Assistance Program*, Identity and citizenship or satisfactory Immigration status must be documented. For the purpose of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for the purpose of Medicaid.

Documents which Establish both Citizenship and Identity

- U.S. passport;
- Naturalization Certificate (N-550 or N-570);
- U.S. Citizenship Certificate (N-560 or N-561).

Documents which Establish Citizenship but also require one identity document from the Identity Documentation list

- U.S. Birth Certificate showing birth in: One of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 1/13/1941), Virgin Islands of the U.S. (on or after 1/17/1917), Northern Mariana Islands (after 11/4/1986 (NMI local time), or Guam (on or after 4/10/1899);
- Certification of Report of Birth (DS-1350);
- A Report of Birth Abroad of a U.S. Citizen (FS-240);
- Certification of Birth issued by Department of State (Forms FS-545 or DS-1350);
- U.S. Citizenship Identification Card (I-197 or (I-179);
- American Indian Card (I-872);
- Northern Mariana Card (I-873);
- Evidence of civil service employment by U.S. government (before 6/1/1976);
- Official Military record of service;
- Final adoption decree;
- Federal or State census record; or
- The following documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date:
 - Extract of hospital record on hospital letterhead;
 - Life or health or other insurance record;
 - Institutional admission papers from a nursing facility, skilled care facility or other institution; or
 - Medical (clinic, doctor, or hospital) record;

- Other documents: One of the following and must show a U.S. place of birth:
 - Seneca Indian tribal census record;
 - Bureau of Indian Affairs tribal census records of the Navajo Indians;
 - U.S. State Vital Statistics official notification of birth registration;
 - U.S. public birth record that is amended more than 5 years after the person's birth; or Statement signed by physician or midwife who was in attendance at the time of birth.
 - Written affidavit (to be used only in rare instances).

Documents which Establish Identity

- Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska native tribal document.
- Any identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act (INA), such as:
 - A valid driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color;
 - School identification card with a photograph of the individual;
 - U.S. military card or draft record;
 - Identification card issued by Federal, State, or local government with the same information included on driver's license;
 - Military dependent's identification card;
 - Native American Tribal document; or
 - U.S. Coast Guard Merchant Mariner card.

NOTE: For children under 16, school records may include nursery or daycare records. If none of the above documents in the preceding charts are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of birth of the child and cannot be used if an affidavit for citizenship was provided.

Evidence that establishes U.S. citizenship for collectively naturalized individuals

Puerto Rico

- Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's statement that he or she was residing in the U.S. possession or Puerto Rico on 1/13/1941; or
- Evidence that the applicant/recipient was a Puerto Rican citizen and the applicant's/recipient's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain.

U.S. Virgin Islands

- Evidence of birth in the U.S. Virgin Islands, and the applicant/recipient's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927;
- The applicant/recipient's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on 1/17/1917, citizen and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/ 25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the applicant/recipient's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932.

Northern Mariana Islands (NMI)(formerly part of the Trust Territory of the Pacific Island (TTPI))

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time);
- Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time); or
- Evidence of continuous domicile in the NMI since before 1/1/1974 and the applicant/recipient's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time).

NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

Immigrant Status

- The following are the most common United States Citizenship and Immigration Services (USCIS) Forms:
 - I-551 Resident Alien Card;
 - I-94 Arrival-Departure Record;
 - I-688B or I-766 Employment Authorization Card;
- United States Citizenship and Immigration Services (USCIS) Form I-797-Notice of Action; or
- Evidence of continuous United States Residence prior to 1972.

NOTE: If you are applying only for Medical Assistance, you do not have to tell us about your citizenship or immigration status, if you are:

- pregnant; or
- an undocumented immigrant applying for Medical Assistance coverage because of an emergency medical condition. (See Medical Assistance section of Book 2, LDSS-4148B for more information on citizenship or immigration status).

- **Whether you are Drug/Alcohol Dependent** Alcohol/Drug screening assessment which may include a drug test. This does not apply to many Medical Assistance applicants, nor does it apply to Family Health Plus, Medicaid Buy-in Program for Working People with Disabilities, Medicare Savings Program or to the Family Planning Benefit Program.
- **Earned Income** Current pay stubs, statement from employer, tax records, business records, statement from roomer or boarder of amount paid for lodging.
- **Unearned Income**

<p><i>Examples of Unearned Income are:</i></p> <ul style="list-style-type: none"> - Child Support or Alimony - Social Security Benefits - Veteran's Benefits - Unemployment Insurance Benefits - Interest and Dividends - Educational Grants and Loans - Worker's Compensation 	<p><i>Examples of Proof of Unearned Income are:</i></p> <ul style="list-style-type: none"> Statement from person paying support, or alimony Current benefit check or current award letter Current benefit check, current award letter, official correspondence from Veteran's Administration Official correspondence from New York State Department of Labor Statement from bank, credit union or broker Statement from school or bank current award letter Current award letter or check stubs
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- **Resources**

Examples of Resources are:

- **Bank Accounts**
- **Checking Accounts**
- **Burial Trust or Fund**
- **Burial Plot or Agreement**

- **Life Insurance**
- **Real Estate Other Than Where You Live**
- **Motor Vehicle**
- **Stocks and Bonds**

Examples of Proof of Resources are:

- Bank books or credit union records
- Bank statements
- Bank statement or copy of funeral agreement
- Statement from cemetery, funeral director or church, copy of funeral agreement
- Insurance Policy
- Deed, appraisal/estimate of current value by real estate broker

- Registration, title, financing information
- Stock certificates, bonds

- **School Attendance of Those Attending School**

School records, statement from school

- **Health Insurance**

Insurance policy, insurance card, statement from provider of coverage, Medicare card

- **Unpaid Rent or Utilities**

Copy of each bill, statement from landlord or utility company

- **Paid or Unpaid Medical Bills**

Copy of each bill and proof of payment if a paid bill

- **Noncustodial parent**

Death certificate, survivor 's benefits, divorce papers, Veteran's Assistance or military records

- **Disabled/Incapacitated/Pregnant**

Statement from medical professional, proof of Social Security Disability or Supplemental Security Income (SSI) benefits

- **Other Expenses/Dependent Care Expenses**

Cancelled checks or receipts, statement from child care provider, court order, statement from aide or attendant

- **Job Search**

Completion of job applications or the Job Search Handbook

If you are applying for **Services (other than Foster Care) only**, you do **not** have to provide proof of the following items:

- **Shelter Expenses**
- **Resources**
- **Unpaid Rent or Utilities**
- **Health Insurance**
- **Paid or Unpaid Medical Bills**
- **Other/Dependent Care Expenses**

If you are applying for **Medical Assistance** only and are seeking coverage of long term care services, you will have to provide proof of your resources. Pregnant women or persons applying for the Family Planning Benefit Program do not have to tell us about their resources. Usually, children up to the age of nineteen do not have to tell us about their resources.

If you are not seeking coverage of long term care services, you will have to tell us about your resources, but you are allowed to attest to the amount of your resources rather than provide proof. When you apply for or renew your Medical Assistance eligibility, you will be told if you must provide proof of your resources.

4. RESPONSIBILITY TO ENROLL IN THE AUTOMATED FINGER IMAGING SYSTEM (AFIS)

If you are applying for or receiving regular or emergency Temporary Assistance or Food Stamps Benefits, you must enroll in the Automated Finger Imaging System (AFIS) if you are an adult (18 years of age or older) or if you are the head of household. For the Medical Assistance program, only those applicant/receipts whose Medical Assistance Identification card must contain a photo image are required to enroll in AFIS. This requirement does not apply to Family Health Plus or to the Family Planning Benefit program. Generally, for Medicaid only applicants and recipients, all individuals age 18 and over whose benefit card requires a photo ID must enroll in AFIS. However, there are specific exemptions to this rule, and they may vary by the county in which you live. If you have any questions about whether or not you must be finger-imaged, contact the local department of social services office in your county and inquire how this requirement may apply to your specific situation.

5. RESPONSIBILITY TO REPORT CHANGES

General Information On Changes

If your situation changes in any way while you are waiting to hear about your Application, you should let your worker know as soon as possible.

-You must inform your worker right away of any change in your situation such as income, employment, living arrangements or child care arrangements, or other changes which may affect your continued eligibility or the amount of your benefit.

For Temporary Assistance, you must report changes within **10** days of the change. There is **only one** exception. If you are receiving temporary assistance for a child and you know that the child will be absent from home for 45 days or more, you must report that change within **5** days of knowing that the child will be absent for that long. These reporting timeframes must be met, even when you receive other benefits, such as Food Stamps and Medicaid, and those programs have different reporting requirements. **This is very important for Temporary Assistance since failure to report changes may affect your ongoing eligibility.**

You must inform the agency of any change including, but not limited to, any change in your needs, (for example, the amount you pay for rent goes up or down), income, resources, living arrangements, residence/address, household size, employment, health status, new information about your child's absent parent, health insurance that becomes available to you or your child, immigration/citizenship status or pregnancy. If you are not sure if you should report a change, **REPORT**.

If you are only receiving Food Stamp Benefits and have not been informed that you are a six-month reporter, you must report within 10 days:

- Changes in any sources of income for anyone in your household.
- Changes in your total household earned income, when it goes up or down by more than \$100 a month.
- Changes in your total household unearned income, when it goes up or down by more than \$25 a month, if received from a **public** source (such as Social Security Benefits, Unemployment Insurance Benefits (UIB), etc.).
- Changes in your total household unearned income, when it goes up or down by more than \$100 a month, if received from a **private** source (such as Child Support Payments, Private Disability Insurance Payments, etc.).
- Changes of \$100 or more in court-ordered child support paid to a child outside of the Food Stamp Household.
- Changes in the number of people in your household.
- Your new address, if you move.
- A new or different car, or other vehicle.
- A change in your rent or mortgage expense.
- Increases in your household's cash, stocks, bonds, money in the bank or savings institution, if the total cash and savings of all household members now amounts to \$2,000 or more (\$3,000 or more if one household member is disabled or 60 years old or older).

Whenever you report a change, we must see how it affects your eligibility. Sometimes a change, such as having a baby or your rent going up, may mean that you will get more money or other help. However, a change, such as someone permanently leaving your home, starting a new job or getting more income, may mean that you will get less help.

If you are getting Temporary Assistance, Food Stamp Benefits or Medical Assistance and are **not** required to file Quarterly Reports and are not a Food Stamp six-month reporter, you must tell your worker about changes within 10 days and give your worker proof of the change (such as a pay stub, award letter, landlord statement). If you **do not** report a change, such as more income, and this means that you get too much money or other help, you may have to pay it back. There could also be legal action taken against you. Also, you may not be able to get Temporary Assistance or Food Stamp Benefits for a certain amount of time.

If you are receiving Food Stamp Benefits and are subject to work requirements for Able Bodied Adults Without Dependents (ABAWDS) you must report when your monthly participation in employment or other work activities falls below 80 hours.

The following are examples of the types of changes you must report within 10 days, unless you are a six-month reporter for Food Stamp Benefits:

- You get a job or you lose a job or the hours that you work change.
- The number of people in your household changes. For example:
 - A non-custodial parent returns.
 - A child leaves home or comes back.
- You are pregnant, or you just had a baby.

- Your income or actual work hours change.
- You start or stop getting other income, such as:
 - Social Security Benefits or Supplemental Security Income (SSI)
 - Child support, alimony or any money from a non-custodial parent or spouse
 - Unemployment Insurance Benefits (UIB)
 - Pensions or retirement benefits
 - Worker's Compensation or an accident settlement
 - Money from a roomer, boarder, or from renting a house or an apartment to another person
 - Tax refunds
 - Earned Income Tax Credit (EITC) (Food Stamp Benefits Only)
 - Any other money you get, from working or from other ways.
- Your address changes, the amount of your rent changes or you start getting more help to pay for your housing, such as a subsidy from the government.
- A child under age 18 leaves school (not required if you are applying just for Medical Assistance).
- A child age 16 or older in your home leaves school (not required if you are applying just for Medical Assistance).
- An adult in the home goes into the hospital, gets sick or has a condition which affects his/her being able to work, to participate in an employment activity, or to take care of the children in the household (not required for Medical Assistance).
- You learn any new information about a non-custodial parent, such as where the parent is. (Unless you receive Medicaid Buy-In Program for Working People with Disabilities).
- You get married, separated or divorced.
- You or other family members get health insurance, even if someone else pays for the insurance. (If you are applying for Food Stamp Benefits only, you do not have to report this).
- You or someone who lives with you receives property.
- You or someone who lives with you transfers any property or money.
- You or someone who lives with you gets hurt in an accident, gets medical treatment paid for by Medical Assistance and is suing the person who caused the accident.
- A child will be out of the home for 45 or more consecutive days or 30 days for Medical Assistance.

Requirement To Report A Lump Sum Payment

A lump sum payment is a one-time payment, such as an insurance settlement, an accumulated retroactive monthly benefit, any inheritance or a gambling winning that, when combined with your other countable monthly income, is more than your monthly Temporary Assistance needs (i.e., the Temporary Assistance grant before income is counted). When a one-time payment is small, that is, when it is combined with your other countable monthly income, is less than your monthly Temporary Assistance needs (this is the Temporary Assistance grant before income is counted), it is not considered a lump sum; it is treated as income. If you or any member of your household gets or expects to get a lump sum payment, or a one-time income payment you must tell your worker **right away**. If you get a lump sum payment, and you are getting Temporary Assistance, your grant may be affected as follows:

- 1) If you get a lump sum payment, you may be allowed to keep that portion of the lump sum, which together with your countable resources does not go over the resources limit. This is called the resource set aside. The resource limit is \$2,000 for a person or family, or \$3,000 if the person is, or the family contains, a member age 60 or older.
- 2) If the remaining amount (what is over the resources level) is **less than** your monthly Temporary Assistance needs (this is the TA grant before income is counted), this is the remainder of the lump sum payment, and will be counted as income for the month in which you get it. Be sure to look at the **Exceptions** below.
- 3) If the remaining amount is **more than** your monthly Temporary Assistance needs, you must do one of the following options:

Option 1

- **TURN OVER** the lump sum payment to the local department of social services to pay back the money and help you got in the past.
- If the lump sum payment is less than the amount of the assistance that was paid to you in the past, your case may stay open.
- If the lump sum payment is more than the amount of the assistance that was paid to you in the past, the rules in the "**Keep**" section below apply.

Option 2

KEEP the lump sum payment or the balance of the lump sum payment. Your Temporary Assistance case will then be closed for a certain amount of time. The length of time for which your case will be closed depends on how much the lump sum payment is, and how much your Temporary Assistance needs are.

EXAMPLE: If you get \$4,750 in a lump sum, and had income of \$250 for a total of \$5,000, and you have \$500 in countable resources, you can keep \$1,500 (\$2,000 resource limit-\$500 in resources). This is the resource limit set aside. If you do not turn the remainder (\$3,500) over to the agency, it will be used to figure out how long you cannot get Temporary Assistance. If your monthly Temporary Assistance needs are \$500, your household cannot get Temporary Assistance for 7 months (\$3,500 divided by \$500 needs = 7 months).

Be sure to look at the Exceptions below.

NOTE: If you are receiving child care benefits, some lump sum payments will impact your child care eligibility or the amount of your child care benefits. You must tell your worker about any lump sum payments right away.

EXCEPTIONS

You and anyone who is in your case during the month in which you got the lump sum will not be able to get Temporary Assistance for a certain amount of time, even if the lump sum payment was spent, **unless** one of the following shortens that amount of time:

- Within ninety days of receipt of the lump sum, you document to us that you have used any or all of the lump sum for the following exempt resources:
 - to purchase an automobile that is exempt from the Temporary Assistance resource limit and needed to seek or retain employment or for travel to and from work activities (maximum amount \$9,300, or higher if set by the local department of social services);
 - to open a separate bank account or bank accounts that is exempt from the Temporary Assistance resources limit such as a First or Replacement Automobile Account for the purpose of purchasing an automobile to seek or retain employment (maximum amount \$4,650), or a College Tuition Account for the purpose of paying tuition at a two year post secondary educational institution (maximum amount \$1,400);
 - to purchase a burial plot that is exempt from the Temporary Assistance resource limit; or
 - to purchase a bona-fide funeral agreement (maximum amount \$1,500) that is exempt from the Temporary Assistance resource limit.

If you use up the remainder of the lump sum within 90 days of receipt and document to us that the remainder has gone into one or more of these exempt resources, we will reopen your case back to the date it was closed if you reapply and are found otherwise eligible. If you have questions about using the lump sum on these exempt resources, talk to your worker before you do anything with the money.

Note: If the local department of social services determines you have not used any of these exempt resources (set-asides) for the purposes for which they were intended (i.e. you later close out or remove funds and do not use these bank accounts for the purpose for which these funds are set aside, or you otherwise liquidate burial plots or funeral agreements etc.) the local department of social services may calculate an overpayment of assistance granted.

- Something happens which would make your Temporary Assistance go up if you were still getting Temporary Assistance. For example, your rent goes up or you have a special need such as pregnancy.
- Some or all of the lump sum payment was used for a reason that you could not help. Some examples are: your family is faced with an emergency, you have unusually high household expenses such as fuel or shelter or the money is stolen.
- During the time you are ineligible for Temporary Assistance, a family member gets and pays for medical care that would be covered under the Medical Assistance Program.

If your local department of social services finds out that you have countable property or that you may be getting a lump sum payment, they may place a lien against that property or the lump sum payment. This means that before you get any money from the property or lump sum payment, your local department of social services may take the amount of Temporary Assistance you, your spouse and child(ren), including stepchildren, have gotten. Liens may also be placed on personal injury settlements and any real property that you own. Real property includes the home you own and live in, as well as other real estate you may own.

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If you are receiving Food Stamp Benefits and you receive a non-recurring lump sum, it will be counted as a resource starting in the month it was received and will not be counted as income.

If you are receiving Medical Assistance, a lump sum payment may affect your eligibility. You must tell your worker right away about any lump sum payments you receive.

6. RESPONSIBILITIES REGARDING YOUR COMMON BENEFIT IDENTIFICATION CARD (CBIC)

To access Temporary Assistance cash or Food Stamp Benefits you will need your Common Benefit Identification Card (CBIC) and Personal Identification Number (PIN). Your CBIC and your PIN will act as your signature when you access your benefits.

It is your responsibility to keep track of your account balances. If you suspect that your accounts have been accessed without your knowledge, you should contact the EBT Customer Service hotline to disable your CBIC. After doing that you should contact your worker to receive a replacement card.

You will be held responsible for Cash and Food Stamp Benefits that are accessed using your CBIC card and PIN. If someone else uses your Common Benefit Identification Card (CBIC) and PIN to access your account, no replacement of benefits will be issued even if you claim that you did not receive those benefits.

It is your responsibility to keep your Personal Identification Number (PIN) secret. You should **NOT** tell your PIN to anyone and you should **NOT** write it on your CBIC card. Never tell your PIN number; even if the person claims to be from the local department of social services and claims to need the information. **NO ONE FROM** the local department of social services **SHOULD EVER ASK YOU FOR YOUR PIN NUMBER.**

If your Common Benefit Identification Card (CBIC) is lost, stolen or damaged call Customer Service at 1-888-328-6399. To get your card replaced you must call your eligibility worker. Misuse or abuse of your card, such as selling it, may result in an investigation by State and/or Federal authorities. Documented violations will result in sanctions including:

- Disqualification from Program, and/or
- Recovery through recoupment/restitution; and/or
- Prosecution

If you have forgotten your Personal Identification Number (PIN) you may call Customer Service at 1-888-328-6399 to select a new PIN. You may also select a new PIN in person at your local department of social services office, or you can ask your worker to have your current PIN mailed to you by the Electronic Benefit Transfer contractor.

You will also need to show your CBIC card to access Medical Assistance services. To access Family Health Plus services, use the card sent to you by the health plan that you have chosen.

7. RESPONSIBILITY TO ACCESS YOUR FOOD STAMP BENEFITS

If you are receiving Food Stamp Benefits with Electronic Benefit Transfer (EBT):

If you are approved to get Food Stamp Benefits, your benefits will be issued to your Electronic Benefit Transfer (EBT) Food Stamp Benefits account on the same date each month. If you do not use your EBT Food Stamp Benefits account for 365 consecutive days, it will fall into expungement status. This means that any Food Stamp Benefits that have been available in your account for at least 365 days will be expunged (removed). Expunged Food Stamp Benefits cannot be replaced.

8. RESPONSIBILITY TO REPAY YOUR BENEFIT OVERPAYMENTS

For Temporary Assistance:

If you get more Temporary Assistance than you should have (overpayment), you must pay it back. If your case is active, we will take back the amount of the overpayment from future Temporary Assistance benefits that you get. If your Temporary Assistance case is closed, the local department of social services will contact you about repayment of the amount you owe.

For Medical Assistance:

Any Medical Assistance Payments made for services you received or premiums paid on your behalf for a period of time when you were not eligible for Medical Assistance may have to be paid back. The local department of social services will contact you about repayment of the amount you owe.

For Food Stamp Benefits:

If you get more Food Stamp Benefits than you should have (overpayment), you must pay them back. If your case is active, we will take back the amount of the overpayment from future Food Stamp Benefits that you get. If your case is closed, you may pay back the overpayment through any unused Food Stamp Benefits remaining in your account, or you may pay cash.

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges.

Any expunged Food Stamp Benefits will be put towards your overpayment. If you apply for Food Stamp Benefits again, and have not repaid the amount you owe, your Food Stamp Benefits will be reduced if you begin to get them again. You will be notified, at that time, of the amount of reduced benefits you will get.

For Child Care Benefits:

If you get more Child Care benefits than you should, you must pay them back. If your case is active, your parent share of child costs may be increased or your amount of child care benefits may be reduced until the amount you owe is paid back. If your case is closed, you must still repay the amount you owe or you will not be eligible when you re-apply.

9. EMPLOYMENT RESPONSIBILITIES

For Temporary Assistance:

As an applicant for or recipient of Temporary Assistance you must:

- Continually look for a job, even if you are not assigned to do so, and be prepared to provide evidence that you have been looking for a job. If you need child care in order to look for a job, you must tell your worker.
- Take a job when one is available.
- Participate in an assessment of your ability to work and participate in work activity assignments.
- Unless a determination has been made that you are exempt from work activities, you must participate in work activities as assigned by the local department of social services. You may also be required to get a medical examination or medical statement to participate in a work activity assignment or to verify that you have a medical condition that prevents you from working.
- If a determination has been made that you are exempt from participation in work activities, you may be required to accept medical care or other employment services to restore your ability to work. You may also be required to attend a meeting with the local department of social services and provide evidence to determine whether or not you continue to be exempt from work requirements.
- If you have a temporary waiver from employment activities due to domestic violence, you must meet with a domestic violence liaison prior to the end of each waiver period to determine continued eligibility for the waiver.

If you do not comply with the above listed requirements, you or your household may be denied Temporary Assistance or have your household's Temporary Assistance benefits reduced.

You are considered able to work and must participate in work activities unless you are determined by the local department of social services to be:

- 1) disabled, incapacitated, ill or injured to the extent that you are unable to engage in work activities;
- 2) younger than sixteen years of age or sixty years of age or older;
- 3) under the age of nineteen and attending full time a secondary, vocational or technical school;
- 4) needed in the home full time to care for an ill, incapacitated or disabled household member and you are the only one who can reasonably provide such care;
- 5) pregnant and expected to deliver your child within thirty days;
- 6) needed in the home to care for a child under twelve months of age. This exemption shall last no longer than three months after a child is born unless the local department of social services makes a determination to extend the exemption for up to a maximum of twelve months over your lifetime;
- 7) unable to participate due to a lack of child care;
- 8) unable to participate and you have a waiver from employment requirements due to domestic violence granted by a domestic violence liaison.

Sanctions for Failure to Comply with a Temporary Assistance Work Assignment:

If you are not exempt from participation in work activities and do not comply with the above requirements, you or your household may be denied Temporary Assistance or have your household's Temporary Assistance benefits reduced. The length of time the benefits will be reduced depends on whether or not your household contains a dependent child and the number of times you have failed to comply.

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For a household with dependent children, the household grant will be reduced as follows:

- the first failure to comply – until you comply,
- the second failure to comply – at least three months and until you comply,
- the third failure and subsequent failures to comply – at least six months and until you comply,

For a household without dependent children, the household grant will be reduced as follows:

- the first failure to comply – at least 90 days and until you comply,
- the second failure to comply – at least 150 days and until you comply,
- the third and subsequent failures to comply – at least 180 days and until you comply.

If a local department of social services official determines that you have intentionally misrepresented that you suffer from an impairment that would limit your ability to participate in work activities, your Temporary Assistance grant may be reduced for a period of time. If you are sanctioned for this reason, the sanction also will continue until you are willing to comply with employment requirements and no longer intentionally misrepresent that you suffer from an impairment. (The fact that medical evidence does not support your claim of an impairment does not, in itself, indicate that you will be sanctioned.)

For Food Stamp Benefits:

Unless you are exempt from work registration requirements as an applicant for or recipient of Food Stamp Benefits you must:

- accept a job or a referral to an actual or potential job opening;
- participate in an assessment of your ability to work;
- provide information regarding your employment status and availability for work;
- participate in work activity assignments.

If you do not comply with the above listed requirements, you may lose your Food Stamp Benefits.

You are deemed to be a work registrant and required to comply with work registration requirements unless you are determined by the social services official to be:

- younger than 16 years of age or 60 years of age or older;
- mentally or physically disabled, incapacitated, ill or injured to the extent that you are unable to engage in work activities;
- subject to and complying with a federally funded (TANF) Temporary Assistance work requirements. If you are assigned to TANF work experience, this exemption from Food Stamp Benefits work requirement does not apply;
- responsible for the care of a dependent child under the age of six. If you are participating in TANF work experience, this exemption from food stamp work requirements does not apply;
- responsible for the care of an incapacitated person;
- an applicant for or recipient of Unemployment Insurance Benefits who is required to register for work as part of the unemployment compensation process;
- a regular participant in a drug or alcohol treatment and rehabilitation program and the local department of social services official determines that you are either unable to work or that assignment to work activities is impractical;
- a student enrolled at least half-time in a recognized school, training program or institution of higher education;
- an applicant for Supplemental Security Income (SSI) and Food Stamp Benefits under the joint processing provisions until you are either determined to be eligible for Supplemental Security Income (SSI) and, thereby, exempt from work registration, or determined to be ineligible for Supplemental Security Income (SSI); or
- 16 or 17 years old who is not head of household or who is attending school or an employment training program at least half-time.

Sanctions for Failure to Comply with a Food Stamp Benefits Work Assignment:

If you are not exempt from participation in work activities and do not comply with the above requirements, you may lose your Food Stamp Benefits. The length of time you will lose your benefits depends on the number of times you have failed to comply.

- the first failure to comply – at least two months and until you comply
- the second failure to comply within a three year period – at least four months and until you comply
- the third and subsequent failures to comply within a three year period – at least six months and until you comply

Additional Requirements for Food Stamp Benefits Recipients who are Able-Bodied Adults without Dependents (ABAWDs):

If you are a work registrant, you may also be required to meet additional Food Stamp Benefits eligibility requirements unless you are:

- under 18 years of age or 50 years of age or older;
- pregnant;
- any adult (including a parent) residing in a food stamp household where a member is under 18 years of age.
- unable to work for at least 80 hours per month due to a physical or mental limitation.

If you are a work registrant and not exempt based on one of the above three reasons, you will only be eligible to receive Food Stamp Benefits for three months in every 36 months unless you are:

- working for at least 80 hours a month; or
- participating in a work program approved by the local department of social services for at least 80 hours a month; or
- fully complying with a work experience assignment.

If you want to continue to receive Food Stamp Benefits beyond the three month limit, your local department of social services must make a qualifying work or training opportunity available to you. Contact your worker to discuss what work or training opportunities are available.

If you lose your eligibility for Food Stamp Benefits because you did not meet the above requirement for three or more months during which you received Food Stamp Benefits, you may begin to again receive Food Stamp Benefits, if otherwise eligible, after you have met the requirement for a 30-day period or demonstrate that you will do so within 30 days following your application for Food Stamp Benefits. You would then be required to continue to work or participate in a work program to continue to receive Food Stamp Benefits.

After you reestablish your eligibility for Food Stamp Benefits by working or participating in a program, if you lose your job or are unable to participate in your assigned program, you may be eligible to receive Food Stamp Benefits for up to an additional three months in the same 36-month period without working or participating in a work program.

For Medical Assistance:

Medical Assistance has no employment requirements. However, to be eligible for the Medicaid Buy-In Program for Working People with Disabilities, an individual must be engaged in work.

10. RESPONSIBILITIES REGARDING CHILD CARE

It is your responsibility to **look for and choose** a child care provider. You must pay promptly any family share of the cost of child care services.

For Temporary Assistance Recipients:

If you need child care in order to participate in work activities and are unable to find a child care provider, you must:

- Let your worker know what you have done to find a provider and ask for help in finding a provider.
- Follow up on all referrals you are given by your worker or other programs that are helping you locate a provider. This means you must contact or visit all providers that you are referred to until you are able to choose a provider that is appropriate, accessible, suitable and affordable.
- If you have contacted all providers you were referred to and are still not able to choose any of these providers, you must let your worker know in writing which providers you contacted and when and why you did not choose any of these providers. Your reasons must include one of the following:
 - - The provider was not open for the days or hours needed or could not care for your child's special needs.
 - You were unable to get to the provider by car or public transportation.
 - The provider was not located within a "reasonable distance" from your home or work activity. Each local department of social services has a different meaning of "reasonable distance". The local department of social services must tell you what reasonable distance means in your district.
 - Friends, relatives or neighbors you considered or contacted were unsuitable.
- If you show that you are unable to locate a provider, your worker must offer you a choice of two providers. At least one of these choices must be a child care provider who is licensed or registered with the State of New York or New York City Department of Health and Mental Hygiene. You must choose one of these providers or show why they are not appropriate, accessible, affordable or suitable.

- You must continue to look for a child care provider and follow up on all referrals during the time you are excused from your work activity.
- If you cannot show that you were unable to locate a provider and that the two choices of providers offered to you were not appropriate, accessible, affordable, or suitable, then your Temporary Assistance cash grant will be reduced if you fail to participate in your work activity.

11. RESPONSIBILITIES REGARDING CHILD AND SPOUSAL SUPPORT

As a Temporary Assistance applicant or recipient who is receiving child care, you must cooperate with your local department of social services in establishing paternity and collecting support as follows:

SUPPORT COLLECTION – TEMPORARY ASSISTANCE

When you sign an Application for Temporary Assistance and for as long as you get Temporary Assistance, you turn over to your local department of social services your right to get any support payments owed to you or anyone else for whom you are applying or getting Temporary Assistance.

