ADMINISTRATIVE DIRECTIVE

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
40 North Pearl Street
Albany, New York 12243
Cesar A. Perales, Commissioner

TRANSMITTAL NO:	89 ADM-21
DATE:	May 22, 1989
DIVISION:	Income Maintenance/Medical Assistance
TO:	Commissioners of Social Services
SUBJECT:	Mandatory Client Notices (Public Assistance, Food Stamps, Medical Assistance)
SUGGESTED DISTRIBUTION:	Public Assistance Staff Medical Assistance Staff Food Stamp Staff Services Staff Fair Hearing Staff Staff Development Coordinators
CONTACT PERSON:	1-800-342-3715 Public Assistance: Dorothy O'Brien extension 4-9323 Food Stamps: County Representative extension 4-9225 Employment: Technical Advisor, extension 3-8377 Medical Assistance: o Eligibility: County Representative extension 3-7581 o Long Term Care: Rick Ruid extension 3-5504 o Recipient Restriction Program: Sandy Spulnick extension 3-7359 o Personal Care: Marcia Anderson extension 3-5617

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Department Regs.	Social Services Law and Other Legal References	Manual References	Miscellaneous Reference
80 ADM-12,80 ADM-98 81 ADM-55,82 ADM- 5 82 ADM-55,84 ADM-41 84 ADM-44,85 ADM-17 85 ADM-29,85 ADM-37 85 ADM-45,86 ADM- 7 86 ADM-10,87 ADM- 4 87 ADM-48,88 ADM- 4 88 ADM- 8,88 INF-28 88 INF-83,89 ADM- 6 89 ADM-8	84 ADM-41 85 ADM-29	350.5,351.22 351.23 352.31(d) 355,358-3.3 360 - 2.4-2.5, 2.6, 6.4, 7.5, 369.6 387.14 387.20 505.14(b)(5) (v), (viii) (x) 385.3,385.14	SSL 22 SSL 366-a	MARG pp.378-387 FSSB Section VI,A,B VII-all PASB Section VI - all Local District Manager's Guide	GIS 89 MA007 DCL 7/13/83 89 LCM-22

DSS-6 (Rev. 6/87)

I. PURPOSE

This Directive provides local social services districts with information and instructions regarding new and revised mandated Public Assistance, Medical Assistance and Food Stamp client notices of eligibility decisions.

II. BACKGROUND

Previously the Department issued instructions to local districts on the wording to be used in timely and adequate notices in 81 ADM-55, 82 ADM-5, 82 ADM-55, 84 ADM-41, 85 ADM-29 and 87 ADM-48. As a result of the recodification of 18 NYCRR Part 358 which governs the fair hearing process, the Department formed a committee to reexamine all client notices to determine whether such notices would require revisions as a result of changes to Part 358. The Division of Legal Affairs transmitted information about the recodification of Part 358 to local social services districts in 88 INF-83.

The committee, comprised of representatives of the Divisions of Medical Assistance, Legal Affairs, Legal Affairs/Fair Hearings and Income Maintenance decided that the necessity of changing client notices to conform to the recodification of Part 358 would be used as an opportunity to: (1) review all existing State-printed notices towards making their format and language as consistent as possible; (2) develop State-printed notices for which, in the past, only a prototype notice was provided for local district duplication; and, (3) combine those notices for different program areas when an eligibility decision for one program necessitated the notification to the applicant/recipient of his/her status in another program.

The result of this effort is the 36 new or revised notices introduced through this ADM.

III. ORGANIZATION AND CONTENT

IV. NOTICES DIRECTORY

Since the notices presented in this Directive address a variety of program determinations, this ADM will discuss each notice individually. The following table shows the attachment number of each notice and where the narrative concerning each notice can be located.