This means that as long as you get Temporary Assistance, the local department of social services has the right to get current support and past due support (**arrears**).

If you are getting support paid directly to you without a support or paternity order, you must report that money to your local department of social services.

Any collections made will be used to reimburse the local department of social services for assistance provided to you and your children, except for the “pass-through” payment or excess support payments. (**See “Your Rights,” Section 10, Rights Regarding Support Pass-Through And Excess Support Payments-Temporary Assistance”.**)

Even after your Temporary Assistance case closes, your local department of social services will sometimes have the right to the past due support (**arrears**). This means that your local department of social services will take legal action to collect these payments.

As a **Temporary Assistance** applicant or recipient, you must cooperate with the Child Support Enforcement Unit of your local department of social services **unless** you have a good reason not to. If you feel you have a good reason for not cooperating (**“good cause claim”**), you must tell your local department of social services.

Your local department of social services will allow your **“good cause claim”** if:

- your cooperation with the Child Support Enforcement Unit is likely to cause physical or emotional harm to you or your children;
- your child came from a pregnancy due to incest or rape;
- you are working with an authorized adoption agency to have your child adopted.

You will be asked to give as much information and/or documentation as possible about your ex-spouse, or the parent of the child, such as that person's social security number, date of birth, address, employer's name and address and any court information related to paternity or support actions. This information will be used to:

- establish paternity of each child born out of wedlock;
- get child support from the non-custodial parent of each child until each child is 21 years old;
- arrange to have your support payments turned over to the Support Collections Unit of the local department of social services.

You will also be required to appear, as necessary, at the child support office to provide information or documentation and at any court proceeding. If you believe compliance with any of these requirements will place you or your children at risk due to domestic violence, you may be eligible for a temporary waiver from this requirement. To obtain a waiver, you must complete the Domestic Violence Screening Form or notify your worker that you want to see a domestic violence liaison for an assessment.

In the absence of a “good cause claim,” if you do not cooperate with the Child Support Enforcement Unit, your Temporary Assistance grant will be reduced by 25% for each incidence of non-compliance, and any Temporary Assistance for your children may be paid to another person, called a **“protective payee”**.

If you do not agree with any of the actions of your local department of social services regarding your “good cause claim,” you may ask for a Conference and a Fair Hearing (**See “Your Rights,” Section 5 “Conferences and Fair Hearings”.**)

CHILD SUPPORT COOPERATION – IS NOT A REQUIREMENT FOR LOW INCOME CHILD CARE ASSISTANCE

Pursuing child support is not required in order to receive child care assistance. However, establishing paternity and placing responsibility for supporting children on those parents that have the financial resources provides a step toward family self-sufficiency and economic security. Child support is a vital source of income for New York State's single parent households. Next to the custodial parent's earnings, child support is the second largest source of income for low income families. Obtaining child support income and any health care insurance benefits for your child from the absent parent is important for the well being of your family.

Each local social services district has a Child Support Enforcement Unit (CSEU) that will help to establish paternity of your child. The CSEU will help you file a petition with family court to get a support order that is based on the child support guidelines. Child support may cover some of your child care costs. Also, the CSEU will make sure you get the child support you are entitled to and will help you file a petition with family court to collect unpaid support. Upon your request the CSEU will review your support order and if eligible apply a cost of living adjustment to the child support amount.

These services are available to you whether the noncustodial parent lives in or outside of New York State. A \$25 dollar annual services fee will be charged when you receive child support services in any year if you have never been in receipt of Temporary Assistance for Needy Families and child support collects at least \$500 for you during a 12-month period beginning October 1st each year.

CHILD SUPPORT REFERRAL AND COLLECTION-FOSTER CARE

If you voluntarily place your child in foster care, or your child has been removed and placed in foster care and you are the child's biological parent, stepparent or adoptive parent, you must cooperate with the local social services district so that the district can determine whether there is a circumstance that exists that would prohibit them from referring you to the child support enforcement unit of the local social services district. If no such circumstance exists, you must cooperate in providing the requested information, including third party health insurance information, and providing any necessary documentation and you have a legal obligation to contribute toward the cost of your child's foster care.

Circumstances or conditions that prohibit a referral to child support are:

- (1) when the appropriate social services official determines that such referral will adversely affect the health, safety or welfare of the child on whose behalf such payments are to be made or other persons in the child's household or will adversely affect the length of the child's placement or impair the ability of the child to return home when discharged from foster care ; or
- (2) when a surrender of a child born out of wedlock has been accepted by the appropriate social services official from the mother or father of such child, the parent surrendering the child must not be referred to the child support enforcement unit of the social services district; or
- (3) in the case of a non-adopting spouse, when a non-adopting spouse is living separate and apart from an adopting spouse pursuant to a written agreement of separation or when a non-adopting spouse has been living separate and apart from an adopting spouse for at least three years prior to the adopting spouse's commencing an adoption proceeding.

CHILD SUPPORT COOPERATION - MEDICAL ASSISTANCE

When you want to get Medical Assistance for yourself and you are also applying for your child under 21, and the child's other parent is not living with the child or will not help with the child's medical bills, you must cooperate with the Child Support Enforcement Unit of your local department of social services. This is not required if you are pregnant, or it is within two months following the month of the end of your pregnancy or you are only applying for the child. You are required to cooperate with the Child Support Enforcement Unit to try to get help from the noncustodial parent to pay for your child's medical bills, and, if your child is born out of wedlock, to establish paternity.

You are required to pursue medical support only. You are not required to pursue or assign your rights to cash support from a noncustodial parent to the local department of social services. If you are applying for Medical Assistance for your child, your child's eligibility will not be affected if you do not cooperate in establishing paternity.

You must turn over your right to collect money for medical bills or health insurance to your local department of social services. You must also cooperate with the department to get health insurance and money for medical bills from people legally responsible for you and your children.

As a Medical Assistance applicant or recipient, you must cooperate with the Child Support Enforcement Unit **unless** you have a good reason not to. If you feel you have a good reason for not cooperating ("**good cause claim**") you must tell your local department of social services. Your local department of social services will allow your "**good cause claim**" if:

- your cooperation with the Child Support Enforcement Unit is likely to cause physical or emotional harm to you or your children;
- your child came from a pregnancy due to incest or rape; or
- you are working with an authorized adoption agency to have your child adopted.

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You will be asked to give as much information and/or documentation as possible about the noncustodial parent of the child, such as the parent's social security number, date of birth, address, employer 's name and address and any court information related to paternity or support actions.

This information will be used to:

- establish paternity of each child born out of wedlock for whom you are applying for or getting Medical Assistance, when the child is at least two months old; or
- get health insurance and money for medical bills from the non-custodial parent of each child until each child is 21 years old.

You will also be required to appear, as necessary, at the child support office to provide information or documentation and at any court proceeding.

If you do not cooperate with the Child Support Enforcement Unit, you cannot get Medical Assistance for yourself, unless you have "**good cause**" for not cooperating, or you are pregnant, or it is within two months following the month in which your pregnancy ended.

CHILD SUPPORT DISREGARD - MEDICAL ASSISTANCE

Generally, the first \$50.00 of current child support collected each month is not counted when the local department of social services decides if you can get Medical Assistance. When a child is certified blind or certified disabled, one third of any support payment the child receives from an absent parent is not counted.

SUPPORT YOURSELF

You are required to cooperate in pursuing medical support from an absent spouse or, where applicable, an ex-spouse. You are required to tell us if a spouse or ex-spouse, is, or may be, required to help pay for your medical bills or provide you with health insurance coverage. You must do so unless you are pregnant, within two months following the month in which your pregnancy ended, or you have "**good cause**" not to cooperate.

If you do not agree with any of the actions of your local department of social services regarding your "good cause claim," you may ask for a Conference and a Fair Hearing. (See "Your Rights," Section 5 "Conferences and Fair Hearings.")

12. RESPONSIBILITY TO COMPLETE ALCOHOL AND SUBSTANCE ABUSE SCREENING REQUIREMENTS FOR TEMPORARY ASSISTANCE

All adult and head of household applicants for and recipients of Temporary Assistance must complete the Alcoholism and Substance Abuse Screening Questionnaire. After completing the Questionnaire, you may be required to go to a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) for a formal assessment to determine whether or not you have an alcohol or substance abuse problem. After completing the assessment the local department of social services will determine what treatment, if any, will be required. If it is determined that a treatment program is required, you must sign a consent form for disclosure of treatment information and must document compliance with your treatment progress to your local department of social services.

If you believe compliance with alcohol and substance abuse assessment or treatment will place you or your children at risk due to domestic violence, you may be eligible for a temporary waiver from this requirement. To obtain a waiver, you must complete the Domestic Violence Screening Form or notify your worker that you want to see a domestic violence liaison for an assessment.

If you fail to participate in the screening or assessment process or fail to sign the consent form to release information from the treatment program, you will not be eligible for Temporary Assistance and your family's Temporary Assistance grant will be reduced. The Safety Net Assistance program will provide benefits to all otherwise eligible household members.

If you fail to:

- participate in or complete the required treatment;
- document treatment compliance; or
- attend the treatment program that the social services district determines appropriate for you;

you may be sanctioned from receiving Temporary Assistance. Additionally, if you leave a residential treatment program prior to completion, you will not get any personal needs allowance (PNA) which accumulated while you were in the treatment program.

13. RESPONSIBILITY TO COMPLETE ALCOHOL AND SUBSTANCE ABUSE SCREENING FOR MEDICAL ASSISTANCE

Certain Medical Assistance applicants and recipients are required to comply with the alcohol and substance abuse screening, assessment and treatment requirements. The following Medical Assistance applicants and recipients must meet these alcohol and substance abuse requirements: a person who is between 21 and 65 years of age and not pregnant, certified blind, or certified disabled; a husband or boyfriend of a pregnant woman with no other children in the household; a stepparent with no children of his/her own in the household when the birth parent is also in the household; a single individual; or a childless couple.

Persons applying for or in receipt of Family Health Plus or the Family Planning Benefit program are not required to participate in alcohol and substance abuse screening.

14. RESPONSIBILITIES REGARDING THE USE OF MEDICAL ASSISTANCE PROVIDERS

Before you get medical care, you must make sure that the doctor, pharmacist or other person you want help from agrees to bill Medical Assistance. Not all medical providers accept Medical Assistance.

If you need medical care after you apply for Medical Assistance but before you get your Common Benefit Identification Card (CBIC), you must still make sure the provider accepts Medical Assistance. If you have to pay a bill, after you apply for Medical Assistance but before you get your CBIC, we can only pay the bill if you are determined eligible for Medical Assistance and the provider accepts Medical Assistance.

When you are approved for Medical Assistance, you may be able to join a Medicaid Managed Care health plan. In some counties, you may have to join a plan. You will get information from your local department of social services about whether or not you have to join, and your plan choices. If you have a doctor you want to keep seeing, you need to check to see if he or she is in the Medicaid Managed Care health plan you join. When you join a Medicaid Managed Care health plan, you will get a health insurance card from your plan.

You must use your CBIC to access your Medical Assistance Benefits. Even if you join a Medicaid Managed Care health plan, you will still use your CBIC card for some services such as pharmacy. It is important to use your CBIC in a responsible manner when you use it to get medical care.

If you are eligible for Family Health Plus, you must receive all of your health care from the managed care plan that you selected. If you receive another health plan card for the family planning services, you will use that card just for family planning.

If you abuse Medical Assistance, you will be placed in the **Recipient Restriction Program (RRP)**. This program limits the range of Medical Assistance providers from which you receive medical care, unless you have an emergency. A Medical Assistance provider is a person or facility that gives medical care. Some reasons why you might be restricted in your choice of Medical Assistance providers are:

- You are getting care from several doctors for the same problem.
- You are getting medical care more often than needed.
- You are using prescription medicine in a way that may be dangerous to your health.

If you are in the **Recipient Restriction Program**, you may ask to change your single Medical Assistance provider every three months or sooner if there is a good reason.

Some good reasons are:

- You or your Medical Assistance provider moves, and it is hard to get to your provider.
- Your Medical Assistance provider no longer accepts Medical Assistance.
- Your Medical Assistance provider does not want to see you.

The first time you abuse Medical Assistance, you will be assigned to one Medical Assistance provider for two years. If the abuse happens a second time, you will be restricted for a new 3-year period. If you abuse Medical Assistance again, you will be restricted for six years.

15. RECERTIFICATION RESPONSIBILITIES

Federal and State regulations require that your case be reviewed to see if you are getting all the help you should be getting. This review is called Recertification or Renewal.

You will be asked many of the same questions to determine if your circumstances have changed. If you have any questions or have trouble filling out any of the forms, ask for help.

If you miss a required interview without telling your worker why, your case may be closed. Therefore, you must make sure to tell your worker the reason. If you have a good reason, your case will not be closed. An example of a good reason would be being ill

on the day of the interview. You must meet all recertification requirements in order to keep getting help. As one of these requirements, if you are asked to provide certain papers or proof, you should do so within ten days, or your benefits may be reduced or stopped.

You will not be required to complete a personal interview to renew your Medical Assistance or Child Care Assistance. Persons receiving Medical Assistance only or Child Care Assistance only will receive a renewal package in the mail with instructions for completing and returning the renewal to your local department of social services. If you are receiving Food Stamp Benefits and Medical Assistance or Food Stamp Benefits and Child Care Assistance, your Food Stamp interview may also serve as your Medicaid renewal or your Child Care Assistance Renewal.

16. MINOR PARENTS RESPONSIBILITIES APPLYING FOR OR GETTING TEMPORARY ASSISTANCE

If you are under 18 and you are a parent who is not married and who is caring for a child and have no children under twelve weeks of age, you must be working toward a high school diploma or its equivalent (if you have not completed high school), or participating in an alternative educational program approved by your worker.

If you believe compliance with minor educational requirements will place you or your children at risk due to domestic violence, you may be eligible for a temporary waiver from this requirement. To obtain a waiver, you must complete the Domestic Violence Screening Form or notify your worker that you want to see a domestic violence liaison for an assessment.

If you are pregnant and under 18 or are a parent who is under 18 and not married, you must live with a parent, legal guardian, or other relative. If your worker determines that this is not possible or not in your child's best interest, the local department of social services will decide if your current living arrangement is appropriate. If it is not, the local department of social services will assist you in finding other appropriate living arrangements.

These rules do not apply to Medical Assistance.

17. YOUR RESPONSIBILITIES REGARDING TEMPORARY HOUSING IF YOU ARE HOMELESS

If you need Temporary Housing Assistance because you are homeless, it is very important that you read this!

You might not get Temporary Housing Assistance if you do not follow some important rules.

Sometimes, if you lose Temporary Housing Assistance because you do not follow the rules, you may be able to get that help again right away if you will follow the rules.

Other times, if you lose Temporary Housing Assistance you may not get Temporary Housing Assistance again for a specified period of time even if you agree to follow the rules. The amount of time that you may lose eligibility for Temporary Housing Assistance will depend on which rule you violate.

Some of the rules that you will have to follow in order to prevent losing Temporary Housing Assistance help are listed below:

- You must help the local department of social services staff to find out if you are eligible for emergency housing assistance.
- You may be required to meet with the local department of social services staff or a person appointed by the local department of social services to help develop an Independent Living Plan for you. If an Independent Living Plan is developed for you, you will receive a copy of the plan. The Independent Living Plan will tell you about the rules that you must follow.
- You must actively look for permanent housing and you must not unreasonably refuse permanent housing that is offered by the local department of social services staff.
- You must behave in a manner that does not interfere with the orderly operation of the Temporary Housing Facility where you are staying. You must not commit acts which endanger anybody's health or safety.

It is important for you to know that if you fail to follow the rules, you and your family might lose eligibility for Temporary Housing Assistance for a period of time!

You will also be required to comply with all the other eligibility requirements for receiving Temporary Assistance, such as complying with employment requirements. If you fail to comply with these other Temporary Assistance requirements, and you do not have good cause for failing to comply, you may be sanctioned, or lose eligibility for Temporary Assistance, depending upon which requirement you fail to comply with. Losing eligibility for a Temporary Assistance grant will make you and your family ineligible for Temporary Housing assistance. Being sanctioned, which will result in a reduction in your grant, may also result in the loss of Temporary Housing if there is not sufficient money in your grant to pay for Temporary Housing.

18. RESPONSIBILITY TO APPLY FOR SUPPLEMENTAL SECURITY INCOME (SSI)

If you have a medical condition that prevents you from working, you **may** be required to file for Supplemental Security Income (SSI).

If you have a physical or mental medical condition or conditions that is or are so bad that it prevents you from working, you must report this information to your worker. If your worker agrees that your medical condition may be preventing you from working, your worker will **require** you to apply for SSI at the Social Security Administration.

This means that:

- You must apply for SSI.
- You must cooperate with all the requirements for SSI.
- You may not withdraw a pending application for SSI while you are receiving Temporary Assistance,
- If your SSI application is denied, you must appeal this denial unless your worker tells you that you don't have to file an appeal.

If you fail to meet these requirements, you will not be eligible for Temporary Assistance.



Book 2

What You Should Know About Social Services Programs

Questions and Answers

If you are blind or seriously visually impaired and need an application or these instructions in an alternative format, you may request them from your social services district. The following alternative formats are available:

- Large print;
- Data format (a screen-reader accessible electronic file);
- Audio format (an audio transcription of the instructions or application questions); and
- Braille, if you assert that none of the other alternative formats will be equally effective for you.

Applications and instructions are also available for download in large print, data format and audio format from www.otda.ny.gov or www.health.ny.gov. Please note that applications are available in audio format and Braille solely for informational purposes. In order to apply, you must submit an application in written, non-alternative format. If you require another accommodation, please contact your social services district.

Also See

BOOK 1 (LDSS-4148A)

“What You Should Know About
Your Rights and Responsibilities”

and

BOOK 3 (LDSS-4148C)

“What You Should Know If
You Have an Emergency”

SAVE THIS BOOK FOR FUTURE USE

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PLEASE NOTE:

This book tells you many of the ways your local department of social services may be able to help if you or your family is in need.

Please remember that these programs and services have Federal or State rules that must be followed.

This should not keep you from asking about these programs and services when you or your family needs help.

SECTION A

TEMPORARY ASSISTANCE

Q. What Is Temporary Assistance?

A. Temporary Assistance is temporary help for needy adults and children. If you are unable to work, can't find a job, or your job does not pay enough, Temporary Assistance may be able to help you pay for your expenses. Temporary Assistance programs include Family Assistance and Safety Net Assistance.

Q. If I Have Or Get A Job, Can I Still Get Help?

A. You can work and still get Temporary Assistance if your income is under a certain amount.

- If your case is closed because your income is over a certain amount, you **may** still be able to get help with child care and Medical Assistance.
- You may be able to get Food Stamp Benefits (**See "Food Stamp Benefits", Section D of this Book**) and Services (**See "Services", Section G of this Book**).
- If you get a job, you must notify your local department of social services worker within 10 days.

Q. Can I Get Help To Get A Job?

A. When you apply for or get Temporary Assistance and/or Food Stamp Benefits, you may be able to get help with:

- job search or job placement services to help you find a job
- job readiness services to help you obtain the skills you need to find a job
- education, especially if you have not finished high school or do not have a high school equivalency diploma (G.E.D.)
- training
- child care, so you can work, take part in work activities or education or training programs approved by the local department of social services
- transportation and other work related expenses that are necessary for you to participate in assigned work activities

Q. What If I Have An Emergency And I Need Help Right Away?

A. You may be able to get help right away. Be sure to tell your worker that you think you have an emergency. (**See Book 3 (LDSS-4148C) "What You Should Know If You Have An Emergency".**)

Q. What Kinds of Expenses Will Temporary Assistance Help Me Pay?

- Food and clothing costs
- Rent or mortgage costs
- Heat, gas, electricity, water and other utilities
- Other special needs such as:

- Meals

You may get extra money for restaurant meals or home-delivered meals if you are unable to fix meals at home.

- Pregnancy

If you are pregnant, you may be able to get extra money. You can get this money from your fourth month of pregnancy to the end of your pregnancy if you give your worker a medical note. The medical note must say that you are pregnant and give the date your baby is due. You cannot get this extra money for any month before you give your worker the medical note.

- Transportation and other work-related support services

You may be able to get help with transportation or other work-related expenses, which are necessary for you to participate in assigned activities. For example, if you take part in an education or training program approved by the local department of social services, you may be able to get help with certain expenses, such as child care, transportation or work-related clothing, which are needed for you to participate in the approved activity. **(See the Question, "Can I Get Extra Help When I Take Part In Training or Education?" in this book.)**

- Housing and Household-Related Items

You may be able to get help for any of the following:

- (1) To prevent eviction or to pay your rent, mortgage or taxes that you have owed for a period of time before you applied for Temporary Assistance
- (2) If you must move from where you now live, you may be able to get help for:
 - Storing furniture and other personal things you own
 - Broker's or finder's fees
 - A rent security deposit or security agreement
 - Moving expenses
- (3) Repair of needed household items such as heating equipment, stove or refrigerator
- (4) You may be able to get help to buy needed furniture or other household items if:
 - A family member returns home after being discharged from an institution or from foster care.
 - You must move for health and safety reasons and cannot find a furnished apartment or home.
 - You need the items to set up your household.
- (5) If you own your own home, you may be able to get help for property repairs that are needed for your health and safety.
- (6) If you lose your furniture or clothing in a fire, flood or other natural disaster, you may be able to get help to replace these household items or clothing.

<p>NOTE: Most people who can get Temporary Assistance will also get Medical Assistance and Food Stamp Benefits if requested.</p>

Q. What Are The Temporary Assistance Programs?

- A.** 1. **Family Assistance** provides Temporary Assistance to eligible needy families that include a minor child living with a parent (including families where both parents are in the household) or a caretaker relative. It is operated under federal Temporary Assistance for Needy Families (TANF) guidelines.

Under Family Assistance, eligible adults are limited to receiving benefits for a total of 60 months in their lifetime, including months of TANF-funded assistance granted in other states. Months of cash Safety Net Assistance (#2 below) also count toward the 60-month lifetime limit. Once this limit is reached, that adult and all members of his or her Family Assistance household are ineligible to receive any more Family Assistance benefits. The months need not be consecutive, but rather each individual month in which TANF-funded benefits (or cash Safety Net Assistance) are received is included in the lifetime count. The counting of this 60-month limit began in December 1996.

Each person who is applying for or receiving Family Assistance, is also required to cooperate in good faith with the State and local social services district in establishing the paternity of a child born out of wedlock, in efforts to locate any absent parent or putative father, in establishing, modifying and enforcing orders of support; and in obtaining support payments or any other payments or property; as a further condition of eligibility for Family Assistance. Failure to cooperate without good cause will result in a reduction of Family Assistance benefits.

2. **Safety Net Assistance**

If you are not eligible for other assistance programs, you may be eligible for Safety Net Assistance.

Safety Net Assistance is for:

- single adults
- childless couples
- children living apart from any adult relative
- families of persons found to be abusing drugs or alcohol
- families of persons refusing drug/alcohol screening, assessment or treatment
- persons who have exceeded the 60-month limit on assistance
- aliens who are eligible for Temporary Assistance, but who are not eligible for federal reimbursement.

Generally, you can receive Safety Net Assistance in cash for a maximum of two years in a lifetime. The count for this time limit began in August 1997. After that, if you are eligible for Safety Net Assistance, it will be provided in non-cash form, such as a two-party check or a voucher. In addition, Non-Cash Safety Net Assistance is provided for:

- families of persons found to be abusing drugs or alcohol
- families of persons refusing drug/alcohol screening, assessment or treatment
- families with an adult who has exceeded the 60 month lifetime time limit

NOTE: Individuals who apply for or receive Temporary Assistance are required to participate as soon as possible in work activities as assigned by the local department of social services. Individuals who are determined exempt from work requirements due to a medical condition may be required to participate in a treatment program or other services which could restore or improve the ability to work. Failure to comply with work requirements, willfully and without good cause may result in the reduction or discontinuance of Temporary Assistance and/or Food Stamp Benefits.

Q. How Do I Apply For Temporary Assistance?

- A.** If you live outside of New York City, call or visit your local department of social services and ask for an application package. If you live in New York City, call or visit your local Income Support/Job Center. You must fill out the Application and turn it in. Remember, you may turn in **(file)** the Application the same day you get it.

Q. What Happens When I Apply For Temporary Assistance?

- A.** You will have an interview to find out if you are able to get Temporary Assistance. You will be asked to prove certain things. **(See Book 1 (LDSS-4148A) "What You Should Know About Your Rights And Responsibilities.")**

You may be required to participate in an interview to find out what types of work you are able to do. We may also discuss the activities and services, including education and training activities that are available, which may help you get a job.

During the interview, you will be asked:

- About your education, training and work history
- What types of jobs you are able to do, and your preferences
- To talk about and agree to an employment plan just for you
- The child care or other work related services, such as transportation, that you may need in order to participate in work activities, including employment

Unless you are determined by the local department of social services to be exempt from participation in work requirements, you must participate in work activities as assigned by the local department of social services. Individuals who are applying for or receiving Temporary Assistance and are able to work are expected to continually look for a job and take a job when one is available.

Q. What Happens If I Only Want Temporary Assistance For Children That Live With Me Who Are Not My Biological Or Adopted Children?

- A.** Many people have children living with them who are not their children, for example, a grandparent who has grandchildren living with them, or a neighbor who is caring for their neighbor's children in the absence of the parents. If you have a child living with you who is not your child, you may apply for Temporary Assistance (TA) on behalf of that child. This type of TA case is called nonparent caregiver and provides a cash grant to be used for the care of the child.

Here are some things to consider if you are in this situation:

- State and federal laws require certain information be provided for any household that applies for TA. This means even if only one person in the household applies, the entire application must be completed. Also, your household may be eligible for Food Stamps, Medicaid, Child Care or Services. If you are also applying for these other programs, the information from filling out the entire application will help your worker to determine your eligibility for these other programs. You may choose, however, to apply for only Medicaid, Child Care or Food Stamp Benefits. Also, if your household is determined ineligible for TA for the children and you are applying for Food Stamp Benefits and Medical Assistance, your eligibility for Food Stamp Benefits and Medical Assistance will be separately determined.
- Your income and resources will not be considered when determining the TA grant for the child in your care. The only time your income and resources will be counted is if you are applying for TA also. Even then it will not count against the TA grant for the child you are caring for. Nonparent caregiver grants are based exclusively on the income and resources of the applying children.

- You will have to provide information on who lives with you, where you live and what expenses, income and resources the child has. If you are a non-parent relative of the child you are applying for, you will be asked to state your income and resources, but you do not have to provide proof of them unless you are also applying. You will be asked this information because it is a federal requirement that local social services districts obtain this information.
- You must cooperate with the requirements of the Child Support Enforcement program for any application for temporary assistance for your child(ren). You also have the right to claim good cause not to actively pursue child support if pursuing child support would adversely affect: you or your child(ren)'s health, safety or welfare. If you are afraid that the parent from whom you are seeking child support enforcement services will harm you or the child, let the temporary assistance worker know immediately. The worker will advise you of what you need to do to obtain a domestic violence waiver from child support cooperation requirements.

Q. If I Am The Caregiver Of A Child Who Lives With Me And Who Is Not My Biological Or Adopted Child, And I Need Additional Help Or Resources To Care For The Child, Can You Tell Me Where To Find Them?

A. The NYS Kinship Caregiver Program has been created to form a statewide network of community-based supportive programs that promote household stability and permanency through services for kinship caregivers and their kin. The Program includes 13 community-based programs, located in different parts of the State that provide services to help kinship caregivers who are raising their kin. Families providing informal kinship care, kin who are legal guardians or custodians of a child, as well as those providing kinship foster cares, are eligible to be served by these programs. Services offered may include:

- Counseling
- Legal information
- Support groups
- Respite
- Parenting skills
- Education advocacy
- Child Medicaid Information
- Case management
- Budgeting & tax information
- Housing
- Referrals
- Child-only payment information

In addition, a 14th program, the NYS Kinship Navigator Program, provides information and referral services to assist caregivers and the children in their care. A caregiver residing anywhere in New York can call a toll free number or go to a website to find information about the services that are available in or near their county. Trained specialists are also available to assess caregiver's needs and develop a plan of action. The Kinship Navigator Program can be reached, toll-free **1-877-6463 (1-877-4KinInfo)** Monday thru Friday from 9:30 am to 4:30 pm, or online via the Internet at "<http://www.nysnavigator.org/>."

Q. What Happens If I Apply For Temporary Assistance And I Feel I Am Unable To Work Or Participate In Work Activities Because Of A Medical Condition?

A. An individual who applies for Temporary Assistance and claims he/she is unable to work or participate in work activities because of a medical condition may be required to provide documentation from their doctor. The individual may also be required to participate in a medical examination which is completed by another doctor as arranged by the local department of social services to evaluate the individual's medical condition, to identify any limitations that the individual may have and to identify medical care, rehabilitation or treatment that may help restore or improve the individual's ability to work. The local department of social services will review the medical documentation available and inform you in writing of their decision as to whether you are required to participate in work activities (non-exempt or work limited) or are exempt from work requirements. This notice will also inform you of the right to request a fair hearing if you disagree with the local department of social services decision on your ability to work or participate in work activities and the timeframes in order to request a fair hearing.

Q. Are There Certain Individuals Who Are Not Eligible For Temporary Assistance?

- A. Yes, Temporary Assistance cannot be given to individuals who:
1. are under the age of eighteen, who are not married, are caring for a child, but have no children under twelve weeks of age in their care, and who have not successfully completed or are not working towards a high school diploma or its equivalent, or not participating in an alternative program approved by your worker.
 2. have been convicted in federal court of having made a fraudulent statement or representation with respect to their place of residence in order to receive Temporary Assistance from two or more states. The period of ineligibility is ten years.
 3. are fleeing to avoid prosecution or custody or confinement under the laws of the place from which the individual flees for a crime or attempts to commit a crime which is a felony under the laws of the place from which the individual flees, or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that state.
 4. are violating a condition of probation or parole imposed under federal or state law.
 5. are penalized by an individual or program sanction because of failure to comply with certain eligibility rules.

Q. Can I Get Temporary Assistance If I Am Not A Citizen Of The United States?

A. If you are not a citizen of the United States, you must document that you are an alien in one of the categories listed below in order to be eligible for Temporary Assistance (some aliens may only get Safety Net Assistance):

1. a United States (U.S.) non-citizen national; or
2. an American Indian born in Canada with at least 50 per centum of blood of the American Indian race under section 289 of the Immigration and Nationality Act (INA); or
3. a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S. C. 450b(e)); or
4. an alien admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act; or
5. an alien granted asylum under Section 208 of the Immigration and Nationality Act; or
6. an alien whose deportation has been withheld under Section 243(h) of the Immigration and Nationality Act as in effect prior to April 1, 1997, or whose removal has been withheld under Section 241(b)(3) of the Immigration and Nationality Act; or
7. an alien admitted to the United States as a Cuban and Haitian entrant; or
8. an alien admitted as an Amerasian immigrant; or
9. an alien admitted as a Hmong or Highland Laotian, including the spouse and dependent children, or,
10. an alien who is on active duty in the U.S. armed forces, or an honorably discharged veteran, their spouse or dependent children, or the unmarried surviving spouse and unmarried dependent children of an active duty member or veteran who has died; or
11. an alien who has been admitted as a lawful permanent resident; or
12. an alien who has been paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act, for a period of at least one year; or
13. an alien who has been granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act, as in effect prior to 4/1/1980; or
14. an alien who has been battered or subject to extreme cruelty in the United States by a family member and who meets certain other requirements; or
15. an alien who has been subjected to a Severe Form of Trafficking in Persons under the Victims of Trafficking and Violence Protection Act of 2000; or
16. an alien not listed above who is considered to be Permanently Residing in the United States Under Color of Law (PRUCOL), including:
 - a. an alien paroled into the United States for less than one year;
 - b. an alien residing in the United States pursuant to an Order of Supervision under Section 241(a)(3) of the INA;
 - c. an alien granted cancellation of removal pursuant to Section 240A of the INA;
 - d. an alien granted deferred action status, which defers their departure;
 - e. an alien granted "K3" or "K4" visa established under the Legal Immigration Family Equity Act (LIFE Act);
 - f. an alien granted "V" visa status under the LIFE Act;
 - g. an alien granted "S" visa status;
 - h. an alien granted deferred action as interim relief for a "U" visa; and
 - i. an alien who demonstrates that s/he entered and has continuously resided in the United States since January 1, 1972 pursuant to Section 249 of the INA.

Q. What If An Undocumented Alien Lives In My Household?

A. Aliens who do not have documents that permit them to reside legally in the United States are eligible only for certain kinds of emergency benefits. When citizens or aliens who are legally present in the country live together with undocumented aliens all members of the household must be listed on the application. Any person who does not sign the certification in the application that he/she is a citizen or an alien with satisfactory immigration status cannot receive Temporary Assistance. However, if otherwise eligible, the rest of the household is entitled to benefits. NOTE: If the U.S. Citizenship and Immigration Services (USCIS) has made a final determination that a member of the household is illegally present in the country (for example, if USCIS has issued a final order of deportation) and that person applies for benefits, we will notify USCIS.

Q. Can I Get Extra Help When I Take Part In Training Or Education?

A. If you are receiving Temporary Assistance and/or Food Stamp Benefits and are participating in a training or education program approved by the local department of social services, you may be able to get extra help to pay for costs related to participation in training or education programs such as:

- Child care
- Work-related clothing
- Tuition, books and supplies
- Transportation
- Work tools

Q. What Happens If I Get A Job?

A. If you get a job, you may still be able to get Temporary Assistance and/or Food Stamp Benefits depending on how much you make.

If you have a child living with you, a large portion of your earned income may not be counted toward your Temporary Assistance.

If you get a job, and make enough money so that you no longer get Temporary Assistance, you may be able to get the following:

- Child Care and/or Medical Assistance for up to one year (**See "Transitional Help", Section E of this Book**)
- Food Stamp Benefits (**See "Food Stamp Benefits", Section D of this Book**)
- Earned Income Credits (**See "Other Benefits", Section H of this Book**)

Q. Can I Get Help With An Expense Which, If Not Paid, May Cause Me To Lose My Job?

A. You may be eligible for a "diversion payment". This is a payment which would deal with a specific crisis situation or episode when such a payment would enable the individual or a family to avoid the need for ongoing assistance. In order to be eligible for a "diversion payment" you must be without available financial resources of your own to meet the need. *Examples of "diversion payments" are employment-related expenses, including employment-related transportation expenses, or relocation costs to a living arrangement that will allow the individual or family to be self-sufficient.*

Q. What Will Happen If I Do Not Agree Or Fail To Take Part In A Required Employment Program?

A. If you are able to work and you willfully and without good cause, fail or refuse to participate in a required employment program, you could lose Temporary Assistance, Food Stamp Benefits, and other services. Before you lose your Temporary Assistance, Food Stamp Benefits or other services, you may be offered a meeting, called a Conciliation Conference or Agency Conference, to discuss why you failed or refused to participate.

You will not lose your Temporary Assistance, Food Stamp Benefits, or other services if you have good cause for failing or refusing to participate. You may be asked to provide documents to support your claim of good cause for not participating in an employment program as required by the local department of social services. You also have a right to a Fair Hearing. For how to request a Fair Hearing, **see Book 1 (LDSS-4148A) "What You Should Know About Your Rights And Responsibilities"**.

Q. Does Everyone Who Lives With Me Have To Apply For Temporary Assistance?

A. When you apply for Temporary Assistance all of your children who live with you (under the age of 18) must also apply. If anyone else living in your household is a blood related or adoptive parent or blood-related or adoptive brother or sister (under age 18), of your children, they must also apply and have their income and resources applied toward the Temporary Assistance household. This is called the Filing Unit Rule. In addition, a parent cannot apply for Temporary Assistance without also applying for his or her children living with the parent.

Q. What Happens If My Child Gets Social Security Benefits?

A. If any of the children in your household have or must apply for Social Security benefits, and you are applying for Temporary Assistance for these children, you should know the following:

Congress and the Social Security Administration have deemed it legal for you to spend the Social Security benefits of a child in your care on that child's parents and siblings if they want to apply for or are in receipt of Temporary Assistance benefits. This means that the Social Security benefits will be counted as income to the filing unit and can be used for basic household expense items, such as food and shelter, in addition to providing for the child's immediate needs.

Q. If I Am Found Eligible, How Do I Access My Temporary Assistance Benefits?

A. You will receive a brochure entitled "EBT How to use your Benefit Card to get Food Stamp and/or Cash Benefits."

- You must access your cash benefits from participating retailers or Automatic Teller Machines (ATMs) that display the QUEST logo. To find the location of a non-surcharging participating retailer, or ATM that does not surcharge, call toll free **1-800-289-6739**.
- You will use your Common Benefit Identification Card (CBIC) and Personal Identification Number (PIN).
- Your regular monthly cash grant will be split into two benefits per month (if over \$25.00).
- You will be given a form that will tell you your availability dates for each of your cash grants.
- Benefits can be used throughout the month. Unused benefits carry over in your cash benefit account from month to month.
- If your cash account goes unaccessed for a 90 consecutive day period, any cash benefits in the account that are at least 90 days old will be removed (expunged) and returned to the agency. You may ask your worker to reissue any expunged cash benefits for which you are eligible.
- Remember to check your receipts after any Electronic Benefit Transfer (EBT) transaction.

Q. Is There A Limit On How Long I Can Get Temporary Assistance?

A. There are two time limits on Temporary Assistance in New York State.

- 1. State sixty-month time limit** - In New York State this time limit includes the following Temporary Assistance Programs:
 - Cash benefits received since December 1996 under the Aid to Families with Dependent Children (AFDC), Family Assistance (FA), Safety Net Assistance (SNA), Child Assistance Program (CAP) and the Refugee Cash Assistance (RCA) programs.
 - Temporary Assistance benefits from other states under the federal Temporary Assistance for Needy Families (TANF) Program.
 - Non-cash Safety Net benefits received by families in which the adult is required to participate in substance abuse treatment programs.
- 2. Twenty-four month cash Safety Net time limit** – This time limit includes all cash Safety Net Assistance payments received since August 1997.

NOTE: Once you have reached the 24-month time limit you are only eligible for non-cash benefits.

NOTE: TANF assistance received in other states may include time periods before December 1996.

NOTE: If you are HIV positive or have an incapacity that prevents you from working you may be exempt from time limits.

NOTE: Temporary Assistance time limits do not affect your Food Stamp Benefits or Medical Assistance.

Q. I Believe I Am A Victim of Domestic Violence. How Can This Agency Assist Me?

A. You must meet certain requirements to be eligible for Temporary Assistance. However, if you are a victim of domestic violence and you think that meeting one or more of the Temporary Assistance requirements would put you or your children at further risk of harm, you may request a meeting with a domestic violence liaison to address the risk of harm. Some requirements can be waived if necessary. Your Temporary Assistance worker can give you more information during your interview.

Additionally, you can call a 24-hour hotline for information about emergency shelter, support groups, and counseling. These services will help keep you and your children safe.

To get information and referrals to your local domestic violence services provider you may call the following numbers, toll-free, 24 hours a day:

In New York City call 1-800-621-HOPE (1-800-621-4673)

In any other area of New York State call the NYS Domestic Violence Hotline at 1-800-942-6906

(Spanish-speaking call toll free 1-800-942-6908).

A Services caseworker can also arrange for you to get this information.

Q. As An Alien Lawfully Residing In The United States, How Will My Sponsor's Income And Resources Affect My Eligibility And Grant?

A. The income and resources of the sponsor who signed an affidavit of support after December 1997 will be deemed available to you when determining eligibility for Family Assistance. If you are eligible, only the amount actually contributed by the sponsor is considered income for purposes of calculating your Temporary Assistance benefit. However, under the revised federal sponsorship agreement, the local department of social services will request and pursue reimbursement from the sponsor. This information as to the sponsor's obligation will be shared with the federal government.

Q. What Happens If Someone In My Household Has Resources That Are Not Counted Towards Temporary Assistance Eligibility?

A. Resources include, but are not limited to, real property, personal property, cash, bank accounts, insurance policies, trust funds, automobiles, etc. The resource limit for TA is \$2,000.00 for a household. If the household contains a member who is disabled, or age 60 or over, the resource limit is \$3,000.00.

Some resources such as Earned Income Tax Credit (EITC) payments, undergraduate educational grants and loans, bank accounts for a first or replacement vehicle to seek, obtain or maintain employment and savings from Supplemental Security Income are exempt resources. These funds should be kept in accounts separate from other funds. If they are not kept separate they could be counted toward the resource limit for your household.

For example, if someone in your household receives Supplemental Security Income (SSI) they should have a separate account for the SSI money to be deposited in. This way, the SSI money will not be counted toward your resource limit.

Q. What Happens If I Have Income That I Receive Regularly But Not Every Month? (For Example, Income That Only Comes In Once A Year)?

A. If you have earned or unearned income that is received on a regular periodic basis you should use the income in equal amounts for each month until the next payment is received.

For example, if you receive an annuity (once a year payment) of \$1,200.00, you should use \$100.00 every month for 12 months. Your worker would also budget \$100.00 every month toward your monthly Temporary Assistance grant.

SECTION B

MEDICAL ASSISTANCE

Q. What Is Medical Assistance (Also Called Medicaid)?

A. Medical Assistance is help for people who cannot pay for all of their medical care.

- Medicaid provides health care coverage for children and adults and who have income and resources below certain levels.
- Family Health Plus provides health care coverage for persons age 19 through age 64 who have incomes too high for Medicaid.
- The Family Planning Benefit Program provides family planning services, certain health education and related medical care to people of childbearing age who have income below certain levels. (See the Question and Answer “**Can Medical Assistance Help Me Get Family Planning Services?**” later in this section on Medical Assistance.)
- The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD)- offers people with disabilities who are working, and earning more than the allowable limits for regular Medicaid, the opportunity to retain their health care coverage through Medicaid.

Q. Who May Get Medicaid?

A. You may get Medical Assistance if you:

- meet certain income, resource, age, disability or other requirements.
- generally, are eligible for Temporary Assistance or Supplemental Security Income (SSI).

Q. How Do I Apply For Medicaid?

A. You must fill out an application and check the Medicaid box.

- An application for Temporary Assistance is not an application for Medicaid. Persons who get Temporary Assistance do not automatically get Medical Assistance. If you want both Medicaid and Temporary Assistance, **you must check both boxes on the application.**
- When you are getting Supplemental Security Income (SSI), you do not have to apply separately for Medicaid. If you want Medical Assistance before you get SSI, you must apply.
- If you wish to apply for family planning services only, you may apply at a Medicaid enrolled family planning provider who has an agreement with the local department of social services to accept applications. Your local department of social services will be able to provide you with a listing of these locations, or you may call toll free **1-800-541-2831**.

If you want to apply for Medicaid, you must do one of the following:

- If you live in New York City, call the Human Resources Administration Info Line at **(718) 557-1399** or **toll free 1-877-472-8411** for information about how and where to apply.
- If you live outside of New York City, call or visit your local department of social services in the county where you live and ask for an application packet.
- If you are a resident of a New York State Office of Mental Health or Office of Mental Retardation and Developmental Disabilities living arrangement, contact the office listed after the type of facility:
New York State Office of Mental Health facility - Patient Resource Office; or
New York State Office of Mental Retardation and Developmental Disabilities facility - Revenue Support Field Office
- If you are pregnant or applying for young children, call toll free at **1-800-522-5006**.
- Additional information concerning applying for Medicaid is available on the Internet at: **www.nyhealth.gov** and click on Medicaid.

There are enrollment facilitators throughout New York State who can assist you with applying for Medicaid. For the name of the organization nearest you, call toll free **1-800-698-4543** or toll free **1-877-934-7587**.

Q. How Can Medicaid Help Me?

A. Medicaid may help you pay for:

- Health Insurance Premiums
- Hospital inpatient and outpatient services
- Home health care
- Laboratory and X-ray services
- Nursing home care
- Treatment and preventive health and dental care (doctors and dentists)
- Family planning services
- Treatment in psychiatric hospitals (for persons under 21, or 65 and older), mental health facilities, and mental retardation and developmental disabilities facilities
- Medicine and supplies
- Clinic services
- Emergency ambulance transportation to a hospital
- Other health services

Medicaid may also help pay for the following, but you or the person/facility providing the service must have the service **approved ahead of time (prior approval)**:

- Transportation to medical appointments, including bus tokens and car mileage
- Personal care
- Private Duty nursing
- Certain dental care
- Durable medical equipment (wheelchairs, orthopedic shoes, etc.)
- Long term home health care, under the Long Term Home Health Care Program (**LTHHCP**). This is care in the home that is very much like nursing home care for people who require home care for more than 90 days and who need nursing or therapy services. (This program is not available in all local departments of social services).
- Home and community based services in special programs that help you stay at home so you do not need to go to a nursing home.

If you are pregnant or have a child, the following programs may be able to help you:

- **Prenatal Care Assistance Program (PCAP)** If you are pregnant, the **Prenatal Care Assistance Program** can help you get the care you need to have a healthy baby. You can have a higher income and still get care from Prenatal Care Assistance Program. There is no limit to the amount of resources you may have. At your first Prenatal Care Assistance Program visit, a worker will help you apply for Medical Assistance. For more information about this program, call the Healthy Baby Hotline at **1-800-522-5006**.
- **WIC** - You may also get **WIC** (Special Supplemental Food Program for Women, Infants and Children) –The **WIC** Program provides helpful information about nutrition and the importance of eating healthy foods. The **WIC** program provides checks that can be exchanged in participating stores for infant formula, milk, juice, eggs, cheese, cereal, peanut butter, dry peas and beans.

For more information about the WIC Program and where you can apply, call **1-800-522-5006**.

- **Managed Care Plans** will also help you to find a doctor who can give you prenatal care and will continue to see you for follow-up after your pregnancy. Managed Care Programs also provide the Child/Teen Health Plan Services for children and adolescents.

Child/Teen Health Plan For Children

All children need a “medical home”. A medical home is the doctor, nurse, physician’s assistant or healthcare team who takes care of your child’s health as he or she grows and develops from an infant to a toddler, to a preschooler, and all throughout childhood and adolescence. A medical home is the place you always bring your child for a check up or when your child is sick. And a medical home is the place where you go with questions and concerns about your child’s health and development.

Child/Teen Health Plan - The Child/Teen Health Plan helps you find a “medical home”. It is a way for children and teens to receive preventive care (checkups), medical exams and follow-up care they need to make sure they are healthy and growing right.

The **Child/Teen Health Plan** is for children from birth up to age 21 who have Medical Assistance. It is free of charge.

The **Child/Teen Health Plan** gives your children:

- Complete medical exams
- Tests to see if your child is growing and developing and doing the right things for his or her age
- Blood lead level testing
- Hearing, lab, and eye tests
- Any shots they may need
- Dental care
- Necessary treatment for a condition or illness found during an examination, such as asthma, cystic fibrosis, diabetes, sickle cell anemia and vision and hearing problems

For more information about this program, or for help finding a doctor for your child, ask the **Child/Teen Health Plan Services** coordinator at your local department of social services.

Q. If I Move To A New County, Do I Have To Reapply To Get Medical/FHPlus?

A. No. If you move, you must notify your local department of social services of your new address. If there are no other changes in your circumstances that affect your eligibility. Your Medicaid case will be transferred to your new county of residence.

Q. Can Medicaid Help Me Get Family Planning Services?

A. Yes. If you are of childbearing age and are eligible for Medical Assistance or Family Health Plus, family planning services are included. If you were denied or terminated from Medical Assistance and/or Family Health Plus, you may be eligible for the Family Planning Benefit Program because the income level is higher and there is no resource limit. You can also apply for the Family Planning Benefit Program only, without applying for Medical Assistance or Family Health Plus.

The Family Planning Benefit Program (FPBP) provides Medical Assistance coverage for family planning services to eligible persons of childbearing age based on their income. Both the application process and the services provided are confidential.

If you are eligible, you will have access to family planning services from all Medical Assistance enrolled family planning providers. These services include: all FDA approved birth control methods, devices, and supplies, comprehensive reproductive health history and physical/gynecological examination, male and female sterilization, pregnancy testing and counseling, and preconception counseling. If you are eligible, coverage will begin on the first of the month in which you apply.

Most local county health departments, publicly-supported family planning clinics, and Prenatal Care Assistance Program providers (Medicaid enrolled family planning providers) may assist you in completing the application and obtaining required documentation. Eligibility for the Family Planning Benefit Program will continue for 12 months unless eligibility circumstances change. After the 12 months you will receive a renewal form in the mail. For more information about this program, call or visit your local department of social services and ask for an application. You may be able to apply at a family planning provider's office. To find out where a participating family planning provider is in your area, you may call **1-800-541-2831**. (See the description of Family Health Plus at end of the Medical Assistance section of this booklet.)

Q. What Is The Medicaid Buy-In Program For Working People With Disabilities?

A. Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) offers Medical Assistance coverage for working people with disabilities who have net incomes at or below 250% of the Federal Poverty Level (FPL) and non-exempt resources at or below \$10,000. The program is designed to help working people with disabilities retain their healthcare coverage. Depending on your income, you may be asked to pay a monthly premium.

Q. What Are The Eligibility Requirements For The MBI-WPD Program?

A. To qualify for the MBI-WPD program, you must:

- be certified disabled by either the Social Security Administration (SSA) or State or local Disability Review Team; and
- live in New York State; and
- be a U.S. Citizen, a National, a Native American or an Immigrant with satisfactory immigration status; and
- be at least 16 but less than 65 years of age; and
- be engaged in work activity for which all applicable State and Federal income and payroll taxes are paid; and
- meet the income and resource limits (see below); and

- pay a premium, if required.

Q. How Does Medicaid Work?

A. After an application is approved, most persons will get a plastic card called a **Common Benefit Identification Card (CBIC)**. When you get medical care, give this card to the doctor, pharmacist or other person from whom you want help. Your doctor, pharmacist or other person must agree to bill Medicaid and be a Medicaid enrolled provider. Your bills will be sent to the New York State Medical Assistance program to be paid. Persons enrolled in Family Health Plus will receive a card from the health plan that they selected. Eligible persons enrolled in Family Health Plus or a Medicaid managed care health plan must use providers in their health plan for services covered by the Plan.

In most counties in New York, you will have the option to join a managed care health plan. Most counties have mandatory managed care. (See the Question and Answer “What Is A Medicaid Managed Care Health Plan?”)

Q. Do I Pay Any Money For My Medical Care?

A. Medical Assistance recipients age 21 or older may be asked to pay part of the costs of some medical care/items. This is called a co-payment or co-pay. Your health care provider is allowed to ask you for the co-payment. For each 12 months beginning April 1, there is a \$200 maximum per recipient for all co-payments.

If you are unable to pay the requested co-payment, tell your health care provider when the provider asks you for payment. You can still get the services you need from your provider. The provider cannot refuse to give you services or goods because you tell the provider that you are unable to pay the co-payment. Call 1-800-541-2831 to report any provider who refuses to give you care or services because you are unable to pay the co-payment.

- **Co-payment amounts are as follows:**

Service	Amount(\$)
Inpatient Hospital	\$ 25.00 per stay upon discharge
Outpatient Hospital and Clinic	\$ 3.00 per visit
Non-emergency/Non-urgent Emergency Room Visits.....	\$ 3.00 per visit
Prescription Drugs	
(preferred brand name)	\$ 3.00
(generic)	\$ 1.00
Over-the-Counter Drugs	\$.50
Drugs to treat Mental Illness	NO CO-PAYMENT
Tuberculosis Directly Observed Therapy	NO CO-PAYMENT
Family Planning	\$ 1.00 per order/prescription
Nutritional Medical Formulas and Supplies	\$ 1.00 per order
Medical/Surgical Supplies	\$.50 per procedure
Laboratory.....	\$ 1.00 per procedure
X-rays	\$ 1.00 per procedure

- **Recipients exempt from a co-payment include the following:**

- Recipients under the age of twenty-one;
- Pregnant women (this exemption continues for two months after the month in which the pregnancy ends);
- Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in nursing facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- Recipients enrolled in Medicaid Managed Care Health Plans except that such persons shall be subject to co-payments for each generic prescription drug dispensed, each brand name prescription drug dispensed, and each over-the counter medication ordered by a recognized practitioner;
- Residents of New York State Office of Mental Health or Office Of Mental Retardation and Developmental Disabilities certified community residences and recipients enrolled in a Comprehensive Medicaid Case Management Program (CMCM) or in a Home and Community Based Services (HCBS) Waiver Program. Participants in the Long Term Home Health Care program are **not** exempt from co-payments.

- **Services exempt from co-payments include the following:**

- Emergency services;
- Family planning services (for example; birth control pills or condoms);
- Tuberculosis Directly Observed Therapy;
- Methadone Maintenance Treatment Programs, mental health clinic services, mental retardation clinic services, alcohol and substance abuse clinic services.

NOTE: Co-payments are not charged by practicing physicians and dentists or for home health and personal care services.

NOTE: If you are getting **Family Health Plus**, you have different co-payments. (“See the question “How Much Does It Cost?” in the **FAMILY HEALTH PLUS** subsection in this **MEDICAL ASSISTANCE** section, several pages after this note.)

Q. How Often And How Much Medical Assistance Help Can I Get?

A. The number of times Medical Assistance will pay for visits to doctors or clinics, labs and drug stores may be limited. This limit is called "**Medicaid Utilization Thresholds**". Your worker can tell you if **Medicaid Utilization Thresholds** apply to you.

Q. What Is A Medicaid Managed Care Health Plan?

A. Most counties have a Medicaid Managed Care program through one or more Medicaid Managed Care health plans. When you join a Medicaid Managed Care health plan, you use the providers and hospitals that are in your plan. You choose your own doctor or nurse practitioner who will keep track of all your health care. This person is called Primary Care Provider (PCP). Your Primary Care Provider will send you to a specialist if you need one. Under Family Health Plus, all services are received from managed care plan that you select.

Q. Why Join A Medicaid Managed Care Health Plan?

A. In many counties, you must join a managed care health plan to receive most of your Medicaid health care services. Call your local department of social services to find out if you can join or must join a Medicaid Managed Care health plan. Most Medicaid Managed Care health plans offer more providers to choose from than regular Medical Assistance. You get to choose your own Primary Care Provider (PCP), which means you don't need to use the emergency room for medical care that is not life threatening. Your Primary Care Provider will give you a referral when you need to see a specialist. You can call your Primary Care Provider or a health plan phone number 24 hours a day if you think you need medical care.

If you are pregnant, you will have your own doctor or nurse practitioner who will give you all the medical care and tests that you need. Your newborn baby will get follow-up visits. Your children will also have their very own Primary Care Provider.

There are no co-payments or utilization thresholds except for pharmacy services when you are in a Medicaid Managed Care health plan. You will get your own health plan card that is separate from your Common Benefit Identification Card (CBIC).

More information is available on the New York State Department of Health website at www.nyhealth.gov and click Health Insurance Programs, then click Managed Care.

Q. Can Medicaid Pay For Past Medical Bills?

A. We can pay you for some bills you paid before you asked for Medical Assistance – even if the doctor or other provider that you paid does not take Medical Assistance. The following explains when we will pay you for these bills.

What bills can be paid? You can be paid for bills you paid before you asked for Medical Assistance and for bills you pay until you get your Common Benefit Identification Card (CBIC). Bills you paid before you asked for Medical Assistance must be for services you received on or after the first day of the third month before the month that you asked for Medical Assistance. Example: If you ask for Medical Assistance on March 11, we can pay you for services you received and paid for from December 1 until you get your Common Benefit Identification Card (CBIC).

What if the doctor or other provider that you paid doesn't take Medical Assistance? We can pay you for some bills even if the doctor or other provider you paid does not take Medical Assistance. If you paid the bills before you asked for Medical Assistance, we can pay you even if the doctor or other provider does not take Medical Assistance. After the day you ask for Medical Assistance, we can pay you only if the doctor or other provider takes Medical Assistance.

Like public sponsored health insurance, once your application for Medicaid or Medicaid sponsored insurance with a managed care organization is approved, you must go to Medicaid providers or in network health care organizations to be paid for services rendered.

Always ask the doctor or other provider if he or she takes Medicaid. After you ask for Medical Assistance, we will not pay you if the doctor or other provider does not take Medicaid.

Are there more rules? Yes. You also need to know that:

1. The bills you paid must be for services that the Medical Assistance program pays for. These services include, but are not limited to, doctors, home care, hospitals, and drugs.
2. We can only pay what Medical Assistance pays for these services. This may be less than the bill you paid.
3. We can pay you only when we decide you can get Medical Assistance and only if you could have gotten Medical Assistance when you paid the bill.
4. We can pay you only when the bills you paid were for services that you needed.

5. You must give us the bills and prove you paid them.

What if my family or friend paid the bills for me? If your bills were paid by a family member or friend, we may be able to pay them. Ask your worker.

Any questions? Please ask your worker if you have any questions.

Q. Can Medical Assistance Pay For Medical Care I Get Outside Of New York State?

- A.** Maybe. Medical Assistance will pay for medical care you get out of state if:
- people from your county usually get medical care in that state and you see a provider who is enrolled in and accepts New York State Medicaid; or
 - your local department of social services placed or helped place you in a nursing home or foster care in another state; or
 - your doctor has gotten approval for you to get medical care out of state (prior approval); or
 - you need emergency medical care while traveling in another state, but **only** if the doctor or other person providing care agrees to bill the New York State Medicaid program.

If you are a member of a Medicaid Managed Care health plan, call the health plan member services number on the back of your card to find out how to get services if you are going out of state.

Q. What Is Medicare?

- A.** **Medicare** is not the same as Medical Assistance (Medicaid). Medicare is a federal insurance program administered by the Social Security Administration that pays for hospital bills (Part A) and doctor bills and some other medical services (Part B), and prescription drugs (Part D). You can apply for Medicare at your local Social Security Office.

Q. Can I Have Both Medicare And Medicaid?

- A.** Yes. If you are eligible for both programs, Medicare will be billed first and Medicaid will pay for services that Medicare does not cover but that are covered by the Medical Assistance program.

Q. Can Medical Assistance Pay My Medicare Premiums?

- A.** Yes, under certain conditions, Medical Assistance may pay for Medicare Part A or Part B premiums, coinsurance and deductibles. Medical Assistance does not pay for Part D premiums or co-payments.

Q. If I Have Both Medicare And Medical Assistance, Do I Have To Get My Prescription Drugs Through Medicare Part D?

- A.** Yes, if you have both Medicare and Medical Assistance, enrollment in Medicare Part D is a condition of eligibility for receiving Medical Assistance. The only exception to this rule is if you or your dependents have other health insurance through a retiree insurance plan, and you have been told that if you enroll in Medicare Part D, you will lose your health insurance coverage. Medical Assistance may sometimes pay for certain prescription drugs that are not available through Medicare Part D.

Q. Should I Cancel Any Other Health Insurance I Already Have?

- A.** No. Wait and ask this question at your interview.

Q. Can I Still Keep Some of My Income If I Am In A Nursing Home Or Other Medical Facility?

- A.** Yes. You can keep a small amount for your own personal use. You can also keep some of your income and resources for your family if they are dependent on you.

Q. Are There Higher Income And Resource Limits For Pregnant Women And Children?

- A.** Yes, if you are pregnant or want help for a child younger than age 19, you can have higher income and your family's resources are generally not considered.

CHILD HEALTH PLUS

If you have children and your income is too high for Medical Assistance, you may want to apply for **Child Health Plus** for your children. You can apply for **Child Health Plus** by calling toll free **1-800-698-4543**.

NOTE: If you are pregnant or want help for a baby under the age of one, there is no limit to the amount of resources the family can have.

Q. What Are Home And Community Based Services (HCBS) Waiver Programs?

- A. Home and Community Based Services (HCBS) Waiver, programs permit a state to furnish an array of home and community based services that assist Medicaid-eligible individuals to live in the community and avoid medical institutionalization. These are Medical Assistance programs which may provide special services that are not typically paid for by Medical Assistance. The programs may also have different financial eligibility rules.

New York has HCBS Waiver programs for:

- Developmentally Disabled Adults and Children
- Adults with Traumatic Brain Injuries
- Long Term Home Health Care Program Needs
- Children with Serious Emotional Disturbance
- Children with Severe Physical Disabilities

In 2007 a new HCBS Waiver, "Bridges to Health" (B2H) was approved. The B2H Waiver allows for services to be provided to children who are in foster care and who have serious emotional disturbance, are medically fragile, or have developmental disability.