A. COMBINED PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE NOTICES

1. DSS-4013: ACTION TAKEN ON YOUR APPLICATION: PUBLIC ASSISTANCE, FOOD STAMPS AND MEDICAL ASSISTANCE COVERAGE

   Attachment 1 - Narrative: Page 11

2. DSS-4014: ACTION TAKEN ON YOUR RECERTIFICATION: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES

Attachment 2 - Narrative: Page 14
Attachment 3 and 4 - Completed Notice Examples

3. DSS-4015: NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY AND ADEQUATE)

   Attachment 5 - Narrative: Page 17

4. DSS-4016: NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY)

   Attachment 6 - Narrative: Page 18

5. DSS-4017: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE)

   Attachment 7 - Narrative: Page 19

6. DSS-4018: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (ADEQUATE ONLY)

   Attachment 8 - Narrative: Page 19

B. **Employment Combined Notices (Upstate Only)**

1. DSS-4003: NOTICE OF INTENT TO CHANGE PUBLIC ASSISTANCE GRANT AND/OR FOOD STAMP BENEFITS AND/OR MEDICAL ASSISTANCE COVERAGE FOR NON-COMPLIANCE WITH EMPLOYMENT RELATED REQUIREMENTS (TIMELY AND ADEQUATE) (Notice A)

   Attachment 9 - Narrative: Page 20

2. DSS-4004: NOTICE OF INTENT TO CHANGE PUBLIC ASSISTANCE GRANT AND/OR FOOD STAMP BENEFITS AND/OR MEDICAL ASSISTANCE COVERAGE FOR NON-COMPLIANCE WITH EMPLOYMENT RELATED REQUIREMENTS (TIMELY AND ADEQUATE) (Notice B)

   Attachment 10 - Narrative: Page 21

3. DSS-4005: NOTIFICATION OF EMPLOYABILITY AND THE RIGHT TO CONTEST (TIMELY AND ADEQUATE)

   Attachment 11 - Narrative: Page 21

C. **Public Assistance Only Notices**

1. DSS-2425: REPAYMENT OF INTERIM ASSISTANCE NOTICE

   Attachment 12 - Narrative: Page 22

2. DSS-4002: NOTICE OF ACCEPTANCE/DENIAL OF REQUEST FOR ASSISTANCE TO MEET AN IMMEDIATE NEED OR A SPECIAL ALLOWANCE

Attachment 13 - Narrative: Page 22

D. **Food Stamps Notices**

1. General Notices

a. DSS-3152: ACTION TAKEN ON YOUR FOOD STAMP CASE

o Attachment 14 - Narrative: Page 24

o Attachment 15 - Completed Notice Example

b. DSS-3153: CONTINUING YOUR FOOD STAMPS

Attachment 16 - Narrative: Page 24

c. DSS-3620: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE)

Attachment 17 - Narrative: Page 25

d. DSS-3621: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (ADEQUATE ONLY)

Attachment 18 - Narrative: Page 25

2. Food Stamp Overissuance, Disqualification and Repayment Notices

a. Overissuance Notices

(1) DSS-3156: NOTICE OF FOOD STAMP OVERISSUANCE

Attachment 19 - Narrative: Page 26

(2) DSS-4052: NOTICE OF FOOD STAMP OVERISSUANCE - INTENTIONAL PROGRAM VIOLATION

Attachment 20 - Narrative: Page 26

b. Disqualification Notices

(1) DSS-4050: FOOD STAMP NOTICE TO HOUSEHOLD OF DISQUALIFIED INDIVIDUAL

Attachment 21 - Narrative: Page 27

(2) DSS-4051: FOOD STAMP NOTICE TO DISQUALIFIED INDIVIDUAL(S)

Attachment 22 - Narrative: Page 27

c. Repayment Agreement

DSS-4053: FOOD STAMP REPAYMENT AGREEMENT

Attachment 23 - Narrative: Page 28

E. Medical Assistance Notices

1. Eligibility

a. DSS-3622: NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION

Attachment 24 - Narrative: Page 29

The following notices, while not part of the notices project, are included here because they are required to be sent with some notices of eligibility determination and are referred to in some of the Medical Assistance narratives.