Q. What If I Have Emergency Medical Needs?

- A. New York State law requires hospitals to give you emergency care, even if you cannot pay for it. If you have a medical emergency, like a heart attack or other life-threatening illness, go to a hospital **right away**, before you find out if you are able to get Medical Assistance or before you have applied for Medical Assistance. If you are sick and need medical care right away, and you have applied for but have not gotten your Common Benefit Identification Card, your worker may be able to help you get a temporary card for the medical help you need. You must show the card when you get medical treatment and the doctor or other person providing medical care must agree to bill Medical Assistance.

Medical Assistance may be able to pay medical bills for care you were given during the three months before you applied for help. Remember to tell your worker if you have any paid or unpaid medical bills.

Q. What Is Prospective Drug Utilization Review?

- A. The Prospective Drug Utilization Review Program lets a pharmacist check a computer before you get your prescription filled to see if you recently received any other medicines that should not be taken with your new prescription. If the pharmacist sees a problem, the pharmacist may check with your doctor to find out if you should be given the new medicine. This is done to make sure you get the right medicine. By checking with the computer, your pharmacist will also be better able to answer any questions you may have about your medicines.

Q. If I Sell, Give Away Or Transfer Any Money Or Property, Can I Still Get Medical Assistance?

- A. This section explains what may happen if you are institutionalized and you or your spouse transfer any property or money and apply for Medical Assistance. A transfer is when you give away money or property or sell property for less than it is worth. You **can keep** certain money or property for you and your family and still get Medical Assistance. If you or your spouse transferred **other** money or property, Medical Assistance **might not** pay for the following medical care for a period of time, depending on how much money or property you transferred:

1. Nursing home care
2. Certain care in your own home, which is like nursing home care
3. Care you get in a hospital, when you no longer need hospital care and you are waiting for nursing home care

However, Medical Assistance **will** pay for **other** medical care if you are eligible.

In most cases if you want full Medical Assistance coverage, you cannot transfer money or property. Sometimes, you can transfer money or property and still get full Medical Assistance coverage if:

- You transfer money or property to your husband or wife.
- You transfer money or property to your child who is certified blind or certified disabled. The local department of social services where you are applying must decide if your child is certified blind or certified disabled.
- The property transferred was your home, and it was transferred to your husband, wife, child under age 21 or child of any age who is certified blind or certified disabled. The local department of social services where you are applying must decide if your child is certified blind or certified disabled.
- You transfer your home to your brother or sister who already has a right to part of your home and lived in the home for at least one year immediately before you went into a nursing home.
- You may transfer your home to your child if your child was living in your home at least two years immediately before you entered a nursing home, and your child took care of you so that you could stay home rather than go into a nursing home.
- You set up a trust for a certified disabled individual under 65 years of age. The local department of social services must decide if the individual is certified disabled.

When the local department of social services decides that you have transferred any property or money and you think that they have made a mistake, you have a right to prove that you did not transfer the property or money by:

- proving that you meant to sell the property for what it was worth or to get something else of equal value in exchange
- proving that you got rid of the money or property only for some reason other than to get the medical care listed above as 1, 2, or 3 of this answer.
- proving that despite all your attempts, you cannot get the money or property back or get something of equal value, and that you cannot get the medical care you need without Medical Assistance. You must work with the local department of social services when trying to get the money or property back.

Q. Will A Claim Be Made Against My Estate When I Die?

A. If you receive medical services paid for by Medical Assistance on or after your **fifty-fifth** birthday, or when permanently residing in a medical institution, Medical Assistance **may** recover the amount of the cost of these services from the assets in your estate upon your death.

Q. Can I Get Medical Assistance If I Am Not A Citizen Of The United States?

A. For the Medical Assistance Program, identity, citizenship and/or satisfactory immigration status must be documented. If you are pregnant, you do not have to tell us about your citizenship or alien status. If you do not have satisfactory immigration status you may be eligible for Medicaid for the treatment of a medical emergency. For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for the purpose of Medical Assistance. Additionally, if you are a Native American born in Canada, with at least 50% Native American blood or a Native American who was born outside the United States and belong to a federally recognized tribe, you are also regarded as a United States citizen for the purpose of Medical Assistance.

Otherwise, if you are **not** a citizen of the United States, in order to be eligible for Medical Assistance you must provide documents that show you are an alien in one of the following immigration categories:

- an alien admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act (INA); or
- an alien granted asylum under Section 208 of the Immigration and Nationality Act; or
- an alien whose deportation or removal has been withheld under Sections 241(b)(3) or 243(h) of the Immigration and Nationality Act; or
- an alien admitted to the United States as a Cuban/Haitian entrant; or
- an alien admitted as an Amerasian immigrant; or
- an alien who is on active duty in the U.S. Armed Forces or, veterans who have received a discharge characterized as honorable or the spouse, unremarried surviving spouse or unmarried dependent children of any such immigrant; or
- an alien who has been admitted as a lawful permanent resident; or
- an alien who has been paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one year; or
- an alien who has been granted conditional entry under Section 203(a)(7) of the Immigration and Nationality Act; or
- an alien who has been battered or subjected to extreme cruelty in the United States by a family member and who meets certain other requirements; or
- an alien who has been subjected to a Severe Form of Human Trafficking in Persons under the Victims of Trafficking and Violence Protection Act of 2000; or
- an alien who meets the DOH Permanently Residing Under Color of Law (PRUCOL) criteria and who may be eligible for Medical Assistance include:
 - a. an alien paroled for less than one year;
 - b. an alien residing in the United States pursuant to an Order of Supervision; under Section 241(a)(3) of the Immigration and Nationality Act (INA);
 - c. an alien residing in the United States pursuant to an indefinite stay of deportation; granted cancellation of removal pursuant to Section 240A of the INA;
 - d. an alien granted deferred action status, which defers their departure;
 - e. an alien granted "K3" or "K4" visa status established under the Legal Immigration Family Equity Act (LIFE Act);
 - f. an alien who has filed an application for adjustment of status to lawful permanent resident that the United States Citizenship and Immigration Services (USCIS) has accepted as properly filed or has granted;
 - g. an alien granted a stay of deportation;
 - h. an alien granted voluntary departure;
 - i. an alien who entered and has continuously resided in the United States since before January 1, 1972;
 - j. an alien granted suspension of deportation; or
 - k. alien living in the United States with the knowledge and permission or acquiescence of the federal immigration agency USCIS and whose departure such agency does not contemplate enforcing. Examples include, but are not limited to: permanent non-immigrants, pursuant to P.L.99-239, (applicable to citizens of the Federated States

of Micronesia and the Marshall Islands); applicants for adjustment of status, asylum, suspension of deportation or cancellation of removal or for deferred action; persons granted extended; voluntary departure or Deferred Enforced Departure due to conditions in their home country; immigrants granted Temporary Protection Status (TPS); and immigrants having a “K” “V” “S” or “U” visa.

If you are an alien who is not in any of the immigration categories listed above, you may be able to get help with your medical care if you are pregnant or you need medical care because of an emergency medical condition.

Q. Are There Limits On The Number Of Times I Can Receive Certain Medical Services Through The Medical Assistance Program?

A. Yes. There are limits on the following types of services:

Service Type	Number of visits, items or lab tests allowed in a year.	
	Recipients who are: - Under 21 or 65 or over - Certified disabled - Certified blind - Single caretaker of a child under 18	Most Other People who are: - between 21 and 65
Physician and/or Clinic	10 visits	10 visits
Laboratory	18 tests	18 tests
Pharmacy (prescription drugs and over-the-counter medicine.)	40 items	43 items
Mental Health Clinic	40 visits	40 visits
Dental Clinic	03 visits	03 visits

Emergency Medical Care Will Be Covered Even If You Have Reached These Limits.

There are no limits on the following services:

- Family planning services
- Methadone maintenance treatment
- Obstetric services (pregnancy)
- Care given under a managed care program
(See Managed Care Programs in this booklet)
- Kidney dialysis
- Child Teen Health Plan
- Other services call **1-800-421-3891**

Benefit Year

Service limits are for a 12-month period called a benefit year, which begins the month you become eligible for Medical Assistance. You will have these same limits even if you go on and off Medical Assistance during this benefit year. After the benefit year is over, a new 12-month benefit year will begin with the full number of service limits (for example: 18 laboratory tests). Services not used from the last benefit year will not be carried over to the new benefit year.

During each benefit year we will keep track of the number of services you are using and will let you know by mail if you are using services quickly and are in danger of reaching your limit. We will also let you know by mail if you have reached your service limit.

Common Benefit Identification Card (CBIC)

When you go for a medical service, your doctor, clinic or pharmacy must first check with Medical Assistance to see whether you have reached the limit for medical services. It is important that you show your "Common Benefit Identification Card" (CBIC) each time you go for medical services. Each case member will receive a CBIC for Medical Assistance purposes.

If you are enrolled in a managed care plan, you will also get a health plan card that is separate from your CBIC. (See the Question and Answer "What is a Medicaid Managed Care Plan?")

If You Need More Services

Your doctor can fill out a special form called a "Threshold Override Application" to ask Medical Assistance to increase the number of services you can receive or to give you an exemption from service limits.

You should ask your doctor to fill out the Threshold Override Application to get more services when:

- you or other household members have a serious illness or are sick a lot; or
- you get a letter from Medical Assistance warning you that you are using services quickly and are in danger of reaching your service limit; or
- you get a letter from Medical Assistance telling you that you have reached your service limit.

If you need services above your limit make sure that you ask your doctor to fill out the Threshold Override Application. Remember, if you do not ask for more services and you reach your limit. Medical Assistance will not pay for additional services, except for emergency medical care, until your new benefit year begins.

Managed Care Programs

If you enroll in a Medicaid Managed Care Program you will not be subject to the Utilization Threshold Program except for pharmacy. To find out if there is a Medicaid Managed Care Program available to you, please call your local department of social services. If you are enrolled in Family Health Plus, you are not subject to Utilization Thresholds, but there may be limits on some services.

If You Have Any Questions

Call your local department of social services and ask for the Medicaid Managed Care Coordinator (upstate New York). In NYC, call toll free **1-800-505-5678**.

Fair Hearing Rights

You have a right to a Fair Hearing when your application for an exemption or an increase in service limits is denied and you have reached your service limits. At this hearing you can raise the issue of whether we correctly figured the number of services you used.

Your eligibility for Medical Assistance will be determined by your local department of social services. Generally, you should contact your local department of social services with any questions concerning your application for Medical Assistance. If you have general questions concerning Medical Assistance in New York State, you may call toll free **1-800-541-2831**.

Q. Are There Any Program Requirements That May Limit What Drugs I May Get?

- A.** Medical Assistance law requires that New York State Medical Assistance recipients receive generic drugs in place of brand name drugs. The law requires doctors to prescribe the generic version of a drug, unless they get special approval for a brand name drug.

FAMILY HEALTH PLUS (FHPlus)

Q. What Is FHPlus?

- A.** FHPlus is a public health insurance program for adults age 19 through 64 who have incomes too high to qualify for Medical Assistance. FHPlus is available to single adults, couples without children, and parents with limited income who are not eligible for employer-sponsored health coverage through Federal, State, county, municipal or school-district benefits plans. Family Health Plus premium assistance is available to individuals who are covered by health insurance through other employers. To be eligible for FHPlus, you must be a resident of New York State, and be a United States citizen, or an alien who falls into one of the immigration categories listed earlier. There are also income and resource guidelines that must be met. Health care is provided through a participating managed care plan that you select, in your area.

Q. How Do I Qualify for FHPlus Premium Assistance?

- A.** If you have insurance through your employer you may be eligible for help in paying for your share of the insurance premiums.

Q. How Can I Apply?

- A.** When you apply for Medical Assistance, either at a local department of social services or with a facilitated enroller, eligibility determination for Medicaid or FHPlus is made automatically. If eligible, you will be given the appropriate coverage for which you are eligible.

Q. What Benefits Can I Get?

A. FHPlus provides comprehensive coverage, including: prevention, primary care, hospitalization, prescription and other services. Some services have limits. A co-payment may be required for some services. FHPlus does not cover: nursing home care, long term home health care, personal care and non-emergency transportation. Some FHPlus plans offer dental services; others do not.

Q. If I Move To A New County Do I Have To Re-Apply To Get Medicaid/FHPlus?

A. No. If you move, you must notify your local department of social services of your new address. If there are no other changes in your circumstances that effect your eligibility. Your Medicaid case will be transferred to your new county of residence.

Q. How Is Health Care Provided?

A. Health care in the FHPlus program is provided through managed care plans. You must select a participating health plan when you apply. When you choose a health plan, you use the providers and hospitals that are in that plan. You will get your own health plan card so you can get services from the plan. You will also receive a Common Benefit Identification Card (CBIC) to use for covered pharmacy benefits. If you received benefits in the past and were sent a card, a new card will not automatically be mailed to you. If possible, you should use the same card you received before. Please keep your card in a safe place and let you worker know immediately if your card does not work, is lost or stolen. Keep this card even if you stop receiving benefits. The same card will be used again if you become eligible again in the future.

Q. How Do I Choose A Health Plan?

A. In choosing a health plan, you should think about the doctors you want, the services you and your family need, and the health plans available to you. Make sure the doctor you want to see is in the health plan you choose. After you join a plan, you must use the hospital, clinics and doctors that work with that plan.

Q. How Much Does It Cost?

A. There is no cost to join FHPlus, and no yearly fee or deductibles. Once enrolled you may be asked to pay part of the costs of some medical care/services. This is called a co-payment or co-pay.

The co-payment amounts for FHPlus are as follows:

<u>SERVICES</u>	<u>AMOUNTS (\$)</u>
• Brand Name Prescription Drugs	\$6 for each prescription and each refill
• Generic Prescription Drugs	\$3 for each prescription and each refill
• Clinic visits	\$5 per visit
• Physician visits	\$5 per visit
• Dental Services visits	\$5 per visit up to a total of \$25 per year
• Lab Tests	\$0.50 per test
• Radiology Services (like diagnostic x-rays, ultrasound, nuclear medicine, and oncology services)	\$1 per radiology service
• Inpatient Hospital stays	\$25 per stay
• Non-urgent Emergency Room visits	\$3 per visit
• Covered Over-The-Counter drugs (e.g., smoking cessation products, insulin)	\$0.50 per medication
• Covered medical supplies (e.g., diabetic supplies such as syringes, lancets, test strips, enteral formula)	\$1 per supply

Pregnant women or individuals under the age of 21 will not have to pay the co-payment. In addition, enrollees do not have to pay co-payments for family planning services, including birth control, or if they are a permanent resident of a nursing home, a resident of an Intermediate Care Facility for the Developmentally Disabled, or an Office of Mental Health or Office of Mental Retardation and Developmental Disabilities Certified Community Residence. If you are a resident of an adult care facility licensed by the State Department of Health, you do not have to pay co-payments for prescription drugs.

If you cannot afford the co-payment at the time of services, tell your provider. The provider must still provide services but can bill you later.

Q. Can FHPlus Help With Past Medical Bills?

A. No. Unlike Medicaid, FHPlus cannot pay for any care you receive before your enrollment in your FHPlus plan.

Q. Where Can I Get Additional Information On FHPlus?

A. To obtain additional information on the FHPlus program, you can call at the toll free hot line at **1-877-9FHPlus (1-877-934-7587)** or log onto the FHPlus website at **<http://www.health.state.ny.us/nysdoh/whatisfhp.htm>**.

Q. If You Have A Disability And Are Working And Have More Income And Resources Than Is Allowed For Medicaid, Is There Any Way To Get Or Keep Medicaid Health Care Coverage?

A. Yes, if you are between 16 and 64 years old, have a disability as defined by the Social Security Administration, and are working, you can have income up to 250% of the Federal Poverty Level (FPL) and resources as high as \$10,000 by participating in the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD). A monthly premium may be charged for participants in this program who have countable income between 150% and 250% of the FPL.

Q. What If You Do Not Qualify For Medicaid Or FHPlus? Is There Any Other Help?

A. The New York State Department of Health Cancer Services Program provides breast, cervical, and colorectal screening at no cost to eligible individuals who are uninsured. If breast, cervical or colorectal cancer is found, you may be able to get Medicaid coverage. Also, if prostate cancer is found by a doctor in this program, you may be able to get Medicaid coverage for treatment. For more information call toll free **1-800-422-2262**.

SECTION C

CHILD SUPPORT

Q. What Are Child Support Enforcement Services?

- A.** Child support enforcement services are those services provided by the Child Support Enforcement Unit (CSEU) within each social services district. The CSEU will do the following for you, as appropriate:
- find a noncustodial parent through computerized searches;
 - establish legal fatherhood for a child either by helping both parents sign a voluntary acknowledgment of paternity or by referring the matter to court;
 - obtain a support order including provisions for health insurance benefits and cash medical support based on the state's child support guidelines by filing petitions with the family court;
 - modify a child support order by filing a petition with the court where there has been a substantial change in circumstances;
 - collect and disburse child support, or child and spousal support, payments from the noncustodial parent;
 - enforce child support, or child and spousal support, with administrative remedies including: income withholding, state and federal tax refund offset, bank account seizure, lottery offset and suspension of drivers' licenses or with court-based enforcement remedies, including: suspension of state professional or business licenses, suspension of recreational licenses, and any other court-based remedies permitted by law;
 - review the support order for and, if appropriate, apply a cost-of-living adjustment.

If the noncustodial parent lives in another state, either your local CSEU or the child support agency in the other state can provide you with assistance in establishing paternity, and establishing, modifying and/or enforcing a support order as necessary and appropriate.

Q. Who May Get Child Support Enforcement Services?

A. Any custodial or noncustodial parent, or non-parent caregiver acting as a guardian of a child for whom support is needed, may obtain child support enforcement services.

These services are available to the general public, as well as to applicants/recipients of Temporary Assistance, Safety Net Assistance, Medical Assistance, Title IV-E or non-Title IV-E Foster Care, Food Stamp Benefits and Child Care.

Q. How Do I Apply?

- A. You may apply by contacting the CSEU located in your local department of social services or, if you live in New York City, by contacting the Human Resources Administration Office of Child Support Enforcement (HRA OCSE) to obtain and complete a child support services application. If you are applying for Temporary Assistance for a child for whom legal fatherhood needs to be established or where there is a noncustodial parent, you will be automatically referred to the CSEU.

Q. What Happens When I Apply For Or I Am Referred For Child Support Enforcement?

- A. You will have an interview with the CSEU to determine what services are necessary to secure support for your child(ren). During the interview you will be asked to provide information and documentation, such as:
- the noncustodial parent's name, Social Security number, date of birth and mailing and residential address;
 - the name and address of the noncustodial parent's employer;
 - copies of income information for yourself and noncustodial parent (e.g., tax records, pay stubs, bank and business records);
 - information about available health care coverage;
 - the child's birth certificate or a marriage certificate;
 - copies of court orders for support, separation agreements, divorce decrees or acknowledgments of paternity; and
 - information about your child-related expenses (e.g., child care, health care and educational expenses).

This information is critical to the ability of the child support enforcement program to expedite getting child support for you. Your child support worker will assist you with the next steps in the process.

Q. If I Apply For Temporary Assistance Am I Required To Cooperate With The Child Support Enforcement Program?

- A. Yes, as a condition of eligibility you must:
- cooperate with the agency in establishing legal fatherhood for any child born out of wedlock; and
 - cooperate with the agency in establishing, modifying and enforcing child support for any child for whom assistance is sought.

Q. What Happens If I Do Not Cooperate With The Child Support Enforcement Program?

- A. When an individual, without good cause, fails to cooperate with the child support enforcement program, the Temporary Assistance benefit available to the household is reduced by 25 percent.

Q. What If I Do Not Want To Cooperate Because I Have Safety Concerns For My Child Or Myself?

- A. You need to indicate what your concerns are to your worker. The worker will guide you through appropriate steps to determine if you have good cause or if you need a domestic violence waiver from child support requirements.

Q. When I Apply For Temporary Assistance, Do I Have To Assign My Rights To Receive Child Support Payments?

- A. Yes. Beginning October 1, 2009, new Temporary Assistance applicants/recipients are required to assign any rights to support which accrue during the period of assistance that the applicant/recipient may have in his or her own right or on behalf of any other family member for whom the applicant/recipient is applying for or receiving assistance. Individuals who are Temporary Assistance applicants/recipients prior to October 1, 2009 continue to assign all rights to support held on their own behalf or on behalf of any other family member for whom the applicant/recipient is applying for or receiving assistance, whether or not those rights accrue during the period of assistance.

Support rights which were assigned to the State by applicants/recipients for Temporary Assistance prior to October 1, 2009 will continue to be assigned if such individuals re-apply for Temporary Assistance on or after October 1, 2009. However, for new applicants/recipients only the rights to support which accrue while they are in receipt of assistance will be subject to the new assignment made on or after October 1, 2009.

Q. If I Am Receiving Temporary Assistance Will I Also Get Child Support Payments?

- A. When you assign your rights to support, the child support payments collected while you are receiving Temporary Assistance are first distributed to the agency to reimburse the benefits provided to you and other family members on your Temporary Assistance case. However, for each month in which current support is collected, you will receive on your EBT card a "pass-through payment" taken out of the funds distributed to the agency. Once all benefits paid to you have been reimbursed to the extent allowed by any existing assignment of support rights, any excess amount of support that is collected will be paid to you on your EBT card as an "excess support payment."

Q. What Is A "Pass-Through Payment?"

- A. A pass-through payment is a portion of the assigned current support collections which, when paid timely, the state passes through to families who are currently on Temporary Assistance. The pass-through payment is the lesser of an amount of up to the first \$100 of current support collected each month or the current support obligation amount. Effective January 1, 2010, the \$100 pass-through payment will continue where there is one individual under the age of 21 active in the Temporary Assistance case. Where there are two or more individuals under the age of 21 active in the same Temporary Assistance case, the pass-through payment will increase to the lesser of an amount up to the first \$200 of current support collected each month or the current support obligation amount collected for the month. The pass-through payment is disregarded from budgeting when determining the amount of Temporary Assistance that the family will receive but may reduce your Food Stamp Benefits.
- Q. What Happens To My Child Support Arrears When Support Collected Pays Back All Of My Temporary Assistance Benefits?**
- A. While you are on Temporary Assistance, if all of the benefits provided to you that were subjected to a child support assignment have been paid back, you are entitled to receive the support payments collected for any arrears/past-due support owed to you. Beginning October 1, 2009 these arrears will be paid directly to you by the Support Collection Unit as "family arrears." Additionally, the household may receive a "pass-through payment" if there is a current support collection.
- Q. How Will The Family Arrears Payment Affect My Benefits?**
- A. The amount of family arrears payment will be reported to your local department of social services and reviewed to determine whether it affects your eligibility for Temporary Assistance, Food Stamp and/or Medicaid benefits.
- Q. When I No Longer Receive Temporary Assistance, Will Child Support Services And Collections Continue?**
- A. Child Support Enforcement Services automatically continue after your Temporary Assistance case closes unless you request the CSEU to close your case. If you continue Child Support Enforcement Services, you will receive all the child support collected except any collections made for past-due support/arrears owed to the Agency under an assignment of rights made when you applied for Temporary Assistance.
- Q. How Long Does A Parent Have To Pay Child Support?**
- A. A parent has an obligation to pay child support for a child until (s)he is 21 years of age. After the child reaches 21 years of age, the parent remains obligated to pay only past-due support/arrears.

SECTION D FOOD STAMP BENEFITS

- Q. What Are Food Stamp Benefits?**
- A. Food Stamp Benefits are used to purchase food items and are redeemed when you use your Common Benefit Identification Card (CBIC). Most food stores accept the CBIC/EBT card. Look for the Quest sign on the door or window of the store.
- Q. Who May Get Food Stamp Benefits?**
- A. You may be able to get Food Stamp Benefits if you:
- Work and get low wages
 - Have little or no income
 - Are elderly or disabled
 - Get Supplemental Security Income (SSI) or Temporary Assistance
 - Are homeless (even if you are staying with someone temporarily or you are staying at a shelter temporarily)

NOTE: Even if you own a home and a car you may still be able to get Food Stamp Benefits.

- Q. Can I Apply For Food Stamp Benefits If I Have Reached The Temporary Assistance Time Limits?**
- A. Yes. Limits for cash assistance programs do not apply to the Food Stamp Benefits Program.
- Q. How Do I Apply For Food Stamp Benefits?**
- A. In order to apply you must fill out a Food Stamp Benefits application. An application may be requested from your local department of social services. Additionally, you may download and print a food stamp application at <http://www.otda.state.ny.us/main/apps/4826.pdf>. A Food Stamp Benefits application must be accepted at your local department of social services, or in NYC your local food stamp center, if you have filled in at least your name, address (if you have one) and signature. This is important because the amount of your Food Stamp Benefits is figured from the day you turn in (**file**) your Food Stamp Benefits application. You could get more Food Stamp Benefits if you turn in your application the same day you get it. Please note, however, that you will have to fill out the rest of the application to see if you can get Food Stamp Benefits.

NOTE: If everyone in your household has applied for Temporary Assistance, usually you do not have to apply separately for Food Stamp Benefits. Also, you do not have to apply for Temporary Assistance to get Food Stamp Benefits.

Q. Where Do I Apply?

A. You may apply in person, by mail, or fax at your local department of social services. If you live outside New York City, call toll free **1-800-342-3009** for the address and phone number of the local department of social services nearest you. If you live in New York City, you can get the address and phone number of the center nearest you by calling toll free **1-877-472-8411** or toll free **1-800-342-3009** or 311. If you have access to the internet, the following website will provide information of the agency or center nearest you: <http://www.otda.state.ny.us/main/workingfamilies/dss.asp>.

Q. Can Someone Apply For Food Stamp Benefits For Me?

A. You can choose a relative or friend to apply for your household. This person would be called an "**Authorized Representative**". You must print their name, address, and phone number on the application where indicated in the instruction booklet. The space is usually at the back, or end, of the application. Both you and the authorized representative must sign the application unless you reside in an institution. If you want, this person or someone else may also be authorized to access your Food Stamp Benefits and use them to shop for your food. To do this an Authorized Representative can get his or her own EBT card (CBIC).

Q. Do I Have To Apply For Food Stamp Benefits in Person?

A. No. You can also apply by mail or another person can apply for you.

NOTE: If you have access to the Internet, find out if you may be eligible for Food Stamp Benefits and other work supports by visiting www.myBenefits.ny.gov. If everyone in your household is applying for or getting Supplemental Security Income (SSI,) you can also apply at your local Social Security Administration Office.

Q. What Happens When I Turn In My Application?

A. After you turn in your application, you will have a confidential interview with a worker. Usually, you must appear in person for this interview unless:

- you have an Authorized Representative who can go for you.
- you are 60 years of age or older, or disabled, and you do not have an Authorized Representative who can go for you.
- you have a hardship because of transportation difficulties or hardship conditions such as, but not limited to, residing in a rural or remote area, illness, care of a household member, prolonged severe weather, or work hours which make coming to the office difficult.
- you live alone and get Supplemental Security Income (SSI), or you live with your spouse who also gets SSI.
- you are homebound.
- your Non-Temporary Assistance Food Stamp Benefits (NTA-FS) household meets the Working Families Food Stamp Benefits Initiative criteria, that is:
 - any adult member of the food stamp household either works an average of 30 hours per week **or** earns an average weekly income equal to or greater than the federal minimum wage times 30 hours per week; or
 - any two adult members of the food stamp household each either work 20 hours per week **or earns** an average weekly income equal to or greater than the federal minimum wage times 20 hours per week.

Unless the local department of social services determines that you are exempt from Food Stamp Benefits work requirements, you may also be required to participate in Food Stamp Benefits work activities.

NOTE: If you cannot go to the interview and you do not have anyone to go for you, you may be interviewed over the phone or a worker may ask to come to your home.

Q. How Long Will It Take To Get Food Stamp Benefits?

A. It may take up to 30 days from the date you first apply.

Q. Can I Get My Food Stamp Benefits Right Away?

A. Yes, you may be able to get your Food Stamp Benefits within five calendar days. This is called **Expedited Processing**.

Usually, you may be able to get **Expedited Processing** if you are eligible for Food Stamp Benefits and:

- your household has less than \$100 in cash and other available resources **and** has or will get less than \$150 in gross income during the month that you apply; or
- your income and available resources are less than your rent or mortgage, plus heat, utilities and phone, or
- you are a migrant or seasonal farm worker.

NOTE: You do not need to be out of food to get Expedited Processing of Food Stamp Benefits.

Q. If I Am Found Eligible, How Do I Access My Food Stamp Benefits?

A. Please refer to **Section K: “Getting Benefits With Electronic Benefit Transfer (EBT)”**, in this Book.

Q. When Do I Access My Food Stamp Benefits?

A. If you live *outside* of New York City:

The last number of your case, 1 through 9, will tell the earliest date of the month that you can access your Food Stamp Benefits. For example, if your case ends in 2, you can access your Food Stamp Benefits beginning on the 2nd day of the month. If your case ends in 0, you can access your Food Stamp Benefits beginning on the 1st of the month.

If you live *in* New York City:

You will get a form from your Food Stamp Benefits Office that will tell you the earliest date of the month that you can access your Food Stamp Benefits. For example, if the form tells you the first day you can access your Food Stamp Benefits is the 3rd, you can use your Common Benefit Identification Card (CBIC) on the 3rd and thereafter.

NOTE: If your Food Stamp Benefits account goes unaccessed for a 365 consecutive day period, any Food Stamp Benefits in the account that are at least 365 days old will be removed (**expunged**) and not replaced.

Q. Can Food Stamp Benefits Be Used At Senior Citizen Sites And For Home Delivered Meals?

A. You may be able to sign a voucher form for these services to charge your Food Stamp Benefits account.

Q. What Happens If A Person In My Household Does Not Follow A Food Stamp Program Work Requirement Or Quits A Job?

A. A person who does not comply with Food Stamp Benefits work requirements, or voluntarily quits or reduces work hours, without a good reason will be sanctioned (no Food Stamp Benefits for that person), usually for a certain amount of time.

Q. Can I Get Food Stamp Benefits If I Am Not A Citizen Of The United States?

A. Many non-citizens are qualified aliens who are eligible for Food Stamp Benefits. Even if you are not eligible for Food Stamp Benefits, you may receive Food Stamp Benefits for your children if they are eligible. Food Stamp Benefits should not affect your immigration status with respect to any United States Citizenship and Immigration Services' (USCIS) decision regarding your immigration matter.

You may be eligible for Food Stamp Benefits if you are a United States (U.S.) citizen, a non-citizen U.S. national (people born in American Samoa or Swain Island), or a qualified alien. A qualified alien for the purpose of Food Stamp Benefits eligibility is:

1. an American Indian born in Canada with at least 50 per centum of blood of the American Indian race under section 289 of the Immigration and Nationality Act (INA); or
2. a member of an Indian tribe that is a federally recognized Indian tribe (25 U.S.C. 450b(e)); or
3. an alien admitted as a Hmong or Highland Laotian, including spouse and dependent child(ren); or
4. a refugee admitted under section 207 of the INA; or
5. an alien granted asylum under section 208 of the INA; or
6. an alien whose deportation has been withheld under section 243(h) of the INA as in effect prior to April 1, 1997; or removal withheld under section 241(b)(3) of the INA; or
7. an alien admitted as a Cuban or Haitian entrant; or
8. an alien who is a victim of trafficking under section 103(8) of the Trafficking Victims Protection Act; or
9. an alien who is on active duty in the U.S. armed forces or, an honorably discharged veteran, their spouse and dependent children, and the un-remarried surviving spouse and unmarried dependent children of an active duty member or of a veteran who has died; or
10. an alien admitted as an Amerasian; or
11. an alien paroled under section 212(d)(5) of the INA for at least 1 year and who has 5 years in status; or
12. an alien or parent or child of an alien who has been battered or subjected to extreme cruelty in the U.S. by a family member and entered the U.S. before August 22, 1996 or has 5 years in status; or

13. an alien lawfully admitted for permanent residence under the INA and who meets one of the following:
- has 5 years in a qualified status, or
 - has earned or can be credited with 40 qualifying quarters of work, or
 - is in a qualified status and in receipt of certain disability benefits, or
 - is in a qualified status and under eighteen years old.

Fair Hearing Rights

You have a right to a Fair Hearing if you have been denied Food Stamp Benefits, if your benefits have been discontinued, suspended or reduced, or if you disagree with the decision of the local department of social services. For more information about your Fair Hearing Rights, please refer to Book 1 (LDSS-4148A) "What You Should Know About Your Rights And Responsibilities".

Questions?

For further information about Food Stamp Benefits, you may also go to the following internet website:
<http://www.otda.state.ny.us/main/foodstamps/>.

SECTION E

TRANSITIONAL HELP

Q. Can I Still Get Child Care Assistance When My Temporary Assistance Stops?

- A.** Recipients who voluntarily close their assistance case, or who are otherwise ineligible for assistance, may be eligible for a child care subsidy. If you need child care because you are working, and your household income falls within the allowable limits, your worker should determine your eligibility for this child care assistance before your Temporary Assistance stops. You will have to pay a share of the cost of child care. This child care is called transitional child care and is available for up to 12 months after you are no longer eligible for Temporary Assistance.

Q. What If My Medical Assistance Case Closes?

- A.** Transitional Medical Assistance - If your Low Income Family Medical Assistance case closes because you have increased earned income, or the combination of your earned and unearned income increase to make you ineligible, you may still be able to get Transitional Medical Assistance. Low Income Family Medical Assistance is the Medical Assistance program for families who are eligible for Temporary Assistance, but you do not have to be getting Temporary Assistance to get Low Income Family Medical Assistance.

You may be able to get this extra help for up to 6 months if:

- you have been getting Low Income Family Medical Assistance in 3 out of the last 6 months.
- you have a child under the age of 21 living with you.

After the 6 months are up, you may be able to get **6 more** months of Transitional Medical Assistance if:

- your income, less child care cost necessary for employment, is less than 185% of the federal poverty level.
- you fill out the reports sent to you by your local department of social services so that they can see if you are still able to get this help.
- you have a child under the age of 21 living with you.

A woman eligible for Medical Assistance during any month of her pregnancy remains eligible for Medical Assistance until 60 days after the end of her pregnancy. To receive the 60-day postpartum extension, the woman must have applied for Medical Assistance prior to the end of her pregnancy.

An infant, born to a woman eligible for and receiving Medical Assistance during her pregnancy, is eligible for Medical Assistance until the end of the month in which the child turns age one. Medical Assistance includes Medicaid, Family Health Plus, the Family Planning Benefit Program and women presumptively eligible within 3 months of the birth. If a woman applies for Medicaid within 3 months of giving birth and is eligible for the retroactive period when she gave birth, the child is eligible for one year of coverage.

Children up to the age of 19 who are **fully** eligible for Medical Assistance are given Medical Assistance from 12 months from the date that they were determined or redetermined eligible or until their 19th birthday, whichever is sooner, regardless of any changes in income or circumstances.

An individual enrolled in a Managed Care Organization (MCO) is guaranteed six months of Medical Assistance coverage for the capitated benefits offered through the MCO even if he or she loses Medical Assistance eligibility.

Q. Can I Still Get Help With Collecting Child Support After My Temporary Assistance Stops?

A. Yes, as a former recipient of Temporary Assistance child support services continue for you automatically unless you request in writing that such services stop. You should have received notice of the continuation of services at the time your case closed.

Q. Can I Still Get Food Stamp Benefits After My Temporary Assistance Stops?

A. If you work and get low wages, have other low income, or are unable to work, you still may be able to get Food Stamp Benefits (see “Food Stamp Benefits”, Section D of this Book).

SECTION F	CHILD CARE
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Q. What Is Child Care Assistance?

A. Child care assistance helps a parent(s)/caretaker(s) who needs care and supervision for his or her child(ren) when the parent(s)/caretaker(s) is not available to care for his or her child(ren). Child care assistance helps a parent(s)/caretaker(s) to pay some or all of the cost of child care services.

Q. Who May Get Child Care Assistance?

A. There are certain families that are guaranteed child care, some families that are eligible if the local department of social services has funds available, and other families that are eligible if the district has funds available and has decided to pay for child care for those categories of families.

The following families are guaranteed child care, when such services are needed for a child under the age of 13:

- Families applying for or on Temporary Assistance that are participating as required in work activities or involved in other activities required by the local department of social services such as orientation or assessment.
- Families on Temporary Assistance who are participating as required in work activities.
- Families who have applied for and would otherwise be eligible for Temporary Assistance or were receiving Temporary Assistance and voluntarily closed their case while still eligible. The parent(s)/caretaker relative(s) must be in need of child care so the parent(s)/caretaker relative(s) can work, as required.
- Families transitioning off Temporary Assistance, when child care is needed for the parent(s) to work.

The following families are eligible for child care assistance when the local department of social services has funds available and the family has applied for or is receiving Temporary Assistance for an eligible child 13 or older, who either has special needs or is under court supervision, and child care is needed. So that a parent/caretaker/relative can participate in activities required by the local department of social services including orientation, assessment, or work activities.

The following families are eligible for child care assistance when the local department of social services has funds available and, if the family is on Temporary Assistance and child care is needed:

- for a child 13 or older who has special needs or is under court supervision, so that the parent(s)/caretaker(s) relative(s) can work.
- to enable the parent/caretaker relative to engaged in work, or to participate in required work activities, and
- the child has special needs or the child is under court supervision.

The following families are eligible for child care assistance when the local department of social services has funds available:

- The family has applied for or is receiving Temporary Assistance for a child 13 or older,
- Child care is needed to enable the parent/caretaker relative to engage in work or, to participate in required work activities.
- The child has special needs or the child is under court supervision.

Child care is available for families in the following circumstances if the local department of social services has decided to serve these families, the family is on Temporary Assistance, and the local department of social services has funds available. Ask your worker whether your local department of social services pays for child care assistance for one or more of these categories:

- parent(s)/caretaker relative(s) who is participating in an approved activity in addition to their required activity

- parent(s)/caretaker relative(s) is sanctioned but the parent(s)/caretaker relative(s) is participating in unsubsidized employment and receives earned wages at a level equal to or greater than the minimum level required under Federal and State labor law.

Child care is available for families in the following circumstances if the local department of social services has decided to serve these families, the family has income within the allowable limits, the local department of social services has funds available, and the activity has been determined to be a necessary part of a plan for family's self-support. Ask your worker if your local department of social services pays for child care assistance for this category:

- parent(s)/caretaker(s) is looking for a job for a period of up to six months and the parent(s)/caretaker(s) is registered with the New York State Department of Labor's Division of Employment Services Office.
- parent(s)/caretaker(s) is engaged in certain educational or vocational activities.

Child care is available for families in the following circumstances if the local department of social services has decided to serve these families, the family is either on Temporary Assistance or has income within the allowable limits, and the local department of social services has funds available. Ask your worker if your local department of social services pays for child care assistance for one or more of these circumstances:

- parent(s)/caretaker(s) is participating in an approved substance abuse treatment program, or in screening for or an assessment of the need for substance abuse treatment,
- parent(s)/caretaker(s) is homeless or receiving services for victims of domestic violence and is participating in an approved activity or in screening for or an assessment of the need for services for victims of domestic violence,
- parent(s)/caretaker(s) is in an emergency situation for short duration such as cases where the parent(s)/caretaker(s) is absent from the home for a large part of the day because of such things as a fire, looking for housing or providing chore/housekeeping services for an elderly or disabled relative,
- parent(s)/caretaker(s) is physically or mentally incapacitated or has family duties away from home,
- parent(s)/caretaker(s) is involved in certain educational or vocational programs. For some of these programs the parent(s)/caretaker(s) must be working at least 17 ½ hours per week, and must be earning wages equal to or greater than the minimum level required under Federal and State labor law. The local department of social services must decide if the program is expected to improve your ability to earn more money. The local department of social services must also decide whether you are likely to successfully complete the program.

Child care is available for families in the following circumstance if the local department of social services has decided to serve these families, the family has income within the allowable limits and the activity has been determined to be a necessary part of a plan for family's self support. Ask your worker if the local department of social services pays for child care assistance for the following circumstance:

- regardless of income, when there is an open child protective services or preventive services case and it has been determined that the child care is needed to protect the child(ren) or to prevent a foster care placement.

Q. What Does Child Care Guarantee Mean?

- A.** A child care guarantee means that if you meet the eligibility requirements, the local department of social services will provide a child care subsidy to an eligible child care provider for your child care. You will be required to pay for part of the child care cost if you are not receiving Temporary Assistance. Also, if your child care provider charges more than the local department of social services is allowed to pay, you will have to pay the difference between the amount the local department of social services is allowed to pay and the amount your provider charges.

Q. Is There A Time Limit To The Child Care Guarantee?

- A.** Families on Temporary Assistance that are eligible for a child care guarantee will receive child care assistance for as long as they are on Temporary Assistance and are participating in an activity required by the local department of social services. Families that fall under transitional child care guarantee are limited to twelve months of transitional child care assistance. There is no time limit for Child Care In Lieu of Temporary Assistance as long as your income is at or below the amount that would allow you to remain eligible for Temporary Assistance.

Q. What Is The Age Range Allowed For A Child To Receive Child Care Assistance?

- A.** In general, a child is eligible for child care if they are under 13 years of age. However, exceptions are made for children under 18 years of age who are either under court supervision or who have special needs. Children who have special needs or who are under court supervision and are under 19 years of age are eligible so long as the student is a full-time student in an approved educational or vocational program.

Q. How Do I Apply For Child Care Assistance?

- A.** If you live outside of New York City, call or visit your local department of social services and ask for an application package. If you live in New York City and you are on Temporary Assistance or applying for Temporary Assistance, call or visit your local

Job Center. If you are applying only for child care assistance, call the New York City information helpline at 311 and they will direct you where to call. You must complete the application package and turn it in either in person or by mail. Remember, you may turn in the application the same day you get it.

Q. What Happens When I Apply For Child Care Assistance?

A. You will be asked to prove certain things within 30 days of the date the local department of social services receives your application. See Book 1 (LDSS-4148A) "What You Should Know About Your Rights and Responsibilities". The local department of social services will, within 30 days of receiving your application, determine if you are eligible for child care assistance, and will notify you in writing of their eligibility decision within 15 days of the date they make it.

Q. Can I Get Child Care Assistance If I Am Not A Citizen Of The United States?

A. Yes, however, the child who needs child care services must be legally in the United States.

Q. If I Apply For Child Care Assistance Am I Required To Pursue Child Support From An Absent Parent?

A. No, it is not a requirement to pursue child support in order to receive child care assistance. However, establishing paternity and placing responsibility for supporting children on those parents that have the financial resources provides a step toward family self-sufficiency and economic security. Child support is a vital source of income for New York State's single parent households. Next to the custodial parent's earnings, child support is the second largest source of income for low income families. Obtaining child support income and any health care insurance benefits for your child from the absent parent is important for the well being of your family.

Each local social services district has a Child Support Enforcement Unit (CSEU) that will help to establish paternity of your child. The CSEU will help you file a petition with family court to get a support order that is based on the child support guidelines. Child support may cover some of your child care costs. Also, the CSEU will make sure you get the child support you are entitled to and will help you file a petition with family court to collect unpaid support. Upon your request the CSEU will review your support order and if eligible apply a cost of living adjustment to the child support amount.

Your child is legally entitled to health insurance, if it is available from you or the noncustodial parent. The CSEU will help you file a petition with family court to get this coverage if it is available through the noncustodial parent's employer.

These services are available to you whether the noncustodial parent lives in or outside of New York State. A \$25 dollar annual services fee will be charged when you receive child support services in any year if you have never been in receipt of Temporary Assistance for Needy Families and child support collects at least \$500 for you during a 12-month period beginning October 1st each year.

Q. How Much Help Can I Get Paying For Child Care?

A. If you are on Temporary Assistance you are not required to pay a family share of the cost for child care assistance. If you are not on Temporary Assistance you have to pay a share of the cost of child care. The amount depends on the size of your family and your income. If your provider charges more than the local department of social services is allowed to pay you will also have to pay the difference between what your provider charges and the amount the local department of social services is allowed to pay.

Q. How Do I Get Help In Finding A Child Care Provider?

A. The Child Care Resource Referral Agency in your area can help you locate a child care provider. If you live outside of New York City you can contact the New York State Child Care Coordinating Council at **(518) 690-4217** to find a Child Care Resource and Referral Agency that serves your area. If you live in New York City you can call toll free **888-469-5999** for help in locating a child care provider. Or you can visit the New York State Office of Children and Family Services website at **<http://www.ocfs.state.ny.us>**, then go to "Programs and Services", then go to "child day care", and then go to "child care" for help in choosing the right child care setting for your family. You can search all the programs in your area and get information on their record of compliance with New York State standards for child day care providers.

Q. Who Can Care For My Child?

A. You have the right to choose any legally-permissible child care. This includes:

- licensed or registered day care centers
- licensed group family day care
- registered family day care homes
- registered school-age child care programs
- friends, neighbors and relatives who are enrolled with the appropriate legally-exempt caregiver enrollment agency
- caregivers of legally-exempt group child care such as summer day camps that are enrolled with the appropriate legally-exempt caregiver enrollment agency

Q. What Is Transitional Child Care?

- A.** Transitional child care is for families who were receiving Temporary Assistance, but became ineligible when their income increased due to employment or child support. You may be eligible to receive transitional child care assistance for up to 12 months after you become ineligible for Temporary Assistance.

Your worker should determine your eligibility for transitional child care before your Temporary Assistance or guaranteed child care case is closed. As long as you inform your worker before or soon after your Temporary Assistance case is closed, the worker cannot require you to complete a new application. However, they may need some additional information from you in order to find out if you are eligible. Ask your worker if you are eligible for transitional child care.

Requirements for transitional child care are:

- your family's income cannot exceed certain limits;
- you must have been on Temporary Assistance in three out of the last six months, or have received Child Care In Lieu of Temporary Assistance in three of the last six months;
- your child must be under the age of 13 and need child care so you can work; and

You will be responsible to pay a portion of the child care cost each month. The amount you pay depends on the size of your family and your income. If your provider charges above the amount, the local department of social services is allowed to pay, you will also have to pay the difference between what your provider charges and the amount the local department of social services is allowed to pay.

Your transitional child care assistance will be stopped if:

- you are not fulfilling the responsibilities listed above; or
- you are at the end of the twelve month eligibility period; or
- you quit your job without good cause; or
- you no longer need child care to allow you to work; or
- your income exceeds the maximum allowed for your family; or
- your child reaches the age of 13. However, if your child has special needs or is under court supervision, your worker can tell you if there may be other child care programs that can assist you.

Q. What Is Child Care In Lieu Of Temporary Assistance?

- A.** Child Care In Lieu of Temporary Assistance is for families who are applying for or are receiving Temporary Assistance and need child care in order to work; and who choose child care instead of Temporary Assistance.

Requirements for Child Care In Lieu of Temporary Assistance are:

- your household is eligible for Temporary Assistance;
- you are working the required number of hours or are earning gross wages (or if employed in a job where minimum wage is made by the combination of gross earnings and tips you have total wages, or if self-employed you have gross receipts less allowable deductions) equivalent to or greater than the minimum level required under Federal and State Labor law times the required number of hours;
- you need child care for a child under the age 13 so you can work;
- you are using an eligible child care provider.

If you are eligible for Temporary Assistance and decide that all you really need is child care, your worker can tell you how to apply. If you are already receiving Temporary Assistance and are otherwise eligible for Child Care In Lieu of Temporary Assistance, you will need to close your Temporary Assistance case in order to get Child Care in Lieu of Temporary Assistance. If you change your mind and decide that you need Temporary Assistance, as well as child care, you can still apply for Temporary Assistance at any time. If you are found eligible for Temporary Assistance you may still be eligible for child care.

If you choose to receive child care assistance instead of receiving Temporary Assistance and child care, you will have to pay part of your child care costs. This is called your family share. If you live outside of New York City, the minimum amount that you will pay will be \$1 per week. If you live in New York City, the minimum family share for full time care is \$3 per week, and the minimum family share for part time care is \$2 per week. Additionally, if your provider charges more than the amount the local department of social services can pay, you will need to pay the amount that your child care provider charges above the amount the local department of social services can pay.

Fair Hearing Rights

You have a right to a Fair Hearing if you have been denied child care benefits, if your benefits have been discontinued, suspended or reduced, or if you disagree with the local department of social services decision. For more information about your Fair Hearing Rights please refer to Book 1 (LDSS-4148A) "What You Should Know About Your Rights And Responsibilities".

SECTION G	SERVICES
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Q. How Can Services Help Me?

A. Services programs may be able to help you and/or your family with:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Getting child care • Placing a child in foster care or placing a child for adoption • Budget problems | <ul style="list-style-type: none"> • Family abuse problems (child abuse and domestic violence) • Children's behavior • Safely keeping families together • Preventing removal of a child from my home |
|---|--|

Besides these, there are other ways that Services may be able to help you and/or your family. They are described in the rest of this **Services** section.

Q. How Do I Apply For Services?

A. If you live **outside** of New York City, call or visit your local department of social services and ask for an application package.

If you live **in** New York City, call or visit your local Income Support/Job Center or look for the Human Resources Administration (HRA), Administration for Children's Services (ACS), in the Government pages of the telephone book for your borough. Call the number listed for the type of help you need.

Q. What Services Can I Get?

A. You can get or apply for the following services:

1. Child Care - Services to help families who need care and supervision for their children. Children may get child care if the parent in a single parent household or both parents in a two parent household are:

- | | |
|---|---|
| <ul style="list-style-type: none"> • Sick or disabled • Looking for a job • Taking part in an education, job training or employment program which has been approved by the local department of social services • Taking part in a substance abuse treatment program | <ul style="list-style-type: none"> • Receiving domestic violence services • Working • Required to be away from the home for a large part of the day due to unusual situations • Homeless • In an emergency situation |
|---|---|

Children may also get child care in conjunction with protective services to keep them safe, or as part of child preventive services to keep them from entering foster care.

For a more detailed description of child care services and requirements, see **Section F CHILD CARE**, in this book.

2. Preventive Services To Children and Families - Services given to children and families to safely keep the family together and to prevent foster care placement, or to safely return the children from foster care as soon as possible. These services may include:

- Child care
- Parent training and counseling
- Housing services (to enable discharge from foster care)
- Homemaker, housekeeper, parent aide
- Emergency cash, goods, shelter or other essential items
- Clinical services, including drug abuse and alcohol abuse treatment
- Respite care for crisis situations, including AIDS/HIV
- Transportation

Other services may also be available.

There is no income limit to get these services. It is possible that fees could be charged for certain of these services, although that is usually not done.

3. Foster Care

Voluntary Placement – Voluntary placement of a child into foster care is available to provide out-of-home care and services when circumstances or conditions exist that affect the health and safety of the child, to help meet certain parent and child services needs, or if the parent(s) has surrendered the child for adoption.

Birth Families/Legal Guardians – Services given to birth parents or legal guardians of a child who is placed in foster care may include:

- Counseling
- Arranging visits between the child and parent(s)/legal guardian(s)
- Services to help safely return the child home as soon as possible
- Aftercare for children who have been discharged from foster care

Foster Parents – Families who want to provide foster care for a child must apply and be certified (non-relative of a child) or approved (child's relative). Foster parents must undergo a New York State and national criminal background check and meet a number of other licensing requirements, **and** are required to attend training prior to certification or approval. Once certified or approved, upon placement of a child in their care foster parents will receive:

- Monthly payments toward the costs of caring for the foster child, including clothing allowance
- Medical assistance for the foster child including appropriate waiver services, for eligible foster children

Foster parents may receive, as appropriate:

- Child Care for the foster child, if the foster parent has a job or is involved in other activities approved by the local department of social services
- Respite services, where appropriate

4. Adoption –

A. Services given to the birth parent(s) or legal guardian(s) of a child who is being adopted may include:

- Assistance in planning for the child
- Arranging for the surrender of the custody and guardianship of the child to the agency
- Medical, social, counseling and casework services
- Assistance regarding the rights and interests of birth fathers of out-of-wedlock children

B. Services given to families who want to adopt a child may include:

- Help in finding a child to adopt
- Training relating to parenting of an adopted child
- Home Study
- Post-adoption services

Families who want to adopt a child must apply, and will be accepted, for an adoption study. The priority given to the family's application for an adoption study will be based on the characteristics of the children awaiting adoption and the interest that the prospective adoptive parent(s) expresses in adopting children with these characteristics.

In addition, once a child is placed with you for adoption, adoption assistance in the form of extra money (adoption subsidies) and medical assistance may be provided to support children who are handicapped or considered "hard-to-place". There may also be one-time payments for non-recurring costs of adoption.

5. Teenage Pregnancy Programs and Unmarried Parent Services - Social Services to help pregnant teens and unmarried parents may include:

- Education and parent training
- Medical and legal help
- Counseling
- Employment help
- Family planning
- Transportation
- Housing
- Health care and nutrition
- Placement in foster care (A minor mother under age 18 and her baby may be placed in foster care together, with the minor mother retaining custody of her child.)
- Child care

6. Domestic Violence (Physical or Emotional Abuse or Threat of Abuse) - Services given to family or household members, with or without children, to help them with physical or emotional abuse, or threats of physical abuse or emotional abuse. You may be able to get help with:

- Finding a safe place to stay
- Transitional housing
- Medical care
- Assistance with legal issues
- Counseling
- Finding a job
- Child care
- Transportation
- Advocacy services

There is no income limit to get these services.

7. Preventive Services for Adults - Services given to single adults 18 years of age and older or to families without children under age 18. These services may include:

- Counseling
- Support and referral services to prevent or delay having to get long term care outside the home

8. Protective Services For Adults – Services given to individuals 18 years of age or older who are physically or mentally impaired, have been harmed or are at risk of harm, cannot protect themselves, and have no one able and willing to responsibly help them. These services may include:

- Providing prompt response and investigation of referrals of abuse, neglect or exploitation
- Assessing the individual's situation and services needed
- Arranging for appropriate alternative living arrangements in the community where appropriate
- Help getting legal assistance
- Help getting medical care
- Homemaker or housekeeper/chore services for a limited time
- Helping with managing money
- Help obtaining other benefits or services
- Guardianship
- Counseling

There is no income limit to get these services.

9. Residential Placement Services For Adults - Services given to individuals 18 years of age and older who are mentally or physically impaired and need supervised living outside their own homes.

These services include:

- Finding family type homes in the community which can take care of these adults.
- Assisting adults in finding homes that will meet their level of need.
- Providing supportive services for the adults who are placed in these homes.

10. Housing Improvement Services - Services to help with:

- Home repairs and maintenance
- Working out problems with landlords or neighbors
- Getting help from local housing or legal aid agencies
- Finding a place to stay, if necessary

11. Home Management Services - Services to help with learning about budgets, fixing good meals, caring for children, health care, and home care.

12. **Housekeeper/Chore Services** - Services to help with chores such as shopping, light housework, simple repairs and errands when you, or a child or adult's caretaker, is ill, disabled or absent.
13. **Homemaker Services** - Services to help with personal care, home management and household tasks from a trained homemaker when you, or a child or adult's caretaker is ill, disabled or absent.
14. **Kinship Caregiver and Kinship Navigator Programs** – There is a statewide network of community-based supportive programs, and a telephone hotline, that provide services for kinship caregivers and their kin, whether or not the children are in foster care. See the Question and Answer “**If I Am The Caregiver Of A Child Who Lives With Me And Who Is Not My Biological Or Adopted Child, And I Need Additional Help Or Resources To Care For The Child, Can You Tell Me Where To Find Them?**” in the middle of **Section A, TEMPORARY ASSISTANCE**, in this book.
15. **Other Services** you may be able to get:
 - Education services
 - Employment services
 - Family planning services
 - Information and referral services
 - Health-related services
 - Social group services for senior citizens
 - Transportation services

Q. What If Emergency Services Are Needed To Protect Adults, Children or Other Family Members?

A. The following are some services you can get to help you with an emergency.

If you live **outside** of New York City, your local department of social services may be able to help you, in addition to the help that you can get by calling the phone numbers listed below.

If you live **in** New York City, call or visit your local Job Center or look for the Human Resources Administration (HRA) or Administration for Children's Services (ACS) listings in the Government pages of the telephone book for your borough. Call the number listed for the type of help you need. You can also get help by calling the phone numbers listed below. There is no income limit to get these services.

- **Child Protection** - Services given to children under the age of 18 who are abused or maltreated, and to their families.
If you have reasonable cause to suspect that a child has been abused or maltreated, call the Statewide Central Register of Child Abuse and Maltreatment toll free **1-800-342-3720**.
If a report is registered, an investigation will be conducted and, as appropriate, services offered to the family to protect the child(ren).
It is also appropriate to call the Statewide Central Register of Child Abuse or Maltreatment if you have concerns about possible abuse or neglect that may have occurred in a residential child care setting. You may call toll free **1-800-342-3720** to discuss your concerns. If a report is registered, an investigation will be conducted at the residential child care program.
If you are in Monroe County (Rochester and vicinity) or Onondaga County (Syracuse and vicinity) there is a local number you can call instead if you have concerns about child abuse or maltreatment in either a family or a residential child care setting. It is **461-5690** in Monroe County and **422-9701** in Onondaga County.
- **Adult Protection** - Services given to individuals 18 years of age or older who are physically or mentally impaired, have been harmed or may be at risk of harm, cannot protect themselves, and have no one who is able and willing to help them.
To make a referral or to report suspected adult abuse, neglect or exploitation, please call your local Protective Services for Adults (PSA) unit directly at your local department of social services. You may call toll free **1-800-342-3009** (press option 6) to obtain the phone number to reach your local PSA unit.
- **Domestic Violence (Physical or Emotional Abuse or Threat of Abuse)** - Services given to family and other household members, with or without children, to help them with problems of physical or emotional abuse, or the threat of physical or emotional abuse.

To get information and referrals to your local domestic violence services provider you may call the following numbers, toll-free, 24 hours a day:

In New York City call 1-800-621-HOPE (1-800-621-4673)

In any other area of New York State call the NYS Domestic Violence Hotline 1-800-942-6906 (Spanish-speaking call 1-800-942-6908)

A Services caseworker can also arrange for you to get this information.

SECTION H

OTHER BENEFITS

1. **Supplemental Security Income (SSI)** If you are certified blind, certified disabled or age 65 or older and your income and resources are below certain limits, you may be able to get money from the Supplemental Security Income Program. You can apply for Supplemental Security Income at your nearest **Social Security Office**. Most people who get Supplemental Security Income also get Medical Assistance.
2. **Interim Assistance** -You may be able to get money called Interim Assistance through the Safety Net Assistance Programs if:
 - You have applied for Supplemental Security Income (SSI) but your application has not been approved or denied.
 - You are appealing a denial or suspension of your SSI.
 - You are appealing a termination of your SSI because SSA determined you were no longer eligible.

This Interim Assistance will stop once you start getting your SSI, or when your SSI is reinstated. The Social Security Administration (SSA) will reimburse some or all of the interim assistance owed directly to the local department of social services from any retroactive SSI benefits you are eligible to receive. To get interim assistance you must sign an Interim Assistance Reimbursement (IAR) authorization. You must sign a new authorization consistent with NYS rules if you reapply for SSI after this authorization terminates, or if you file a new SSI claim while you have an SSI application or appeal pending. This authorization gives the SSA permission to repay the agency for interim assistance paid to you. If you live **outside** of New York City, you may apply for Interim Assistance at your local department of social services. If you live in New York City, call or visit your local Income Support Center.

Q. What Is Interim Assistance?

- A. Interim assistance is payments you receive from Safety Net Assistance (SNA) funds for basic expenses such as shelter utilities and fuel when:
- You have applied for Supplemental Security Income (SSI) but the Social Security Administration (SSA) has not yet made a decision on your pending application.
 - You had been receiving SSI payments but they were stopped incorrectly and then are paid to you retroactively. This is called post-eligibility interim assistance.

Q. Do I Have To Repay Interim Assistance?

- A. Yes, you must repay interim assistance. The law requires repayment to prevent people from receiving both Temporary Assistance (TA) benefits and SSI benefits for the same period.

Q. For What Months Must I Pay Back The Interim Assistance I Received?

- A. If you receive SNA benefits while your SSI application was pending, you must repay for the months beginning with the first month you were eligible to receive an SSI payment and ending in the month your SSI payments actually began, or the following month if the local department of social services cannot stop your last TA payment.

If you received post eligibility interim assistance, you must repay beginning with the first day of the month for which retroactive SSI payments are paid and ending in the month your SSI payments actually began, or the following month if the local department of social services cannot stop your last TA payment.

Q. How Is Interim Assistance Repaid To The Local Department Of Social Services?

- A. The Social Security Administration (SSA) will pay the interim assistance directly to the local department of social services from any retroactive SSI benefits you are eligible to receive.

Q. How Does The SSA Get My Permission To Reimburse The Local Department Of Social Services For Interim Assistance?

A. You give the SSA permission when you sign the Temporary Assistance application or recertification form, or the Mail-in Recertification/Eligibility Questionnaire.