- DSS-4038: EXPLANATION OF THE EXCESS INCOME PROGRAM

  Attachment 25

- DSS-3622A: NOTICE OF ELIGIBILITY FOR COVERAGE FOR THE TREATMENT OF AN EMERGENCY MEDICAL CONDITION

  Attachment 26

b. DSS-3623: NOTICE OF INTENT TO DISCONTINUE/CHANGE MEDICAL ASSISTANCE

Attachment 27 - Narrative: Page 30

c. DSS-3868: NOTICE OF MEDICAL ASSISTANCE REVIEW

Attachment 28 - Narrative: Page 31

d. DSS-3869: NOTICE OF DECISION ON REIMBURSEMENT OF MEDICAL BILLS BY THE MEDICAL ASSISTANCE PROGRAM

Attachment 29 - Narrative: Page 31

e. DSS-3935: NOTICE OF DECISION TO ACCEPT/DENY/CHANGE YOUR MEDICAL ASSISTANCE COVERAGE (CATASTROPHIC ILLNESS PROGRAM)

Attachment 30 - Narrative: Page 32

f. DSS-3973: NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION (EXCESS INCOME)

Attachment 31 - Narrative: Page 32

g. DSS-4021: NOTICE OF INTENT TO CHANGE THE CONTRIBUTION TOWARD CHRONIC CARE COSTS

Attachment 32 - Narrative: Page 33

h. DSS-4022: NOTICE OF INTENT TO ESTABLISH A LIABILITY TOWARD CHRONIC CARE

Attachment 33 - Narrative: Page 33

i. DSS-4023: NOTICE OF INTENT TO DISCONTINUE FOR FAILURE TO COMPLY WITH RECERTIFICATION PROCEDURES

Attachment 34 - Narrative: Page 34

2. **Long Term Care**

a. DSS-4006: NOTIFICATION OF ADVERSE UTILIZATION REVIEW DECISION AND FAIR HEARING RIGHTS

Attachment 35 - Narrative: Page 34

3. **Personal Care**

a. DSS-4007: NOTICE OF DECISION OF INITIAL AUTHORIZATION/RE-AUTHORIZATION/OR DENIAL PERSONAL CARE SERVICES

Attachment 36 - Narrative: Page 35

b. DSS-4008: NOTICE OF INTENT TO INCREASE, REDUCE OR DISCONTINUE PERSONAL CARE SERVICES

Attachment 37 - Narrative: Page 35

c. DSS-4009: NOTICE OF DECISION TO SUSPEND THE AUTHORIZATION FOR PERSONAL CARE SERVICES

Attachment 38 - Narrative: Page 36

4. **Recipient Restrictions**

a. DSS-4024: NOTICE OF INTENT TO RESTRICT YOU TO A PRIMARY MEDICAID PROVIDER (INITIAL RESTRICTION)

Attachment 39 - Narrative: Page 36

b. DSS-4025: NOTICE OF INTENT TO RESTRICT YOU TO A PRIMARY MEDICAID PROVIDER (RE-RESTRICTION)

Attachment 40 - Narrative: Page 37

c. DSS-4028: NOTICE OF INTENT TO CONTINUE YOUR RESTRICTION TO A PRIMARY MEDICAID PROVIDER (ADMINISTRATIVE CONTINUATION)

Attachment 41 - Narrative: Page 37

V. PROGRAM IMPLICATIONS

Local social services districts must use the notices introduced through this ADM to inform clients of the appropriate eligibility determination. The mandated notices will ensure standardization and additionally ensure that all clients are properly and fully advised of all aspects pertaining to their eligibility, including appeal rights.

VI. REQUIRED ACTION

Local districts are required to implement the new and revised manual notices by June 1, 1989. Where local districts are using automated notices, such notices must be ready for use effective October 1, 1989. Revisions to notices which are now automated must be prepared, and submitted to this Department no later than August 1, 1989 to ensure approval for the October 1st start-up date. If your district plans to automate notices which are now manual, it is required that the new manual notices be in use between June 1 and October 1, 1989.

A. Notice Requirements

The following requirements are applicable to all notices.

1. Notice must be given for:

   a. disposition of an application (accepted, pended or denied);

   b. disposition of the recertification application (discontinued, continued with no change, continued with a change);

   c. changes made between recertifications (increases, reductions or discontinuances); and

   d. changes in the amount of any one of the items used in the calculation of benefits even if there is no change in the benefits.

2. All agency actions on a client's case require the appropriate client notice with the specific reason for the action and the law and/or regulatory citations that support the action clearly stated.