Q. How Does SSA Determine How Much Of My SSI Money To Pay The Local Department Of Social Services District.

A. SSA looks at the amount of money the state claims and also looks at the amount of your retroactive SSI money that can be used to repay the state. SSA matches the months you received interim assistance and the months you received SSI payments. After this matching, SSA pays the amount for each month claimed by the local department of social services district.

Q. How Will I Receive Any Balance From My Retroactive SSI Payment?

A. After the SSA reimburses the local department of social services for interim assistance owed, SSA will send you a notice explaining how they will pay you any remaining SSI money. If you have questions about your SSI payments, or any other questions, you can contact your local SSA office or call 1-800-772-1213.

Q. What Happens If The Amount Of My First Retroactive SSI Payment Is Not Enough To Pay Back All The Interim Assistance Received?

A. The local department of social services will not collect any more money from your SSI Payments. The local department of social services can only be repaid interim assistance by the SSA from your retroactive SSI Payment. They cannot collect from any other SSI Payments.

Q. How Long Does The Interim Assistance Reimbursement Authorization Last?

A. The authorization is in effect for any SSI application or appeal you have pending at the time you apply for TA. The authorization is in effect for 12 months beginning with the date the local department of social services correctly notifies SSA through an electronic system that they receive the authorization. However, if you file for an SSI appeal within the time permitted under SSA's regulations, the authorization will remain in effect, even beyond the 12 month period. The authorization ends when your SSI claim is completely decided; SSA first pays you; or you and the state agree to terminate the authorization. You must sign a new authorization consistent with NYS rules if you reapply for SSI after this authorization terminates, or if you file a new SSI claim while you have an SSI Application or appeal pending.

Q. How Long Is The Interim Assistance Reimbursement Authorization In Effect For A Post-Eligibility Retroactive Payment?

A. The authorization is in effect for 12 months beginning with the date the local department of social services notifies SSA through an electronic system that the local department of social services has received the authorization. However, if you file for an SSI administrative or judicial review within the time permitted under SSA's regulations, the authorization will remain in effect, even beyond the 12 month period unit. SSA makes the initial SSI post-eligibility payment following a suspension or termination of your SSI benefits; or SSA makes a final determination on your appeal; or you and the local department of social services **both** agree to terminate the authorization. You must sign a new authorization consistent with NYS rules if you reapply for SSI after this authorization terminates, or if you file a new SSI claim while you have an SSI application or appeal pending.

Q. Where Do I Get Interim Assistance Reimbursement Authorization?

A. At your local department of social services.

Q. What Can I Do If I Think The Local Department Of Social Services Made A Mistake In The Amount Of Interim Assistance I Received, Or Made A Mistake About The Amount Of Interim Assistance I Got Back?

A. You can request a fair hearing. You must follow the fair hearing instructions listed in Book 1 "What You Should Know About Your Rights and Responsibilities" (LDSS-4148A).

Q. What Is A Protective Filing Date For SSI Benefits?

A. Temporary Assistance (TA) applicants and recipients who apply for SSI within sixty days of signing a TA application or recertification form may be entitled to a “protective filing date” given by the SSA. The SSA may treat the TA application or recertification date as the SSI application date under the “protective filing date” rule. If the SSA establishes a protective filing date, this may give an SSI applicant up to two extra months of SSI.

3. Work Supports –The programs and benefits described in sections A (Temporary Assistance), B (Medical Assistance), C (Child Support), D (Food Stamps Benefits), E (Transitional Help), F (Child Care), and this section H (Other Benefits) can be very helpful if you are struggling to make ends meet, particularly if you are working. Also, if your earnings are less than \$41,646 per year, (the new EITC threshold for two children, married filing jointly) you may be able to bring home more money to support yourself/ your family by filing your tax returns and getting the tax credits you are eligible for.

- **Earned Income Credit** - If you are working or worked last year, you may be able to get additional money from the State and Federal Earned Income Tax Credits (EITC). In order to get these credits, you must file tax returns even if you do not owe any taxes. To get the Earned Income Tax Credits (EITC) federal (EITC), you must file a federal income tax return using either the 1040 or 1040A form and the form Schedule (EITC). (Only workers who are not raising children may use form 1040EZ to claim the Federal EIC.) To get the State (EITC), you must file a State income tax return and the State form IT-215.

If you had earned income and file State and Federal income tax returns, you may still be eligible for the Earned Income Tax Credit (EIC) from both the State and Federal governments. If you owe income tax, the EIC will reduce the amount of tax that you owe. If your EIC exceeds the amount of tax that you owe, you will receive the difference as a refund. Even if you do not owe taxes, you can receive the EIC.

If you are eligible for the EIC and you would like the money spread out over the whole year (advance payments) and get a reduced EIC at the end of the year, ask for a “W-5” is (EIC Advance Payment Certification) from your employer, fill it out and return it to your employer.

- **Child Tax Credit** - The federal Child Tax Credit can be worth up to \$1,000 for each qualifying child under the age 17.

New York State has its own version of the Child Tax Credit called the Empire State Child Credit. Workers can claim a credit equal to the greater of \$100 times the number of children who qualify for the federal Child Tax Credit or 33% of their federal Child Tax Credit.

A working family can claim both of these credits in addition to the EITCs.

- **Non-custodial Parent (NCP) New York State EITC** – This New York State Child Credit is available to noncustodial parents if the following qualifications are met:

- be a New York State resident tax payer;
- be between the ages of 18 and 65;
- be a noncustodial parent and have a child(ren) that does not reside with him or her;
- have a child support order through a New York State Support Collection Unit (SCU) for at least one-half year; and
- have paid 100% of the current amount of child support due for any tax year in which the NCP EITC is claimed.

- **Child And Dependent Care Credit** – The federal Child and Dependent Care Credit is a tax benefit that helps families pay for child care for at least one child under the age of 13. It can also help families that must pay for the care of a spouse or adult dependent who is incapable of caring for himself or herself. The credit can be worth as much as \$1,050 for families with one child or dependent in care and up to \$2,100 for families with more than one child or dependent in care.

The New York State Child And Dependent Care Credit is a minimum of 20% and as much as 110% of the federal credit, dependent upon the amount of the NYS adjusted gross income. Home Energy Assistance Program (HEAP), women, infants and children (WIC), and School Breakfast and Lunch Meals.

- **Education Credits** – There are two education credits that may be claimed by each eligible student:

- Hope Credit: This credit applies to the first two taxable years of post-secondary education. \$1,800 is the maximum credit per student that may be claimed.
- Lifetime Learning Credit: This credit is available for students at any point in their post-secondary education. The maximum credit is \$2,000 for one household, regardless of the number of eligible students in the family.

- **Get connected...to myBenefits!**

Anyone in New York can visit a new website, www.myBenefits.ny.gov, to find out if they might qualify for Food Stamp Benefits, Earned Income Tax Credits, Child and Dependent Care credits, and other programs designed to help low-income working households make ends meet. It will also provide information on where and how to apply. The site will be expanded regularly to allow screening for other programs.

4. Home Energy Assistance Program (HEAP) - The Home Energy Assistance Program can help you with heating and utility costs and certain essential heating equipment repairs. You may be able to get Home Energy Assistance if:

- You receive Temporary Assistance
- You receive Food Stamp Benefits
- Your income is at or below current guidelines
- You receive Supplemental Security Income (SSI)

YOU DO NOT NEED TO HAVE A HEATING OR UTILITY EMERGENCY IN ORDER TO GET HEAP.

5. Grants of Assistance to Guide Dogs - If you are able to get (SSI) and use a guide dog, you may be able to get money to buy food for your dog. If you live **outside** of New York City, you can apply for this money at your local department of social services. If you live **in** New York City, call or visit your local Job Center.

6. LifeLine - If your income is low, you may be able to get a telephone discount service called LifeLine for a little more than \$1.00 a month. You may be able to get LifeLine if you get:

- Temporary Assistance
- Medical Assistance
- Food Stamp Benefits
- Home Energy Assistance
- Supplemental Security Income (SSI)

For information on LifeLine, call your telephone services provider.

7. WIC (The Special Supplemental Program For Women, Infants and Children) - If you have little or no income, are pregnant, breastfeeding or have children up to age 5, and are at nutritional risk, the **WIC Program** may be able to help you. The WIC Program provides helpful information about nutrition and the importance of eating healthy foods. The WIC Program provides checks which can be exchanged in participating stores for infant formula, milk, juice, eggs, cheese, cereal, peanut butter, dry peas and beans.

For more information about the **WIC Program** and where you can apply, call **1-800-522-5006**.

8. Burial -The local department of social services provides for burial when a Temporary Assistance recipient or other person dies leaving no funds or insurance sufficient to pay the burial cost, and there are no relatives, friends or other persons liable or willing to take responsibility for the burial expense. This is true only if the local department of social services limit for the cost of the burial is not exceeded.

Sometimes relatives and friends make burial arrangements for a person. They might be eligible for some reimbursement, provided that no more has been spent on the burial than the local department of social services allows.

Application may be made for burial or for limited burial reimbursement at the burial unit or resource unit of your local department of social services. Contact that agency to find out where you should apply and what the limit is on the length of time you have to apply.

Do not make arrangements with a funeral director until you find out the county limit on how much may be spent on an indigent burial.

9. Voter Registration - You have a right to obtain an application for voter registration, to receive assistance in filling out that application, and to file that application for forwarding to the appropriate local board of elections at any government office accepting applications for benefits described in this book. For further information call the State Board of Elections toll free **1-800-367-8683** or **1-800-533-8683** (TDD) for the hearing impaired.

10. Veteran Benefits – If you ever served in the United States Military (including National Guard or Reserves if ever ordered to active duty by the President), and were discharged under other than dishonorable conditions, there are an array of social, economic, and vocational benefits and services you may be entitled to receive through the US Department of Veterans' Affairs. These include, but are not limited to, the following:

- Healthcare Services
- Service-Connected Disability Compensation
- Non-Service Connected Disability Benefits
- Family and Survivor Benefits
- Substance Abuse Treatment
- Educational Benefits
- Vocational Rehabilitation
- Employment Services

If you are a “low-income” veteran in receipt of SSI, or have otherwise been determined to be permanently and totally disabled, **and** served a minimum of 90 days with at least one day during a period of war, you may be eligible to receive a monthly benefit from the VA that is significantly more than SSI – even if your disability is not the result of military service. If you are age 65 or over and meet the above service requirements, you could also qualify even if you are not disabled.

Veterans suffering from an illness, disease, or injury they feel was incurred or aggravated as the result of military service should pursue eligibility for Service-Connected Compensation benefits - even if the condition was not diagnosed until years later – such as those who served in Vietnam and have since been diagnosed with Type II Diabetes, prostate cancer, respiratory cancers, or Hodgkin’s disease, to name just a few.

For more information about the above or other available benefits and services, contact a federal, state, or county veteran benefits counselor today. Counselors are available to assist you at no cost. To locate one nearest you, call **1-888-VETS-NYS (1-888-838-7697)**.

SECTION I PEOPLE WITH DISABILITIES

Q. Can I Get Help From The Local Department Of Social Services Office. If I Am Disabled And Cannot Go To The Local Department Of Social Services Office, Or Do Other Things The Local Department Of Social Services May Want Me To Do?

A. If you have a physical or mental condition that substantially limits what you are able to do, you may have rights under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. Some examples of physical or mental conditions include, but are not limited to:

- loss of hearing or vision;
- inability to move around easily;
- a learning disability;
- mental retardation;
- history of drug or alcohol addiction;
- depression.

Q. If I Am Disabled And Cannot Go To The Social Services Office, Or Do What The Local Department Of Social Services Asks Me To, What Should I Do?

A. If you cannot do something we ask you to do, we may help you do it or find a different way for you to meet the rules or we may change what you have to do. This is called reasonable accommodations. If you have a disability and you need reasonable accommodations you can let us know. Here are some of the ways we can help a person with a disability:

- If you are not able to come to our office, we can give you the address of another office location that is accessible, or tell you another way that can get access to our social services programs. We may also be able to call or visit if you are not able to come to our office.
- We can tell you what a letter that you have gotten from us means.
- We can help you develop an employability plan that allows you to work even though you have a disability, or we can help if you cannot do something in your plan.
- We can help you appeal a denial of benefits, such as Supplemental Security Income (SSI).
- If you need some other kind of help, let your worker know.

Q. Can I Just Tell The Local Department Of Social Services That I Need Help To Find A Different Way To Meet The Rules To Get The Benefits I Need?

A. Yes. You can tell the local department of social services that you need help. But, the help to find a different way to meet the rules (reasonable accommodation) is for individuals who meet the necessary eligibility requirements for receiving services or participation in the program or activity and who qualify for protection under the ADA. Those are people who have a physical or mental limitation that prevents them from doing certain activities. The local department of social services may ask a person who requests a reasonable accommodation under the ADA to provide documentation or to take part in initial screening and further assessment processes to identify possible disabilities and limitations to ensure that appropriate reasonable accommodations and other services are provided.

Q. What If The Local Department Of Social Services Finds A Different Way For Me To Meet The Program Rules But I Don't Like That Way?

A. If the local department of social services finds a way for you to meet the rules and get the benefits that you need (reasonable accommodation), but you refuse that way, you may be found ineligible for the program and benefits you need, or you may get less of the benefit you need. For example, although drug addiction is a disability under the

ADA, a local social services district may withhold services or benefits when an addict is currently and illegally using drugs or abusing alcohol and refuses to take part in required screening for alcohol and/or substance abuse. If the local department of social services finds you ineligible for the program and benefits you need, or decides that you should get less of them, you will get a notice telling you about your application and your benefits and if your benefits are denied or reduced, or your case is closed.

Q. Will I Automatically Be Eligible For The Programs Of The Local Department Of Social Service If I Am Disabled?

A. You cannot be denied benefits **only** because you are disabled. But you may be ineligible for a benefit that you want for the same reasons that a non-disabled person is ineligible. For example, if your income is above the limit for the program(s) and benefits you want, you will not be eligible.

Q. What If I Disagree With The Decision Of The Local Department Of Social Services?

A. You can request a fair hearing if you do not agree with the decision of the local department of social services. To request a fair hearing follow the instructions listed in the "YOUR RIGHTS" section of Book 1 (LDSS-4148A), ("What You Should Know About Your Rights and Responsibilities"), which you received at the same time that you received this book.

Q. What Can I Do If I Think I Have Been Discriminated Against?

A. Discrimination by the New York State Office of Temporary and Disability Assistance (OTDA), by the New York State Department of Health (DOH), by the New York State Office of Children and Family Services (OCFS), by the New York State Department of Labor (DOL), or by your local department of social services based on race, religion, ethnic background, marital status, disability, sex, national origin, political belief or age is illegal.

If you think you have been discriminated against you should follow the instructions listed in the "YOUR RIGHTS" section of Book 1, (LDSS-4148A) "What You Should Know About Your Rights and Responsibilities", which you received at the same time that you received this book.

SECTION J

IMMUNIZATIONS

Immunizations have reduced, and in some cases, eliminated, many diseases that routinely killed or harmed many infants, children, and adults. However, the viruses and bacteria that cause preventable disease and death still exist and can be passed on to people who are **not protected by immunizations**. Immunizations are the single most important way parents can protect their children against the following childhood diseases:

- Diphtheria
- Haemophilus influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Measles
- Pneumococcal Disease (pneumonia)
- Rotavirus
- Human Papillomavirus (HPV)
- Mumps
- Pertussis (whooping cough)
- Rubella (German measles)
- Tetanus (lockjaw)
- Varicella (chicken pox)
- Influenza (flu)
- Meningococcal meningitis

SECTION K

ELECTRONIC BENEFIT TRANSFER (EBT)

Q. What Is EBT?

A. EBT is Electronic Benefit Transfer. This refers to the method by which your Temporary Assistance and/or Food Stamp Benefits are issued to you. With Electronic Benefit Transfer (EBT) recipients will have accounts set up for Food Stamp Benefits and/or Temporary Assistance benefits. These benefits are electronically transferred into your account(s) on your benefit availability dates.

Q. How Do I Access My Benefits?

A. You will receive a Common Benefit Identification Card (CBIC) that you will use to access your Temporary Assistance, Food Stamp Benefits and Medical Assistance benefits. The Common Benefit Identification Card (CBIC) may be used:

- To get cash at Automated Teller Machines (ATM's) that display the QUEST logo
- To buy food at any store where the QUEST logo is displayed

- To make cash purchases at participating EBT locations
- To access medical benefits

You will receive receipts for all of your Cash and Food Stamp Benefits transactions. These receipts will show the amount of the transaction and the balance remaining in your Cash account or Food Stamp Benefits account. Keep your receipt to make sure it matches the transaction you authorized, and to help you keep track of your account balances.

Q. What Is A PIN?

- A.** PIN stands for Personal Identification Number (PIN). Your PIN is a 4-digit number that was either assigned to you or that you chose. Your PIN is equal to your *electronic signature* and should always be kept a secret. **Remember** - if someone has your Common Benefit Identification Card (CBIC) and knows your PIN they can access ALL of your benefits. These benefits will NOT be replaced. It is YOUR responsibility to keep your card safe and your PIN secret. You may change your PIN at any time.

<p>NOTE: If your Common Benefit Identification Card (CBIC) needs to be replaced you can continue to use the same Personal Identification Number (PIN).</p>

Q. How Can I Change My Personal Identification Number (PIN)?

- A.** You have three options:

- Call Customer Service toll free **1-888-328-6399**.
- Go to your local department of social services and choose a new Personal Identification Number (PIN).
- Go online via the internet to the EBT Account website at www.ebtaccount.jpmorgan.com.

Q. My CBIC Card—How Does It Work And What Kind Of Information Does It Contain?

- A.** The back of your CBIC has a black magnetic stripe. When the card is inserted or swiped through the card opening at the ATM or retailer Point of Sale (POS) device the machine “reads” information coded into the stripe on your card, which in turn initiates a transaction with your Food Stamp Benefits or Cash account. In order for a transaction to be completed, your PIN must be entered. The back of your card also contains the toll free EBT Customer Service number **(1-888-328-6399)**. The front of your card contains your name, your 19 digit card number, your date of birth, your Client Identification Number (CIN) and may contain your photo.

Q. When Should I Contact My Worker About My Benefits?

- A.** You should contact your local department of social services worker regarding the following questions or problems:

- Questions about the Food Stamp Benefits for which I am eligible, including benefit amounts and frequency.
- To report changes in your circumstances that may affect your benefits.
- For replacement of a lost, damaged or stolen Common Benefit Identification Card (CBIC), (after you have called Customer Service).
- Questions about an Authorized Representative (a person other than yourself who is able to access your Food Stamp Benefits with your permission).

Q. Do I Have To Use My Benefits All At Once?

- A.** No, the benefits in your Cash account and Food Stamp Benefit account can carry over from month to month. However, if you do not use your Cash account for a period of 90 consecutive days, any cash benefit in your account that is 90 days old or older will be expunged (removed) and returned to the agency. You may ask your worker to reissue expunged cash benefits for which you are eligible. If your Food Stamp Benefit account goes unused for a period of 365 consecutive days, any benefit in that account which is 365 days old or older will be expunged (removed) and will not be reissued.

Q. Are There Charges For Using My Common Benefit Identification Card (CBIC)?

- A.** You may use your card at a Point of Sale (POS) device in a QUEST participating store to make purchases from your Cash and Food Stamp accounts at no charge. Some EBT participating stores and retailers will allow customers to get cash back from their Cash account. Ask the store about its policy on cash back. If you are getting cash from an ATM machine, you may withdraw money 2 times during each month without having to pay a transaction fee. After the 2 free uses, there will be a 50 cent transaction fee taken from your Cash account every time you use an ATM to withdraw cash for the rest of that month. In addition, some ATMs impose a surcharge per transaction to withdraw cash. The cost to use the ATM should be clearly posted. To find locations of ATMs that do not surcharge in your area, you may call the EBT Locator Service toll free **1-800-289-6739**.

There Is Never A Charge To Access Your Food Stamp Benefits Or Medical Benefits With Your Common Benefit Identification Card (CBIC).

Q. Will I Be Able To Get Any Change Back From My Food Stamp Account?

A. No, your Food Stamp Benefits account may only be used to purchase eligible food items at participating stores. No cash will be issued as a result of a Food Stamp account transaction.

Q. What Is Electronic Benefit Transfer (EBT) Customer Service? And What Information Can They Help Me With?

A. You may call Customer Service toll free **1-888-328-6399**, 24 hours a day/7 days a week, or contact Customer Services online via the internet at www.ebtaccount.jpmorgan.com if you have a concern about your benefits with EBT. Effective August 15, 2007 the EBT Customer Service number (**1-888-328-6399**) will no longer accept calls from public payphones. People with disabilities may use the following relay center numbers: TTY users **1-800-662-1220**; Non TTY users **1-800-421-1220**; and VCO users **1-877-826-6977**. **Most of the questions and answers that follow are examples of how Customer Service can help you.**

Q. What Should I Do If My Common Benefit Identification Card (CBIC) Is Lost, Stolen Or Does Not Work?

A. Immediately call EBT Customer Service toll free **1-888-328-6399** and they will cancel your lost or stolen card. This will avoid the possibility of someone else being able to use this card. To replace your card you need to contact your local department of social Services. EBT Customer Service cannot replace the card for you.

Q. How Can I Find Out How Much Cash Or Food Stamp Benefits I Have In My Accounts? How Can I Find Out Where And When I Spent My Benefits?

A. Call Customer Service toll free **1-888-328-6399** and the Automated Response Unit (ARU) will provide answers to your questions regarding account transactions and balances.

When using the Automated Response Unit (ARU), be prepared to provide your 19-digit card number found on the front of your Common Benefit Identification Card (CBIC). You may also access this information online, via the internet at www.ebtaccount.jpmorgan.com.

Q. What Should Be Done If I Think The Account Balance On The Last Receipt Is Wrong?

A. Contact Customer Service and compare your last several receipts to the information provided regarding your past account record.

Any differences between the account record and your receipts should be reported to a Customer Service representative toll free **1-888-328-6399** so that a claim may be investigated. With regard to Food Stamp Benefits account claims, your claim will be investigated and resolved within 10 business days from the date you filed the claim with Customer Service.

A claim number will be given to you. Remember to write this claim number down because it will be needed when you telephone Customer Service to check on the progress of the claim.

<p>NOTE: A Cash account claim investigation can take up to 30 days from the date you report it to EBT Customer Service to resolve. For both your Cash account and Food Stamp Benefits account, a claim can be taken by EBT Customer Service only if you report it within 90 days of the date of the account transaction that you want investigated.</p>
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Q. Can I Get A Written Record Of My Account?

A. Yes, Customer Service will provide the last ten transactions from either your Cash account and Food Stamp Benefits account or you may also request that a Customer Service Representative mail a report of the last two months of transactions to your home. You can also access this information online via the internet at www.ebtaccount.jpmorgan.com.

Q. How Can I find The Location Of ATMs And Retailer Point Of Sale (POS) Devices That Do Not Surcharge To Withdraw Cash?

A. You may call the EBT Locator Service toll-free **1-800-289-6739**. This information is also available from your local department of social services office, or via the Internet at <http://www.otda.state.ny.us/ebt/zips>.

Q. What Is A "Retailer Adjustment"?

A. When you buy food with your Food Stamp Benefits account, but a computer error happens and your account is not charged, the store can ask Customer Service to investigate their claim. If the investigation shows that the store did not get paid from your account, your account will be charged to pay the store for the food you bought. When a retailer adjustment is requested, you will receive a notice about the request.

Q. Can The State Make An Adjustment To My Cash And/Or Food Stamp Benefits Accounts?

A. If, as a result of an error in the benefits issuance process your account is unjustly enriched with a benefit to which you are not entitled, the State may adjust your account to correct the situation.

Q. Can I Continue To Access My Account(s) After My Case Is Closed?

A. Yes, your card will remain active and you will be able to access your account(s) as long as there are benefits remaining in the account(s).

Q. If I Still Have Paper Food Stamp Coupons To Use, Will Stores Still Redeem Them?

A. After June 17, 2009, stores will no longer accept paper Food Stamp coupons. If you have any paper coupons in your possession, you should redeem them at a participating Food Stamp retailer before that date.



Book 3

What You Should Know If You Have an Emergency

Questions and Answers

If you are blind or seriously visually impaired and need an application or these instructions in an alternative format, you may request them from your social services district. The following alternative formats are available:

- Large print;
- Data format (a screen-reader accessible electronic file);
- Audio format (an audio transcription of the instructions or application questions); and
- Braille, if you assert that none of the other alternative formats will be equally effective for you.

Applications and instructions are also available for download in large print, data format and audio format from www.otda.ny.gov or www.health.ny.gov. Please note that applications are available in audio format and Braille solely for informational purposes. In order to apply, you must submit an application in written, non-alternative format. If you require another accommodation, please contact your social services district.

Also See

BOOK 1 (LDSS-4148A)

“What You Should Know About
Your Rights and Responsibilities”

and

BOOK 2 (LDSS-4148B)

“What You Should Know About
Social Services Programs”

SAVE THIS BOOK FOR FUTURE USE

EMERGENCIES

THE FIRST THING YOU SHOULD DO, IF THE EMERGENCY ALLOWS YOU THE TIME, IS TO TALK WITH A WORKER. YOU SHOULD ALSO TALK WITH A WORKER AFTER YOU HAVE TAKEN CARE OF THE EMERGENCY SITUATION AND/OR IF THE OTHER SUGGESTIONS IN THIS BOOK DO NOT TAKE CARE OF YOUR EMERGENCY SITUATION.

Q. What Is An Emergency?

- A.** An emergency is an urgent need or a situation that has to be taken care of right away. Some examples of an emergency are:
- You are homeless.
 - You have little or no food.
 - You have emergency medical needs and cannot pay for the medical care needed.
 - Your landlord has given you eviction papers or told you that you must move immediately within the next few days.
 - You do not have fuel for heating in the cold weather period.
 - Your utilities are shut off or are about to be shut off or you have received a disconnect notice.
 - You or someone in your family or household has been subjected to physical or sexual abuse, mental abuse, or threats of violence or abuse and these acts have been committed by a family or household member.
 - You have little or no income, few or no resources.
 - The total of your income and resources is less than the total of your rent or mortgage plus heat, utilities and phone.

If you are applying for Temporary Assistance, and you tell us today that you have an emergency, we must interview you today about your emergency, or otherwise address your emergency needs today. We must also tell you in writing today about our decision on your emergency. If you are applying for Food Stamp Benefits, and you are eligible for expedited processing, that interview and the notice of our decision will be no later than five calendar days after the day you filed your application.

If you have little or no food, or not enough money to buy food, you should apply for Food Stamp Benefits, right away.

Q. How Do I Apply For Emergency Temporary Assistance?

- A.** If you **are already getting** Temporary Assistance and an emergency comes up, tell a worker **right away**.

If you **are not getting** Temporary Assistance, fill out an application and tell a worker that you have an emergency. You have the right to be interviewed about your emergency on the same day.

You must cooperate with a worker to find out if you can get help right away with your emergency. The worker will need to find out the details of your emergency. A worker will tell you what information you need to get before you can get assistance to meet your emergency. For example, if you say that you received an eviction notice, the worker will ask to see this notice.

You will be asked for proof of who you are and proof of who your other family members are. You may also have to prove that you and your family have satisfactory alien status.. The worker will also want to know if you have any income or resources, such as bank accounts or other help available to you that can be used to help you with your emergency.

If you cannot get the information or proof of it, a worker must try to help you get that information or proof.

If your request for assistance to meet your emergency need is approved, you will get a notice telling you what type, how much and when you will be getting this assistance.

Q. Will Emergency Temporary Assistance Also Provide For Food?

A. TA will provide for an immediate needs for grant to meet a food need if no other “resources”, (for example food bank, expedited food stamps), is available to meet the emergency food need.

Q. How Will I Know If I Am Approved For Emergency Temporary Assistance And/Or Food Stamp Benefits?

A. We must tell you in writing about our decision on your emergency on the same day that you tell us about your emergency need or situation. If you are applying for Food Stamp Benefits, and you are eligible for expedited processing, that interview and the notice of our decision will occur no later than five calendar days after the day you filed your application.

Q. Can I Get Food Stamp Benefits Right Away?

A. Yes, you may be able to get Food Stamp Benefits within five calendar days **after submitting** your application. This is called **Expedited Processing for Food Stamp Benefits**.

You may be able to get **Expedited Processing**, if you are eligible for Food Stamp Benefits and:

- Your household has less than \$100 in cash or other available resources **and** will have less than \$150 in gross income during the month that you apply; **or**
- Your income and available resources, e.g. cash on hand, bank accounts, savings certificates, and lump sum payments are less than your rent or mortgage plus heat, utilities and phone; **or**
- You are a migrant or seasonal farm worker with no more than \$100 in liquid resources and the only income for the month of application was 1) terminated before application, or 2) is new, and no more than \$25 gross income will be received within ten days after your application for food stamps.

NOTE: You do not need to be out of food to get expedited processing for Food Stamp Benefits.

Q. What If I Am Homeless Or About To Become Homeless?

A. You may be able to get help:

- To stay in your present housing.
- To pay for you and your family to stay with someone other than a "**legally responsible relative**". A **legally responsible relative** is a husband or wife or, if you are under 21, a parent.
- To arrange for you and, your family to stay in a shelter, hotel or motel temporarily when no other suitable housing is available.
- To pay for a restaurant allowance when you and your family do not have cooking facilities and meals are not provided to you where you are staying.

- To arrange for a safe place to stay if you or someone in your family or household, regardless of whether or not you or they are lawfully present in the United States, has been subject to physical or sexual abuse, mental abuse, or threats of violence and these acts have been committed by a family member or household member, or a current or former intimate partner.
- To pay for storing your furniture and other personal things you own when you are evicted or must move.
- To pay for moving expenses, rent security deposit or agreement, or brokers or finder's fees.
- To pay for household items needed to set up a home.
- To pay for you to take your children to and from school while your family is in emergency housing.
- To pay for moving expenses when you move to emergency housing or between emergency housing placements.

Q. What If I Have Emergency Heating Or Utility Needs?

A. If you are out of heating fuel or have an amount of heating fuel that is equal to or less than one-quarter of the household's fuel tank (for oil, kerosene and propane) or have a heating fuel supply that will last less than 10 calendar days (for wood and coal) or your utilities are shut off or are about to be shut off, you may be able to get help.

- If you **are already receiving** Temporary Assistance and you have a heating or utility emergency, talk to a worker.
- If you **are not receiving** Temporary Assistance, call your local department of social services. They may send you to your local Home Energy Assistance Program (HEAP) office. If you live in New York City, call or visit your local Job Center. They may send you to the Community Development Agency's Home Energy Assistance Program (HEAP) office.
- If you are unsure of where to get help for your heating or utility emergency call, toll-free, **1-800-342-3009**.

Q. What If I Have Emergency Medical Needs?

A. New York State law requires hospitals to give you emergency care, even if you cannot pay for it. If you have a medical emergency, seek immediate medical attention by calling 911.

New York State law also requires that hospitals may have to give you non-emergency care that you may need if you have income below a certain amount. The law limits what hospitals can charge you for this care.

If you are sick and need medical care right away, and you have applied for but have not received a Common Benefit Identification Card (CBIC), you should advise your physician that you have a pending Medicaid application.

Medicaid may be able to pay medical bills for care you received up to three months before you applied for Medicaid. Remember to tell a worker if you have any paid or unpaid medical bills.

If you are an undocumented alien, or a temporary non immigrant you may be eligible for Medicaid to help with your medical care if you are pregnant or need treatment of an emergency medical condition.

Medicaid may be able to pay for medical care you get out of state if you need emergency medical care while traveling in another state, but **only** if the doctor, facility or person providing care is enrolled in the New York State Medicaid program.

Q. What If Emergency Services Are Needed To Protect Adults, Children Or Other Family Members?

A. The following are some services you can get to help you with your emergency. There is no income limit to get any of these services.

If you live **outside** of New York City, your local department of social services may be able to help you, in addition to the help that you can get by calling the phone numbers listed below.

If you live **in** New York City, call or visit your local Job Center or look for the Human Resources Administration (HRA) or Administration for Children's Services (ACS) listings in the Government pages of the New York City telephone book for your borough. Call the number listed for the type of help you need. You can **also** get help by calling the phone numbers listed below.

While there are no income limits to obtain domestic violence services, families and individuals in need of domestic violence shelter may be required to contribute to the cost of shelter depending on their personal income and available resources.

- **Child Protection** - Services given to children under the age of 18 who are abused or maltreated, and to their families.

If you have a reasonable cause to suspect that a child has been abused or maltreated, call the Statewide Central Register of Child Abuse and Maltreatment toll free at **1-800-342-3720**. If a report is registered, an investigation will be conducted and, as appropriate, services offered to the family to protect the child(ren).

It is also appropriate to call the Statewide Central Register of Child Abuse or Maltreatment if you have concerns about possible abuse or neglect that may have occurred in a residential child care setting. You may call toll free to **1-800-342-3720** to discuss your concerns. If a report is registered, an investigation will be conducted at the residential child care program.

If you are in Monroe County (Rochester and vicinity) or Onondaga County (Syracuse and vicinity) there is a local number you can call instead if you have concerns about child abuse or maltreatment in either a family or a residential child care setting. It is **461-5690** in Monroe County and **422-9701** in Onondaga County.

If you are pregnant or have a newborn who is five days old or less and you do not feel that you can care for your baby, talk to a worker right away. If for some reason you cannot talk to a worker, or if you still feel that you cannot care for your baby, to find a way that may protect both you and your baby call the Abandoned Infant Protection Act Information and referral hotline toll free at 1-866-505-SAFE **(1-866-505-7233)**.

- **Preventive Services To Children and Families** – Services given to children and families to safely keep the family together and to prevent foster care placement, or to safely return the children from foster care as soon as possible. Emergency cash, goods, shelter or other essential items may be part of Preventive Services To Children and Families. Talk to a worker about this.
- **Protective Services For Adults** - Services given to persons 18 years of age or older who are physically or mentally impaired have been harmed or may be at risk of harm, cannot protect themselves, and have no one who is able and willing to help them.

To make a referral or to report suspected adult abuse, neglect or exploitation, please call your local Protective Services for Adults (PSA) unit directly at your local department of social services. You may call toll free **1-800-342-3009** (press option 6) to obtain the phone number to reach your local PSA unit.

- **Domestic Violence (Physical or Emotional Abuse or Threat of Abuse)** - Services given to family and other household members, with or without children, to help them with problems of physical or emotional abuse, or the threat of physical or emotional abuse. While there is no income limit to obtain domestic violence services, families and individuals in need of domestic violence shelter may be required to contribute to the cost of shelter depending on their personal income and available resources.

You can call 24-hour hotline for information about emergency shelter, support groups, and counseling. These services will help keep you and your children safe. To get information and referrals to your local domestic violence services provider you may call the following numbers toll-free, 24 hours a day:

In New York City call 1-800-621-HOPE (1-800-621-4673).

In any other area of New York State call the NYS Domestic Hotline 1-800-942-6906 (Spanish speaking call 1-800-942-6908).

A Services caseworker can also arrange for you to get this information.

Q. What If I Need Child Care In An Emergency Situation?

- A.** Child Care **may** be available to parent(s)/caretaker(s), if the family is either on Temporary Assistance or has income within the allowable limits, in an emergency situation of short duration such as cases where the parent(s)/caretaker(s) is absent from the home for a large part of the day because of such things as a fire, looking for housing or providing chore/housekeeping services for an elderly or disabled relative. This depends on whether the local department of social services has funds available. Ask a worker if your local department of social services pays for child care assistance in these circumstances.

If you live **outside** of New York City, call or visit your local department of social services. If you live **in** New York City, call or visit your local Job Center or look for the Human Resources Administration (HRA) or Administration for Children Services (ACS listings in the Government pages of the New York City telephone book for the borough in which you live. Call the number listed for the type of help you need.

Q. Can I Get Assistance To Communicate If I Have A Disability When I Ask For Emergency Assistance?

- A.** Yes. At all times, including but not limited to emergencies, your local department of social services must provide the necessary auxiliary aids and/or services, which may include but are not limited to interpreters, to facilitate communication with persons with disabilities that is equally effective as communication with persons who do not have a disability. When an interpreter is provided by the local department of social services, you cannot be asked or required to pay for the interpreter.

Q. Can I Bring A Relative Or Friend To Provide Interpretation Assistance?

- A.** Yes. Your local department of social services may allow persons who are deaf or have a hearing or speech impairment to use a relative or friend to provide interpretation assistance, but may not require applicants/recipients to bring their own interpreter.

Q. If I Have A Disability And My Appointment Is Rescheduled Because Reasonable Accommodations Cannot Be Made On The Date I ask For Emergency Assistance, Can I Still Get Emergency Services?

- A.** Yes, your local department of social services must also address emergency/immediate needs of persons with a disability.

Q. What Happens If My Request For Emergency Temporary Assistance Is Denied?

A. If a worker determines that your situation is not an emergency and that you cannot get assistance to meet your emergency, you will be given a written notice that same day that will tell you this and the reason why. This notice will mean only that your request for **assistance to meet your emergency** has been denied. If you feel your request for assistance to meet your emergency should not have been denied, you may request an Agency Conference or an Emergency Fair Hearing.



SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION/RECERTIFICATION



This application can ONLY be used to apply for SNAP

If you are blind or seriously visually impaired and need this application in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available and how you can request an application in an alternative format, see the instruction book (LDSS-4826A), or www.otda.ny.gov.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? Yes No

**If Yes, check the type of format you would like: Large Print Data CD Audio CD
 Braille, if you assert that none of the other alternative formats will be equally effective for you.**

If you require another accommodation, please contact your social services district.

If you are only applying for SNAP you can use this shorter application. If you would like to apply for other benefits such as Temporary Assistance, Child Care Assistance, Home Energy Assistance or Medicaid please ask for a different application.

When You Are Applying For SNAP

- You can file an application the same day you receive it. We must accept your application if, at a minimum, it contains your name, address, (if you have one), and a signature. This information will establish your application filing date.
- You must complete the application process, including having an interview and signing the certification statement on page 8 of the application/recertification for your eligibility to be determined. If you are eligible, benefits will be provided back to the date you filed your application.
- You can apply for and get SNAP for eligible household member(s) even if you or some other members of your household are not eligible for benefits because of immigration status. For example, ineligible alien parents can apply for SNAP for their children and receive benefits for their eligible children.
- You can still apply and be eligible for SNAP even if you have reached your Temporary Assistance time limits.

Need SNAP Benefits Right Away? You May Be Eligible For Expedited Processing of your SNAP Application:

If your household has little or no income or liquid resources, **or** if your rent and utility expenses are more than your income and liquid resources, **or** you are a migrant or seasonal farmworker with little or no income or resources when you apply, you may be eligible to get SNAP within 5 calendar days of the date you apply. When a resident of an institution is jointly applying for SSI and SNAP prior to leaving the institution, the recorded filing date of the application is the date of release of the applicant from the institution.

Where You Can Apply For SNAP

If you live **outside of** New York City, you can apply on-line at myBenefits.ny.gov, or call or visit the social services district in the county where you live and ask for an application package, which can be mailed or dropped off to that appropriate office. You can get the address and phone number of the social services district in your county by calling toll free **1-800-342-3009**.

If you live in **New York City** and you are **not** also applying for Temporary Assistance, you can apply on-line at myBenefits.ny.gov, or call or visit any SNAP Office and ask for an application package. You can get the address and phone number by calling **1-718-557-1399** or toll free **1-800-342-3009**.

Having Problems Coming To Us For A SNAP Interview Appointment?

If it is difficult for you to come in for a SNAP interview appointment (reasons may include employment, health issues, transportation or child care problems), in some circumstances; we can interview you by telephone, or you may have someone else apply for you. Please contact your social services district if you have any questions, to see if you are eligible for a telephone interview, **or if you need** to reschedule an interview.

NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
SNAP APPLICATION / RECERTIFICATION

Application Date	Interview Date	Center/Office	Unit	Worker	Case Type	Case Number	Registry Number	Version	<input type="checkbox"/> Apply <input type="checkbox"/> Recertify	Lang
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Legal Name: _____ Telephone Number: _____ Other phone where you can be reached: _____

Residence Address: _____ Apt.# _____ City _____, NY Zip Code 1

Mailing Address (if different) _____ Apt.# _____ City _____, NY Zip Code _____

Known by Any Other Name: _____ Are You: Applying **or** Recertifying Do you want to receive notices in: Spanish **and** English **or** English **Only**

We must accept your application if, at a minimum, it contains your name, address (if you have one), and signature in this box.	APPLICANT/REPRESENTATIVE SIGNATURE 2	DATE SIGNED
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List everyone who lives with you even if they are not applying. List yourself first.

L N	First Name	M I	Last Name	Social Security Number (SSN) of applying member (If none, write "NONE")	Date of Birth	Marital Status	Sex M or F	Is this person applying?		Relationship to you	Do you buy and/ or prepare food with this person?		Hispanic or Latino?		Enter Y (Yes) or N (No) for each race* (Codes Defined Below)					
								Yes	No		Yes	No	Yes	No	I	A	B	P	W	
1								✓		self	✓									
2																				
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4																				
5																				
6																				
7																				
8																				

*Race/Ethnic Codes: **I** – Native American or Alaskan Native, **A** - Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** – White
 The provision of this information is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for this information is to ensure that program benefits are distributed without regard to race, color or national origin.

Are you and is everyone living with you a US citizen? Yes No If No, who is not a citizen? _____

Are you or is anyone in your household applying for or receiving SNAP or Temporary Assistance in another place? Yes No

Are you or is anyone living with you a veteran? Yes No If Yes, who _____

Do you or does anyone live in a drug or alcohol treatment center, State-certified group living facility or State-certified supervised/supportive apartment? Yes No

If you are recertifying for SNAP, list on Page 9 what has changed since your last application or recertification (*such as moved, had a baby, someone moved in or out of your household*).

INCOME

List **ALL** your income and the income of everyone living with you. This includes, but is not limited to **wages, income from self-employment minus the cost of producing self-employment (for example: babysitting, cleaning, income from a roomer or boarder), child support, pensions, veterans benefits, disability, social security or SSI, grants or scholarships for rent or food, Temporary Assistance, and income from friends or relatives.**

Name of Person Receiving Income	Source of Income	Hours Worked Per Month	How Often is it Received? (for example, weekly, bi-weekly, monthly)	Gross Amount Received Before Deductions

Do you or does anyone living with you have child/dependent care costs related to employment or training? Yes No If Yes, who _____.

Amount paid \$ _____. How often paid (e.g., weekly, monthly) _____.

Have you or has anyone living with you changed or quit jobs or reduced any form of income in the last 30 days – including reduced work hours or income? Yes No

Do you or does anyone living with you have any potential income that has not yet been received? Yes No If Yes, explain on Page 9.

Are you or is anyone living with you participating in a strike? Yes No If Yes, who _____.

Are you or is anyone living with you a boarder, foster child, or foster adult? Yes No

If Yes, check B for boarder or F for foster and write their name. B F Name: _____.

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RESOURCES

Resources do not affect the eligibility of most households applying for SNAP. However, some resource information is used to determine if you qualify for expedited processing of your application.

How much money does everyone in your household have? (For example, on your person; in your home, in checking and savings accounts, or other locations, including jointly held accounts) \$ _____ Belongs to _____.

Other financial assets? (For example, stocks, bonds, retirement accounts, savings bonds, mutual funds, IRAs, trust funds, money market certificates) Yes No

If Yes, amount \$ _____ Type _____ Owner _____.

How many cars, trucks or other vehicles do you or anyone in your household have?

#1 Year _____ Make _____ Model _____ Owner _____

#2 Year _____ Make _____ Model _____ Owner _____

Do you or anyone applying own any property including your own home? Yes No If yes, list property _____ Owner _____

Has anyone applying sold, given away or transferred cash or property in the last three months to qualify for SNAP? Yes No

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LIVING ARRANGEMENTS AND EXPENSES

Check all the descriptions that apply to your household:

- Own home or paying for home Renting Migrant/seasonal farmworker No permanent residence Live with relatives or friends

List expenses:

Monthly rent or mortgage payment \$ Tax on home per year \$ Insurance on home per year \$

Pay separately for Heat? Yes No If yes, specify type of heating: Gas Electric Oil Wood Coal Propane Other (list)

Heat Co. Name Heat Co. Acct. No.

Pay for air conditioning, either in your electric bill or as a separate fee? Yes No

Pay separately for utilities (other than heating/cooling)? Yes No (for example, lights, cooking gas, garbage/trash, water, initial installation of utilities).

Does anyone else pay any of these expenses for you (some examples are Section 8 or other subsidy program)?

Yes No If yes, who pays what?

Are you or is anyone living with you paying legally obligated child support? Yes No If yes, who

Name(s) of child(ren) support is being paid for

Payment amount \$ Frequency of payments (for example, weekly, bi-weekly, monthly)

Are you, and/or anyone living with you, blind/disabled or at least age 60? Yes No If yes, who

If so, does such person have medical bills? Yes No If yes, list on page 9 what they are for, how much and who is responsible for payment.

Are you, and/or anyone living with you, on Medicaid with a spenddown? Yes No If yes, who Amount \$

Are you or anyone living with you (16 or 17 years of age) enrolled in school or training? Yes No If yes, who Name of School/Training Program

Are you or anyone living with you, between the ages of 18 and 49 years of age, attending a school or training program (above High School)? Yes No If yes, who?

Name of School/Training program Full Time (FT) Yes No Income Yes No Expenses Yes No

Answer these questions:

Are you or is anyone living with you violating a condition of probation or parole or fleeing to avoid prosecution, custody or confinement for a felony and actively being pursued by law enforcement?

Yes No If yes, who

Are you or is anyone living with you in violation of probation or parole according to a court? Yes No If yes, who

Have you or has anyone living with you ever been disqualified from receiving SNAP because of fraud or intentional program violation? Yes No If yes, who

Have you or has anyone living with you been convicted of trading SNAP benefits for firearms, ammunition or explosives, or drugs after September 22, 1996? Yes No If yes, who

Have you or has anyone living with you been convicted of buying or selling SNAP benefits for a combined amount of \$500 or more, after September 22, 1996? Yes No If yes, who

Have you or has anyone living with you been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996? Yes No If yes, who

You may use page 9 if you need more room or there is other information that you think we might need.

READ THE IMPORTANT INFORMATION BELOW

SNAP PENALTY WARNING – Any information you provide in connection with your application for SNAP will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied SNAP. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Anyone who is violating a condition of probation or parole or anyone who is fleeing to avoid prosecution, custody or confinement for a felony, and is actively being pursued by law enforcement, is not eligible to receive SNAP benefits.

If a SNAP household member is found to have committed an Intentional Program Violation (IPV), the member will not be able to get SNAP benefits for a period of:

- 12 months for the first SNAP-IPV;
- 24 months for the second SNAP IPV;
- 24 months for the first SNAP-IPV, that is based on a court finding that the individual used or received SNAP benefits in a transaction involving the sale of a controlled substance. (Illegal drugs or certain drugs for which a doctor's prescription is required.)
- 120 months if found guilty of making a false statement about who you are or where you live in order to get multiple SNAP benefits simultaneously, unless permanently disqualified for a third IPV.

Additionally, a court may bar an individual from participation in SNAP for an additional 18 months.



Permanent disqualification of an individual for:

- The first SNAP-IPV based on a court finding of using or receiving SNAP benefits in a transaction involving the sale of firearms, ammunition or explosives.
- The first SNAP-IPV based on a court conviction for trafficking SNAP benefits for a combined amount of \$500 or more (Trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices.)
- The second SNAP-IPV based on a court finding that an individual used or received SNAP benefits in a transaction involving the sale of controlled substances. (Illegal drugs or certain drugs for which a doctor's prescription is required.)
- All third SNAP-IPV Intentional Program Violations.

Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to \$250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable Federal and State laws.

You may be found ineligible for SNAP or found to have committed an IPV if:

- You make a false or misleading statement, or misrepresent, conceal or withhold facts in order to qualify for benefits or receive more benefits; or
- Purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or
- Commit or attempt to commit an act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of SNAP benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

Additionally the following is not allowed and, you may be disqualified from receiving SNAP benefits and/or be subject to penalties for actions that include:

- Using or have in your possession EBT cards that do not belong to you, without the card owner's consent; or
- Using SNAP benefits to buy nonfood items, such as alcohol or cigarettes, or to pay for food previously purchased on credit; or
- Allowing someone else to use your electronic benefit transfer (EBT) card in exchange for cash, firearms, ammunition, explosives or drugs, or to purchase food for individuals who are not members of the SNAP household.

If you get more SNAP benefits than you should have (overpayment), you must pay them back. If your case is active, we will take back the amount of the overpayment from future SNAP benefits that you get. If your case is closed, you may pay back the overpayment through any unused SNAP benefits remaining in your account, or you may pay by cash.

If you have an overpayment that is not paid back, it will be referred for collection, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges.

Any SNAP benefits expunged from your EBT account will be used to reduce current overpayments. If you apply for SNAP again, and have not repaid the amount you owe, your SNAP benefits will be reduced if you begin to get them again. You will be notified, at that time, of the amount of reduced benefits you will get.

READ THE IMPORTANT INFORMATION BELOW (cont'd)

CONSENT – I understand that by signing this application form I agree to any investigation made by the New York State Office of Temporary and Disability Assistance or my local social services district to verify or confirm the information I have given or any other investigation made by them in connection with my request for SNAP benefits. If additional information is requested, I will provide it. I will also cooperate with State and Federal personnel in a SNAP Quality Control Review.

I understand that by signing this application/certification, I consent to an investigation to verify or confirm the information I have given and other investigation by any authorized government agency in connection with Home Energy Assistance Program (HEAP) benefits. I also consent to allow the information provided on this application to be used in referrals to available weatherization assistance programs and my utility company's low income programs. I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity cost, fuel consumption, fuel type, annual fuel cost and payment history to the Office of Temporary and Disability Assistance and the local Social Services District and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program (LIHEAP) performance measurement.

CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE (UI) INFORMATION – I authorize the New York State Department of Labor (DOL) to release any confidential information, maintained by DOL for Unemployment Insurance (UI) purposes, to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with State and local agency employees working in local social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of SNAP applied for in this application and for investigations to determine whether I received benefits to which I was not entitled.

RELEASE OF INFORMATION TO SERVICE PROVIDERS - I give permission to the social services district and New York State to share information regarding Supplemental Nutrition Assistance Program benefits that I or any member of my household for whom I can legally give authorization have received, for purposes of verifying my eligibility for services and payment related to program administration provided by a State or local contractor. Such services may include, but are not limited to, job placement or training services provided to help me or my household members obtain and retain employment.

SUA (STANDARD UTILITY ALLOWANCE) INFORMATION – I understand that SNAP recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). If I have not received a HEAP benefit of greater than \$20 in the current month or previous 12 months, or other similar energy assistance program benefits, I must pay separately for a heating, air conditioning or utility expense in order to receive a Standard Utility Allowance.

CHANGES – I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangement, able-bodied adult without dependents (ABAWD) status including if my hours of work fall below 80 hours per month, pregnancy status or address to the best of my knowledge or belief in accordance with my reporting requirements.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – I understand that my household must report child care and utility expenses in order to get a SNAP deduction for these expenses. I further understand that my household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a SNAP deduction for these expenses. I understand that failure to report/verify the above expenses will be seen as a statement by my household that I/we do not want to receive a deduction for those unreported/unverified expenses. A deduction for these expenses may make me eligible for SNAP or may increase my SNAP benefits. I understand that I may report/verify these expenses at any time in the future. This deduction would then be applied to the calculation of SNAP in future months in accordance with the rules for change reporting and processing changes.

In applying for SNAP, I understand that the social services district will request and use information available through the Income and Eligibility Verification System to investigate my application, and may verify this information through collateral contacts if discrepancies are found. I also understand that such information may affect my eligibility for SNAP and/or level of SNAP benefits I receive.

PRIVACY ACT STATEMENT – COLLECTION AND USE OF SOCIAL SECURITY NUMBER (SSN) – The collection of SSN's is authorized for each household member with respect to SNAP pursuant to the Food and Nutrition Act of 2008. The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other State and Federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. The information will be used to check identity and to verify earned and unearned income.

If a SNAP claim arises against your household, the information on this application, including all SSN's, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Anyone applying for SNAP must provide a SSN. SSN's of ineligible members will also be used and disclosed in the manner above. If you or anyone applying/recertifying does not have a SSN, a SSN must be applied for with the Social Security Administration (SSA.gov).

READ THE IMPORTANT INFORMATION BELOW (cont'd)

Besides using the information you give us in this way, the State also uses the information to prepare statistics about all the people receiving benefits from the Home Energy Assistance Program. The information is used for quality control by the State to make sure local districts are doing the best job they can. It is used to verify who your energy supplier is and to make certain payments to such vendors.

CITIZENSHIP/IMMIGRATION STATUS– I swear and/or affirm under penalty of perjury that the information I have provided about the citizenship and immigration status of myself and everyone living with me is true and correct. I understand that any information I provide to verify the immigration status of anyone applying for SNAP may be checked for authenticity with the United States Citizenship and Immigration Services.

For SNAP, citizenship must be documented **only if questionable**.

NON-DISCRIMINATION NOTICE – In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audio tape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

READ THE IMPORTANT INFORMATION BELOW (cont'd)

AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to **apply** for SNAP for you. You can also authorize someone outside your household to get SNAP benefits for you and to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may do so by printing the person's name, address and phone number below. When an Authorized Representative is applying on behalf of a SNAP household that does not reside in an institution, **both** the Authorized Representative and a responsible adult member of the SNAP household must sign and date the signature sections at the bottom of this page, unless the Authorized Representative has been otherwise designated by the household in writing.

IF YOU WOULD LIKE TO AUTHORIZE SOMEONE, PRINT THE PERSON'S NAME, ADDRESS AND TELEPHONE NUMBER, AND SIGN BELOW.

Name _____ Address _____ Phone _____

CERTIFICATION: I swear and/or affirm under the penalties of perjury that the information I have given or will give to the local Social Services district is correct. Your signature is required below to complete the application process.

APPLICANT SIGNATURE (or Responsible Adult Household Member) X	DATE SIGNED 10
Authorized Representative SIGNATURE X	DATE SIGNED

IF YOU HELPED COMPLETE THIS APPLICATION / RECERTIFICATION FOR SOMEONE ELSE, PRINT YOUR NAME AND ADDRESS HERE. YOU MAY ALSO VOLUNTARILY PRINT YOUR TELEPHONE NUMBER.

Name _____ Address _____ Phone _____

Use this area for additional information:

Who: _____ Explanation: _____

Who: _____ Explanation: _____

Who: _____ Explanation: _____

11

I CONSENT TO WITHDRAW MY APPLICATION/RECERTIFICATION. I understand that I may reapply at any time.

SIGNATURE

12

DATE

For Agency Use Only

Eligibility Determined by _____ Date _____

Signature of Person Who Obtained Eligibility Information: _____ Date _____

Employed by: Social Services District Provider Agency

(Specify) _____

Reason ____/____/____ Withdrawal Denial Recert. Closing

Eligibility Approved by _____ Date _____

SNAP Authorization Period: From _____ To _____

IN-PERSON INTERVIEW **TELEPHONE INTERVIEW**

Comments:



NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

YES If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below

NO because I choose not to register **OR**

I am already registered at my current address **OR**

I asked for and received a mail registration form

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____/_____/_____
Signature Date

Please Print Name

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料: 若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদি আপনি এই ফর্মটি ইংরেজীতে পেতে চান তাহলে 1-800-367-8683 নম্বরে ফোন করুন

Rev. 2/2015

VOTER REGISTRATION APPLICATION (instructions on back)

Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** Yes, I would like to be an Election Day worker

1	Are you a U.S. citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If you answered NO, do not complete this form</small>	2	Will you be 18 years old on or before election day? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If you answered NO, do not complete this form unless you will be 18 by the end of the year</small>	For Board Use Only	
3	Last Name _____ First Name _____ Middle Initial _____ Suffix _____				
4	Address where you live (do not give P.O. box) _____ Apt. No. _____ City/Town/Village _____ Zip Code _____ County _____				
5	Address where you get your mail (if different than above) _____ P.O. Box, Star Route, etc. _____ Post Office _____ Zip Code _____				
6	Date of Birth _____	7	Sex <input type="checkbox"/> M <input type="checkbox"/> F	8	Telephone (optional) _____ Email (optional) _____
10	The last year you voted _____	Your address was (give house number, street and city) _____		9	ID Number (Check the applicable box and provide your number) <input type="checkbox"/> New York State DMV number _____ <input type="checkbox"/> Last four digits of your Social Security number _____ <input type="checkbox"/> I do not have a New York State DMV or Social Security number
	In county/state _____	Under the name (if different from your name now) _____			
11	Political Party I wish to enroll in a political party <input type="checkbox"/> Democratic party <input type="checkbox"/> Independence party <input type="checkbox"/> Republican party <input type="checkbox"/> Women's Equality party <input type="checkbox"/> Conservative party <input type="checkbox"/> Reform party <input type="checkbox"/> Green party <input type="checkbox"/> Other _____ <input type="checkbox"/> Working Families party I do not wish to enroll in a political party <input type="checkbox"/> No party			12	Affidavit: I swear or affirm that <ul style="list-style-type: none"> I am a citizen of the United States. I will have lived in the county, city or village for at least 30 days before the election. I will meet all requirements to register to vote in New York State. This is my signature or mark on the line below. The above information is true, I understand that if it is not true, I can be convicted and fined up to \$5,000 and/or jailed for up to four years. <p>_____/_____/_____ Signature or Mark in ink Date</p>

(Optional) Register to donate your organs and tissues

Last Name			
First Name		Middle Initial	Suffix
Address			
Apt Number	City/Town/Village		Zip Code
Birth Date		Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Eye Color		Height	Ft. In.

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.



_____/_____/_____
Signature Date

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections

40 North Pearl St, Suite 5

Albany, NY 12207-2729

Telephone: 1-800-469-6872;

TDD/TTY users contact the New York State Relay at 711;

or visit our web site - www.elections.ny.gov

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state party rules allow otherwise.



NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

HOW TO COMPLETE THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION/RECERTIFICATION AND APPLICANT/RECIPIENT RIGHTS AND RESPONSIBILITIES FOR SNAP



This application can ONLY be used to apply for SNAP

If you are blind or seriously visually impaired and need an application or these instructions in an alternative format, you may request them from your social services district (SSD). The following alternative formats are available:

- Large print;
- Data format (a screen reader-accessible electronic file);
- Audio format (an audio transcription of the instructions or application questions); and
- Braille, if you assert that none of the alternative formats above will be equally effective for you.

Applications and instructions are also available for download in large print, data format and audio format from www.otda.ny.gov. Please note that applications are available in audio format and Braille solely for informational purposes. In order to apply, you must submit an application in written, non-alternative format.

If you have any disabilities that prevent you from completing this application and/or from waiting to be interviewed, please notify your SSD. The SSD will make every effort to provide a reasonable accommodation to address your needs.

If you require another accommodation, or need other help completing this application, please contact your SSD. We are committed to assisting and supporting you in a professional and respectful manner.



NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

HOW TO COMPLETE THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION/RECERTIFICATION AND APPLICANT/RECIPIENT RIGHTS AND RESPONSIBILITIES FOR SNAP



This application can ONLY be used to apply for SNAP

If you are only applying for SNAP you can use this shorter application. If you would like to apply for other benefits such as Temporary Assistance, Child Care Assistance, Home Energy Assistance or Medicaid please ask for a different application.

When You Are Applying For SNAP

- You can file an application the same day you receive it. We must accept your application if, at a minimum, it contains your name, address, (if you have one), and a signature. This information will establish your application filing date.
- You must complete the application process, including having an interview and signing the certification statement on page 8 of the application/recertification for your eligibility to be determined. If you are eligible, benefits will be provided back to the date you filed your application.
- You can apply for and get SNAP for eligible household member(s) even if you or some other members of your household are not eligible for benefits because of immigration status. For example, ineligible alien parents can apply for SNAP for their children and receive benefits for their eligible children.
- You can still apply and be eligible for SNAP even if you have reached your Temporary Assistance time limits.

Need SNAP Benefits Right Away? You May Be Eligible For Expedited Processing of your SNAP Application.

If your household has little or no income or liquid resources, **or** if your rent and utility expenses are more than your income and liquid resources, **or** you are a migrant or seasonal farmworker with little or no income or resources when you apply, you may be eligible to get SNAP within 5 calendar days of the date you apply. When a resident of an institution is jointly applying for SSI and SNAP prior to leaving the institution, the recorded filing date of the application is the date of release of the applicant from the institution.

Where You Can Apply For SNAP

If you live **outside of** New York City, you can apply on-line at myBenefits.ny.gov, or call or visit the social services district in the county where you live and ask for an application package, which can be mailed or dropped off to that appropriate office. You can get the address and phone number of the social services district in your county by calling toll free **1-800-342-3009**.