3. If more than one reason exists, the local district must state as many reasons for the action(s) as are applicable.

4. Except in the case of denials, local districts must indicate effective date(s) for the action(s).

5. A notice of increase in benefits must specify both the new and former benefit amount or coverage.

6. A notice of reduction in benefits must specify both the new and former benefit amount or coverage.

7. Timely notice must be postmarked at least ten days before the effective date of the notice. Regulations which govern proper use of timely notice and adequate notice have not changed.

8. The client may request an agency conference at any time up to the date of the fair hearing.

9. When an agency action on a client's case is based in full or in part on a budget calculation/recalculation, even if the result is no change in the benefit amount, a copy of the budget must be sent with the notice. (Where appropriate, the ABEL and/or MBL Budget Narrative should also be included.)

   When notifying individuals of their Medical Assistance eligibility, local districts must specify the budgetary method used to determine eligibility whenever the notice provides space for calculations.

10. Dates

    a. Notice Date

       This is the date the worker completes the notice. On a timely and adequate notice, the date must be at least ten days before the effective date of the action. On adequate - only notices and notices given at application, the date may be less than ten days from the effective date of the action.

    b. Effective Date

       This is the date the action or change will happen. Fair hearing regulations require that notice be given regarding when an action will take effect. Also, in situations which require timely and adequate notice of adverse action (i.e. discontinuance, reduction, suspension), this date is used to determine if aid continuing can be given, since in order for an appellant to have the right to aid-continuing, the fair hearing must be requested by the effective date. In situations which require an adequate - only notice, the postmark date of the notice is used to determine whether the appellant is entitled to aid continuing (reinstatement) when a hearing is requested.

11. The Public Assistance, Food Stamp and Medical Assistance portions of the combined notices must always be completed.

B. Factors Common to All Notices

1. Heading

   a. Completion of all sections of the heading is required except for Office No., Unit No., Worker No. and the telephone number for the unit or worker. The unit or worker responsible for issuing the notice must be identified.

b. Notice Date: This is the date the worker completes the notice.

c. Telephone Numbers

Legal Assistance Information: In districts where there is only one advocacy agency, the telephone number for that agency should be given. Districts that have more than one advocacy agency should list a social services number where the client can receive information about advocacy agencies that represent clients residing in the district.

Use of numbers which are not Department of Social Services numbers should be cleared first with the outside agency to assure they are correct and that the agency is able to handle the telephone inquiries that might result.

Agency Conference, Fair Hearing Information and Assistance, Record Access: The notice is designed so that one general number can be given or specific numbers for each type of information can be given. If districts opt to use a general telephone number, then procedures must be in place to ensure that clients who call to request information in one or more of the above areas are directed to a person who has the knowledge and authority to respond to the specific need.

d. CIN/RID

The CIN/RID number is that of the head of household.

2. Client Rights Language:

The text on the reverse side of each notice is based on one prototype and the only substantive difference between the forms is in the aid continuing sections.

3. Distribution:

The State-mandated notices are comprised of three-ply chemically carbonless paper which will eliminate the need for photo-copying. Two copies of the notice are to be sent to the client and the remaining copy is for the case record.

C. Procedures for Local Equivalents

Local districts must use the attached notices without modification unless the Department has granted approval for local equivalents.

When developing local equivalent notices for consideration by the Department, local social services districts are reminded that no changes in the language of the State-printed forms will be

permitted. Local district equivalent forms may be permitted when a format change will ease local district administration or case processing. For example, on the revised DSS-3153: "Continuing Your Food Stamps", there are three check boxes to indicate the action which must be taken by the recipient of the notice; both automated and manual local equivalent versions of the DSS-3153 would be allowed if the format change is to eliminate the checkbox(es) and action(s) which are never offered as options by a particular local district. Format alterations for the purpose of adapting automated notices to specific local district computer needs may also be permitted. The heading, which is common to all State mandated notices, must be substantially the same on any locally revised form.

When a manual notice with format changes, or an automated notice or notice generated using an electronic form is used in lieu of a State mandated form, it is considered a local equivalent form. As such, the form must have prior approval by this Department. Districts wishing to submit notices to this Department for approval for use as a local equivalent should refer to the Local Managers Guide, section 12, pages 1 through 5. Instructions for class A forms must be followed.