If you live in **New York City** and you are **not** also applying for Temporary Assistance, you can apply on-line at myBenefits.ny.gov, or call or visit any SNAP Office and ask for an application package. You can get the address and phone number by calling **1-718-557-1399** or toll free **1-800-342-3009**.

Having Problems Coming To Us For A SNAP Interview Appointment?

If it is difficult for you to come in for a SNAP interview appointment (reasons may include employment, health issues, transportation or child care problems), in some circumstances; we can interview you by telephone, or you may have someone else apply for you. Please contact your social services district if you have any questions, to see if you are eligible for a telephone interview, **or if you need** to reschedule an interview.

INSTRUCTIONS ON HOW TO COMPLETE THE SNAP APPLICATION/RECERTIFICATION

Be sure to complete each section by PRINTING clearly in blue or black ink.

Do **NOT** print in the shaded areas.

If you are applying as someone's representative, please print information about that person, not yourself.

ALTERNATIVE FORMATS: Check "YES" or "NO" to indicate whether you are blind or seriously visually impaired and would like to receive written notices in an alternative format. If "Yes," check the type of format you would like. Alternative formats are available in large print, data CD, audio CD, or Braille, if you assert that none of the other alternative formats are equally effective for you. If you require another accommodation, or need other help completing this application, please contact your SSD.

SECTION 1: APPLICANT INFORMATION

NAME: PRINT your legal name including your first name, middle initial and last name.

TELEPHONE NUMBER: PRINT your home phone number.

OTHER PHONE: PRINT another phone number where you can be reached, if you have one.

RESIDENCE ADDRESS: PRINT the street, avenue, road, etc., where you now live. PRINT the city you live in. PRINT your zip code.

MAILING ADDRESS: PRINT your mailing address if it is different from your residence.

OTHER NAME: PRINT any maiden names, names from a previous marriage, or other names that any person listed has been known by or now uses.

Check (✓) whether you are applying or recertifying for SNAP.

Check (✓) if you wish to receive notices in Spanish **and** English or just English.

SECTION 2: Sign your name, date, and provide your address (if you have one) **ONLY** if you want to submit your application without completing the next page at this time to establish your application filing date. You must complete the application process, including the interview and sign on page 8 for us to determine your eligibility.

SECTION 3: HOUSEHOLD MEMBERS INFORMATION:

LIST THE NAMES OF EVERYONE WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU.

PRINT your full name first. Then **PRINT** the names of the other people who live with you:

PRINT the Social Security Number (if the individual does not have a SSN, enter "none"), date of birth, marital status and sex for each person applying.

Check (✓) Yes or No to tell us who is applying.

For **each** person in the household, PRINT how they are related to you (for example: wife, son, friend, etc.).

Check (✓) Yes or No if that person buys and/or prepares food with you.

Check (✓) Yes or No to indicate if each person applying is Hispanic or Latino.

Enter Y (Yes) or N (No) for each race *.

Race/Ethnic codes: **I** – Native American or Alaskan Native, **A** – Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** – White

The provision of this information is voluntary. It will not affect the eligibility of the persons applying or the level of benefits received. The reason for this information is to ensure that program benefits are distributed without regard to race, color or nation origin.

SECTION 4: Answer all questions in section 4. Be sure to provide the names of individuals who are not U.S. citizens.

SECTION 5: INCOME: List all your income and the income of everyone living with you. PRINT the name of the person receiving the income, the source of income and how often it is received. Income can include: Regular job (wages), income before strike, on-the-job-training, military reserves, national guard, work study, alimony, child support, educational assistance (grants, scholarships, etc.), friends or relatives (other than loans), temporary assistance, pensions or retirement, Supplemental Security Income (SSI), Social Security benefits, veterans benefits, unemployment benefits, worker's compensation, babysitting, taxi driving, cleaning homes or other buildings, farming/ranching, income from a roomer, income from a boarder or arts and crafts.

NOTE: Foster Care Payments and SNAP – You may choose to include the foster care child or adult in the SNAP household. If you do, any associated foster care payments will be counted as income. All other income or resources of the foster care child also will be counted. If you have any questions about this, make sure to ask your worker.

Be sure to answer all other questions in section 5.

SECTION 6: RESOURCES: Resources do not affect the eligibility of most households applying for SNAP. However, some resource information is used to determine if you qualify for expedited processing of your application.

Answer all the questions in Section 6 for yourself and everyone who is applying for SNAP. List the dollar (\$) amount or value and the name of the person who has the resource. **Be sure to list any joint holdings with non-household members.** Resources may include any of the following: cash on hand, cash held by others, checking or savings account, savings bonds, individual retirement account, pension plan, individual development account, stocks/bonds, mutual funds, trust fund, money market certificates, buildings, land, rental property, vacation or recreational property or house other than home.

SECTION 7: LIVING ARRANGEMENTS AND EXPENSES:

PRINT the amount you pay for rent, mortgage, room and board or other housing. List the dollar (\$) amount that you pay for your property taxes and homeowner's insurance.

If you pay for your heat separately, check (✓) what type of heat you have, and fill in the name of the heating company and your account number.

Also, indicate if:

- you pay for other utilities separately from your rent/mortgage, have air conditioning costs and if you do, who pays the separate expense?
- anyone pays legally obligated child support and if so, who, how much, the frequency of payments, and the name of the child(ren) support is being paid for?
- anyone in household applying, who is blind, disabled or at least 60 has any medical bills such as in-home nursing service, dentures, hearing aid, eyeglasses, seeing eye dog or service animal, health insurance and medical payments, hospital or nursing care, medical or dental services, prescription drugs or medical transportation?
- anyone in your household is on Medicaid with a spenddown and if so, who and how much?
- anyone in your household is enrolled in school or in a training program and if so, who and where, and enrollment status?

Be sure to answer all other questions in section 7.

SECTION 8: LEGAL STATEMENTS, RESPONSIBILITIES AND PENALTIES: Read this section carefully or have someone read it to you.

Note: NY State Law provides for fine or jail, or both, for a person found guilty of obtaining SNAP by hiding the facts or not telling the truth.

I understand that the State will use my Social Security Number to verify with my home energy vendors the receipt of HEAP. This authorization also includes permission for any of my home energy vendors (including my utility) to release certain statistical information, including but not limited to, my annual electricity usage, electricity costs, fuel consumption, fuel type, annual fuel cost and payment history to the Office of Temporary and Disability Assistance and the local Social Services District and the United States Department of Health and Human Services for the purposes of Low Income Home Energy Assistance Program (LIHEAP) performance measurement.

NON-DISCRIMINATION NOTICE – In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audio tape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

SECTION 9: SNAP AUTHORIZED REPRESENTATIVE: If you want someone from outside your household to apply for SNAP benefits or get the SNAP benefits or to buy the food for you, PRINT their name, address and phone number, unless the authorized representative has been otherwise designated by the household in writing.

SECTION 10: SIGNATURES: Sign your name. If you are an Authorized Representative, both you and a responsible adult household member must sign and date the signature sections on page 8 of the Application/Recertification.

When an Authorized Representative is applying on behalf of a SNAP Household that does not reside in an institution, **both the** Authorized Representative and the Head of Household or another responsible adult member of the household must sign and date the signature sections on Page 8 of the Application/Recertification.

SECTION 11: ADDITIONAL INFORMATION: Use this section to let us know additional information that you think we might need to know.

SECTION 12: CONSENT TO WITHDRAW: If you decide you no longer wish to apply for SNAP, sign your name and enter date. You may reapply at any time.

Note: The last page of this application is an application to register to vote. If you would like help filling out the voter registration application form, ask your worker. Applying or declining to register to vote will not affect your eligibility or the amount of assistance that you will be given by this agency.

Information from your application and interview will be entered and stored in the Welfare Management System (WMS), a statewide computer system. This system is used to improve the management of Social Services Programs and to deter fraud.

READ THE IMPORTANT INFORMATION BELOW

APPLICANT/RECIPIENT RIGHTS AND RESPONSIBILITIES FOR SNAP

Additional information regarding your rights and responsibilities is contained in the Client Information Books (LDSS-4148A; LDSS-4148B and LDSS-4148C). These books can be obtained at your social services district, and on-line.

YOU HAVE RIGHTS:

- As an Applicant/Recipient of SNAP you must be interviewed as promptly as possible in order to determine eligibility and to issue benefits within 30 days of application filing.
- You may request that the in-office interview be waived in hardship situations. Hardship generally includes, but is not limited to, illness, transportation difficulties, care of a household member, hardship due to residency in a rural area, prolonged severe weather, or work or training hours that prevent you from coming in during the social services district's office hours. **The in-office interview will be waived, at your request, if all the adult members of your household are elderly or disabled with no earned income.** The agency may waive the in-office interview in favor of a telephone interview or scheduled home visit. In-person interviews may be scheduled in advance at any mutually acceptable location including a household's residence.
- You may bring someone to your interview to interpret for you. If you need an interpreter, the agency will arrange for one at no cost to you. You cannot be denied access to services because you are not fluent in English or hearing or speech impaired. Social Services districts may utilize the TTY/TTD relay systems to gain access to services for hearing or speech impaired applicants/recipients. If you have any special needs you can request special accommodations from your social services district.
- If you have a disability, you have the same right to access and be interviewed for SNAP as someone who does not have a disability.
- Within 30 days of the date you filed your completed application and interview for SNAP, you must be told if your application is approved or denied. If you are eligible for expedited processing you must be told within 5 days after the date you turned in your application if you are qualified for SNAP and/or advised if additional documentation is needed.
- You must be given a written notice telling you if your application for SNAP is approved or denied:
 - If your Application is approved, this notice will tell you the amount of SNAP benefits you will get;
 - If your Application is denied, this notice will tell you why and what you should do if you disagree or do not understand this decision.

WHAT IS A FAIR HEARING

A Fair Hearing is a chance for you to tell an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance why you think the social services district's decision about your case was wrong. After the Fair Hearing, the State will issue a written decision which will state whether the social services district's decision was right or wrong. The written decision may order the social services district to correct your case.

TIME LIMITS TO ASK FOR A FAIR HEARING

If you want to ask for a Fair Hearing for SNAP, call **right away** because there are time limits. If you wait too long, you may not be able to get a Fair Hearing. **If you get a notice about your case** and you want to ask for a Fair Hearing, the notice will tell you how much time you have to ask for the Fair Hearing. **Be sure to read all of the notice carefully. If your notice tells you that your SNAP benefits have been denied, will be stopped or will be reduced, you may ask for a Fair Hearing within 90 days from the date of the notice. You may ask for a Fair Hearing if you think you are not getting enough SNAP benefits at any time within the certification period.**

READ THE IMPORTANT INFORMATION BELOW (cont'd)**HOW TO ASK FOR A FAIR HEARING**

If you live anywhere in New York State, you may request a Fair Hearing by telephone, fax, online, or by writing to the address below.

Telephone: Statewide toll free request number is 800-342-3334. Please have the notice, if any, with you when you call.

Fax: your Fair Hearing Request to: 518-473-6735

Online: Complete online request form at <http://www.otda.state.ny.us.us/oah/forms.asp>

In writing: If you received a notice, fill in the supplied space and send a copy of the notice, **or** write to:

Fair Hearing Section

NYS Office of Temporary and Disability Assistance

Fair Hearings

P.O. Box 1930

Albany, New York 12201-1930 *Please keep a copy of any notice for yourself*

Walk-In: If you live in New York City you may also make your request in person by walking into the **Office of Administrative Hearings, Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York**

EMERGENCY - If your situation is very serious, the New York State Office of Temporary and Disability Assistance will set up a Fair Hearing for you as soon as possible. When you call or write for a Fair Hearing, be sure to explain that your situation is very serious.

NOTE: For New York City emergency fair hearings only – Call 800-205-0110. Do not use this telephone number for anything except emergencies. Requests that do not involve emergencies will not be taken at this number.

INTERPRETERS – You have the right to an interpreter at no cost to you, if English is not your primary language, or if you are hearing or speech impaired.

AID CONTINUING - If you get a notice telling you that your benefits will be stopped or reduced, and you ask for a Fair Hearing before the **effective date** on your notice, your SNAP benefits will, in most instances, stay the same ("**aid continuing**") until the Fair Hearing decision is made. If you do not get a notice about your case, and your benefits are stopped or reduced, at the same time that you ask for a Fair Hearing, you can ask that your SNAP benefits be restored ("**aid continuing**") until the Fair Hearing decision is made.

However, if you get "**aid continuing**" and you lose the Fair Hearing, you may have to pay back any benefits that you received as "aid continuing" while waiting for the Fair Hearing decision. If you **do not** want the SNAP benefits you have been getting to stay the same until the Fair Hearing decision is made, you must tell this to the New York State Office of Temporary and Disability Assistance when you call or write for a Fair Hearing.

HOW TO PREPARE FOR A FAIR HEARING

The New York State Office of Temporary and Disability Assistance will send you a notice, which tells you when and where the Fair Hearing will be held. To help you get ready for the Fair Hearing, you have the right to look at your case record and get free copies of the forms and papers which will be given to the Administrative Law Judge at the Fair Hearing. You can also get free copies of any other papers in your case record which you think you may need for the Fair Hearing. Usually, you can get these papers before the hearing or at the hearing at the latest. If you ask for any papers related to your hearing, and the social services district does not give them to you before or at the hearing, you should tell the Administrative Law Judge about it.

READ THE IMPORTANT INFORMATION BELOW (cont'd)

You should also bring to the Fair Hearing any witnesses who can help you and any information you have such as: **Pay stubs, Bills, Receipts, Leases, Doctor's statements**, to help you explain why you think the social services district's decision is wrong.

You can bring a lawyer, a relative or a friend to the Fair Hearing to help you explain why you think a social services district's decision about your case is wrong. If you think you need a lawyer to help you with your Fair Hearing, you may be able to get a lawyer at no cost to you by calling your local Legal Aid or Legal Services Office. For the names of other lawyers, call your local Bar Association.

Someone from the social services district will also be at the Fair Hearing to explain the social services district's decision about your case. You or your representative will be able to question this person and any witnesses from the social services district.

If you cannot go to the Fair Hearing, you can send someone else in your place. If you are sending someone who is not a lawyer to the Fair Hearing, you must give this person a letter to give to the Administrative Law Judge. This letter should tell the Judge that you want this person to take your place at the Fair Hearing. If the Administrative Law Judge decides that your presence is required, and your testimony is necessary, the hearing may be re-scheduled for another day for you to appear. You will be notified of the new day by mail.

NOTE: If you ask, you will be able to get back the money you had to pay for public transportation, child care and other necessary expenses to go to the fair hearing. If no public transportation is available, you may be able to get back the money you had to pay for another type of transportation. If you are unable to use public transportation because of a medical problem, you may be able to get back the money you had to pay for another type of transportation. However, you may be asked to provide medical verification.

TO LOOK AT YOUR CASE AND COMPUTER RECORDS:

Once you apply for SNAP or other help, case records and computer records are kept about your case. Usually, you have the right to look at those records. However, you may **not** be able to look at all of the records. Your worker can explain the rules to you.

When you write for copies of your computer records, the Personal Privacy Protection Law requires that New York State agencies, send you your records; **or** tell you why they will not give you your records; **or** tell you they have your request and they will determine if you are allowed to get your records within five working days of when they get your request letter.

AS AN APPLICANT/RECIPIENT OF SNAP YOU HAVE SEVERAL RESPONSIBILITIES:**Employment Requirements for SNAP Applicants and Recipients**

Unless you are exempt from work registration requirements, you must:

- Accept a job or a referral to a job opening
- Participate in an assessment of your ability to work
- Provide information regarding your employment status and availability for work
- Participate in work activities as assigned by the social services district

You are a work registrant and required to comply with work requirements unless you are determined by the social services official to be:

- Younger than 16 years of age or 60 years of age or older
- Mentally or physically disabled, incapacitated or ill and unable to engage in work activities
- Responsible for the care of a dependent child under the age of six. If you are participating in work experience under a federally-funded Temporary Assistance program, this exemption from SNAP work requirements does not apply.

READ THE IMPORTANT INFORMATION BELOW (cont'd)

- Subject to and complying with a work requirement under a federally funded Temporary Assistance program. If you are assigned to work experience, this exemption from SNAP work requirements does not apply.
- Responsible for the full-time care of an incapacitated person
- An applicant for or recipient of Unemployment Insurance Benefits
- A regular participant in a drug or alcohol treatment program and the social services official determines that you are unable to work or that assignment to work activities is impractical
- A student enrolled at least half-time in a recognized school, training program or institution of higher education
- Employed at least 30 hours a week or earning at least the equivalent of 30 times the federal minimum wage per week
- An applicant for Supplemental Security Income (SSI) and SNAP benefits under the joint processing provisions
- A 16 or 17 year old individual who is not the head of household or who is attending school or an employment program at least half-time

If you fail to comply with a SNAP work assignment or quit a job, you may lose your SNAP benefits. The length of time you will lose your benefits depends on the number of times you have failed to comply with a work requirement.

Additional Work Requirements for SNAP Recipients who are Able-Bodied Adults without Dependents (ABAWDs)

If you are a work registrant/subject to SNAP work requirements, you also must meet additional SNAP eligibility requirements unless you are:

- Under 18 years of age or 50 years of age or older;
- Living in a SNAP household that includes a member who is under 18 years of age;
- Pregnant; or
- Unable to work at least 80 hours a month due to a physical or mental limitation.

If you are a work registrant and not exempt due to one of the reasons listed above you are only eligible to receive SNAP benefits for three months in a 36 month period unless you:

- Work (including "in-kind" work and volunteer work) for at least 80 hours per month;
- Participate in a qualifying work/training program approved by the social services district for at least 80 hours per month;
- Comply with a Work Experience Program (WEP) assignment for the number of hours equal to your SNAP grant divided by the higher of the federal or State minimum wage;
- Participate in a program under the Workforce Investment Opportunity Act which may include job search, job readiness, occupational skills training and education activities, or the Trade Act of 1974 for at least 80 hours per month; or,
- Participate in a combination of work or qualifying work programs for at least 80 hours per month.

If an ABAWD wants to receive SNAP benefits beyond the 3 month limit and is unable to secure paid employment of at least 80 hours a month, he/she should contact the social services district to discuss what work or work programs may be available to permit the ABAWD to meet the work requirement.

If an ABAWD does not meet the work requirement and loses eligibility for SNAP, he/she may be able to receive SNAP again, if otherwise eligible, and should contact the social services district to discuss what he/she needs to do to regain SNAP eligibility.

In addition, the ABAWD must provide documentation of participation in unpaid work activities on a monthly basis and report to the social services district within 10 days after the end of the month if his/her work hours go below 80 hours a month.

READ THE IMPORTANT INFORMATION BELOW (cont'd)**IF YOU ARE SUSPECTED OF FRAUD**

If you find out that you are being investigated because your worker thinks you did not tell the truth about your case, you should talk to a lawyer. If you are charged with welfare fraud in criminal court, the court will, if you are eligible, assign a lawyer to represent you at no cost.

RESPONSIBILITY TO RESCHEDULE A MISSED INTERVIEW:

As an Applicant/Recipient of SNAP, you are responsible to reschedule a missed interview before the 30th day after the date you applied to avoid losing SNAP.

RESPONSIBILITY TO PROVIDE PROOF

When you are applying for SNAP, you will be asked to provide proof of certain things. Your worker will advise you of what is needed. Document requirements may vary for different assistance programs. If the social services district already has proof of certain things that do not change such as social security number, you do not need to prove it again.

By having proof of identity and other important documents when you first apply for assistance, you may be able to get help sooner.

If you are dropping off documents at your social services office, ask for a receipt which should include the district name, your name, the date, time, list of each specific document being left, and the name of the worker giving you the receipt.

You must provide the proof that your worker tells you is needed to have your eligibility for SNAP determined. If you have trouble getting the requested proof, make it known to your worker.

NON-CITIZEN ELIGIBILITY INFORMATION

Many non-citizens are qualified aliens who are eligible for SNAP. Even if you are not, your children may be eligible. SNAP should not affect your immigration status with respect to any USCIS decision regarding your immigration matter.

READ THE IMPORTANT INFORMATION BELOW (cont'd)

You may be eligible for SNAP if you are a United States (U.S.) citizen, a non-citizen U.S. national (people born in American Samoa or Swains Island), or a qualified alien. A qualified alien for SNAP eligibility is:

1. An American Indian born in Canada with at least 50 per centum of blood of the American Indian race under section 289 of the Immigration and Nationality Act (INA); or
2. A member of a federally recognized Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act; or
3. An alien admitted as a Hmong or Highland Laotian, including the spouse (or un-remarried surviving spouse) or unmarried dependent child; or
4. A refugee admitted under section 207 of the INA; or
5. An alien granted asylum under section 208 of the INA; or
6. An alien whose deportation has been withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under section 241(b)(3) of the INA; or
7. An alien admitted as a Cuban or Haitian entrant under section 501(e) of the Refugee Education Assistance Act of 1980; or
8. An alien who is a victim of trafficking under section 103(8) of the Trafficking Victims Protection Act of 2000; or
9. A lawfully residing alien who is on active duty in the U.S. Armed Forces, an honorably discharged veteran whose discharge is not because of immigration status, his or her spouse, unmarried dependent children, or un-remarried surviving spouse; or
10. An alien admitted as an Amerasian; or
11. An alien lawfully admitted for permanent residence under the INA and who has 5 years in status; or
12. An alien paroled under section 212(d)(5) of the INA for at least 1 year and who has 5 years in status; or
13. A battered spouse or child, parent of a battered child or child of a battered parent with a petition pending or approved under 8 USC 1641(c) who entered before 8/22/96 or has 5 years in status; or
14. Aliens also may be eligible for SNAP if:
 - They are lawfully admitted for permanent residence and have earned, or can be credited with 40 quarters of work; or
 - They are in a qualified status listed above and receive certain disability or blindness benefits; or
 - They are in a qualified status listed above and are under 18 years old; or
 - They are lawfully in the U.S. on August 22, 1996 and are blind, disabled or 60 years of age or older; or
 - They are Iraqi or Afghani nationals granted special immigration status under section 101(a)(27) of the INA or have been granted conditional entry under section 203(a)(7) of the INA as in effect before 4/1/80.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) AUTHORIZED REPRESENTATIVE REQUEST FORM

If you are blind or seriously visually impaired and need this application/form in an alternative format, you may request one from your social services district. For additional information regarding the types of formats available, contact your social services district or visit www.otda.ny.gov.

If you are blind or seriously visually impaired, would you like to receive written notices in an alternative format? ___ Yes ___ No

If Yes, check the type of format you would like: ___ Large Print
___ Data CD ___ Audio CD ___ Braille, if you assert that none of the other alternative formats will be equally effective for you.

If you require another accommodation, please contact your social services district.

Applicant/Recipient Name:	Applicant Address:
Applicant/Recipient Case Number:	

AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to **apply** for SNAP benefits for you. You can also authorize someone to use your SNAP benefit card to buy food for you. If you would like to authorize someone for either of these purposes, you must do so in writing. You may do so by printing the person's name, address and phone number below and signing the next page of this form.

Authorized Representative Name:	Authorized Representative Address:
Authorized Representative Telephone Number:	

I authorize the above designated individual to act as my representative for the purposes checked below. I understand that if I do not check any of the boxes below, my authorized representative will be authorized to perform all of the functions listed next to the boxes. I understand that I may revoke all or part of this authorization at any time by notifying my local district in writing.

Please Check the Appropriate Box(es) Application for SNAP benefits To use my SNAP benefit (EBT card) to purchase food for me
 Recertification for SNAP benefits All of the above

SNAP PENALTY WARNING – Any information you provide in connection with your application for SNAP will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied SNAP. You may be subject to criminal prosecution if you knowingly provide incorrect information which affects eligibility or the amount of benefits. Anyone who is violating a condition of probation or parole or anyone who is fleeing to avoid prosecution, custody or confinement for a felony, and is actively being pursued by law enforcement, is not eligible to receive SNAP benefits.

SNAP PENALTY WARNING (continued)

If a SNAP household member is found to have committed an Intentional Program Violation (IPV), the member will not be able to get SNAP benefits for a period of:

- 12 months for the first SNAP-IPV;
- 24 months for the second SNAP-IPV;
- 24 months for the first SNAP-IPV, that is based on a court finding that the individual used or received SNAP benefits in a transaction involving the sale of a controlled substance. (Illegal drugs or certain drugs for which a doctor's prescription is required.)
- 120 months if found to have made a fraudulent statement about who you are or where you live in order to get multiple SNAP benefits simultaneously, unless permanently disqualified for a third IPV.

Additionally, a court may bar an individual from participating in SNAP for an additional 18 months.

Permanent disqualification of an individual for:

- The first SNAP-IPV based on a court finding of using or receiving SNAP benefits in a transaction involving the sale of firearms, ammunition or explosives;
- The first SNAP-IPV based on a court conviction for trafficking SNAP benefits for a combined amount of \$500 or more (Trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP authorization cards or access devices);
- The second SNAP-IPV based on a court finding that an individual used or received SNAP benefits in a transaction involving the sale of a controlled substance. (Illegal drugs or certain drugs for which a doctor's prescription is required);
- All third SNAP Intentional Program Violations.

Any person convicted of a felony for knowingly using, transferring, acquiring, altering or possessing SNAP authorization cards or access devices may be fined up to \$250,000, imprisoned up to 20 years or both. The individual may also be subject to prosecution under the applicable Federal and State laws.

You may be found ineligible for SNAP or found to have committed an IPV if:

- You make a false or misleading statement, or misrepresent, conceal or withhold facts in order to qualify for benefits or receive more benefits; or
- Purchase a product with SNAP benefits with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit amount; or
- Commit or attempt to commit any act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of SNAP benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

Additionally the following is not allowed and, you may be disqualified from receiving SNAP benefits and/or be subject to penalties for actions that include:

- Using or have in your possession EBT cards that do not belong to you, without the card owner's consent; or
- Using SNAP benefits to buy nonfood items, such as alcohol or cigarettes, or to pay for food previously purchased on credit; or
- Allowing someone else to use your electronic benefit transfer (EBT) card in exchange for cash, firearms, ammunition, explosives, or drugs or to purchase food for individuals who are not members of the SNAP household.

Note: Both the applicant and/or authorized representative are subject to the above penalties.

Applicant Signature:	Date:
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As an authorized representative I acknowledge the information set forth above.

Authorized Representative Signature:	Date:
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**PETICIÓN DE REEMPLAZO DE ALIMENTOS ADQUIRIDOS CON EL
SUBSIDIO DEL PROGRAMA DE ASISTENCIA NUTRICIONAL SUPLEMENTARIA (SNAP)**

Si usted es una persona ciega o tiene un impedimento visual grave y necesita esta solicitud / formulario en un formato alternativo, lo puede solicitar de su distrito de servicios sociales. Si desea información adicional sobre los tipos de formatos disponibles, comuníquese con su distrito de servicios sociales o ingrese a www.otda.ny.gov.

Si usted es una persona ciega o tiene un impedimento visual grave, ¿Le gustaría recibir notificaciones en un formato alternativo? ___ Sí ___ No

Si contestó «Sí», marque el tipo de formato que desea: ___ Letra Grande ___ CD de Datos ___ CD Audio ___ Braille, si usted determina que ninguno de los otros formatos alternos le serán de igual utilidad a usted.

Si usted necesita otra modificación, favor de comunicarse con su distrito de servicios sociales.

NEW YORK STATE		OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE		
CASO A NOMBRE DE:		CONDADO		
Nº DE CASO	Nº DE SEGURO SOCIAL		FECHA DE NACIMIENTO	
DIRECCIÓN (incluya el Nº de la casa o del apto.)	CIUDAD	ESTADO	CÓDIGO POSTAL	Nº DE TELÉFONO

Yo _____, siendo el jefe del hogar o integrante adulto del hogar correspondiente al caso mencionado arriba, deseo informar lo siguiente al representante de la agencia:

Mi hogar sostuvo una pérdida por el monto de \$ _____ de alimentos comprados con subsidios del Programa de Asistencia Nutricional Suplementaria (SNAP) y los cuales se dañaron debido a:

- | | |
|--|--|
| <input type="checkbox"/> Una interrupción del servicio eléctrico | <input type="checkbox"/> Una inundación |
| <input type="checkbox"/> Un incendio | <input type="checkbox"/> Otro desastre Describa: _____ |

Comentarios del trabajador social: _____

Comentarios del cliente: _____

CERTIFICACIÓN

NO FIRME HASTA QUE HAYA LEÍDO Y ENTENDIDO LOS ENUNCIADOS A CONTINUACIÓN

Yo entiendo que el ofrecer un instrumento falso para su registro, tal como lo describe el Artículo 175 de la Ley Penal, es un delito el cual conlleva una pena máxima de cuatro (4) años de prisión. Si lo hago, estaré sujeto a procedimientos judiciales bajo la Leyes Civiles y Penales Estadounidenses y del Estado de Nueva York y según las pautas de la oficina estatal New York State Office of Temporary and Disability Assistance.

Entiendo que tengo el derecho a una audiencia imparcial con el fin de oponerme a la denegación o la demora del remplazo destinado a mi grupo familiar. No se emitirán remplazos mientras se espera por la decisión de la audiencia imparcial.

Entiendo que si no firmo y devuelvo esta declaración a la agencia dentro de diez (10) días contados a partir de la fecha que se informa la pérdida, la agencia no remplazará los subsidios SNAP.

Firma	Fecha
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*Sírvese regresar este formulario completamente relleno al departamento local de servicios sociales de su condado (SSD); o los residentes de la Ciudad de Nueva York, sírvanse ingresar a la página web de HRA para ver la lista de los centros locales más cercanos a su domicilio.

**PETICIÓN DE REEMPLAZO DE ALIMENTOS ADQUIRIDOS CON EL
SUBSIDIO DEL PROGRAMA DE ASISTENCIA NUTRICIONAL SUPLEMENTARIA (SNAP)**

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NEW YORK STATE		OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE		
CASO A NOMBRE DE:		CONDADO		
Nº DE CASO	Nº DE SEGURO SOCIAL		FECHA DE NACIMIENTO	
DIRECCIÓN (incluya el Nº de la casa o del apto.)	CIUDAD	ESTADO	CÓDIGO POSTAL	Nº DE TELÉFONO

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|--|--|
| <input type="checkbox"/> Una interrupción del servicio eléctrico | <input type="checkbox"/> Una inundación |
| <input type="checkbox"/> Un incendio | <input type="checkbox"/> Otro desastre Describa: _____ |

Comentarios del trabajador social: _____

Comentarios del cliente: _____

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Firma	Fecha
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