D. Combined Public Assistance, Food Stamps, Medical Assistance Notices

These notices are sent to Public Assistance applicants and recipients. They are designed so that the effect of the action on eligibility and/or benefit amounts of each of the three program areas (Public Assistance, Food Stamps and Medical Assistance) can be described. On some of the combined notices, information about services is also included. If a Public Assistance recipient is not receiving Food Stamps as part of the Public Assistance case (e.g., the household indicated it did not want Food Stamps, the household is receiving Food Stamps under another Public Assistance case or in a separate mixed household case), this must be written on the Food Stamp section of the combined Public Assistance notice.

1. DSS-4013: ACTION TAKEN ON YOUR APPLICATION: PUBLIC ASSISTANCE, FOOD STAMPS, AND MEDICAL ASSISTANCE COVERAGE

   (ATTACHMENT I)

a. Public Assistance Section

This notice is to be used to inform applicants of the decision made on their application for Public Assistance. This notice supersedes DSS-3515 introduced in 85 ADM-29. It replaces all local forms presently used to inform applicants of the agency's decision.

The recoupment statement is a requirement under Part 358. If a Public Assistance application is accepted and a recoupment for past overpayments is taken, the box before the recoupment statement must be checked and a clear explanation of the reason for the recoupment provided.

NOTE: It is not a requirement under Part 358 that districts provide notice when an application is withdrawn. It is, however, strongly recommended that districts send a notification to the client that the application dated _____ was withdrawn at the client's request and state the reason cited by the client. A copy should be kept in the case record. That notification can be provided by a letter to the applicant or by a form the local district has developed for that purpose.

b. Food Stamp Section

This section is used to tell an applicant the disposition of the application - accepted, denied or pended. Department regulation 358-2.2(a)(4)(i) requires that clients be advised when the Authorization to Purchase (ATP) will be available or when benefits will be available on an automated system. The **ACCEPTED** box has been modified to allow for this entry.

If an established claim is being recovered by allotment reduction, the **RECOUPMENT** box must be checked. However, a recoupment cannot be taken and this box checked unless all appropriate procedures and notices have been used regarding claims establishment. (See Section IV.G.2 of this Directive.)

NOTE: If the Public Assistance applicant is not applying for Food Stamps as part of the Public Assistance application, the worker should make that notation in the Food Stamp section.

c. Medical Assistance Section

(1) MESSAGE [ ] ACCEPTED for Medical Assistance effective (date) for (name(s)). You will be issued a Medical Assistance authorization entitling all eligible applicants to full services. The enclosed letter will clarify coverage under the Medical Assistance Program.

INSTRUCTIONS: This box should be checked when the applicant(s) is entitled to full coverage under Medical Assistance either by virtue of eligibility for Public Assistance or as a result of eligibility under MA-Only rules.

The clarifying letters referred to in this message pertain to any locally developed forms used to provide clients with general information concerning the Medical Assistance Program.

(2) MESSAGE [ ] ACCEPTED for Medical Assistance with a SPENDDOWN, effective (date) for (name(s)). Your total monthly income is $_____. Your total monthly deductions are $_____. The difference between these figures is your monthly net income for Medical Assistance. This is $_____. The allowable income standard for a family household your size is $_____. The difference between your net income and this standard ($_____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

INSTRUCTIONS: This box should be checked when the agency has made a separate MA-Only determination that the applicant(s) does not qualify for full coverage but may be entitled to benefits under the Excess Income Program. This box should only be checked for federally-related persons whose net income exceeds the allowable MA-Only Income Standard.

(3) MESSAGE [ ] ACCEPTED effective (date) for (name(s)). We have determined that you transferred $_____ in resources on (date). Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health-related facility or long term home health care program services until (date). You will be eligible for all other Medical Assistance services effective (date). You will have to meet a spenddown requirement for these services if there is a [✓] in the box above.

INSTRUCTIONS: This box should not be used at this time.

(4) MESSAGE [ ] DENIED Medical Assistance effective (date) for (name(s)) because _____ _____.

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

INSTRUCTIONS: This box should be checked when the agency has made a determination that the applicant(s) is ineligible for Medical Assistance. This ineligibility is likely to be based on the same reason as the ineligibility for Public Assistance.

(5) MESSAGE [ ] PENDED

[ ] We do not have enough information to decide your eligibility under the Medical Assistance Program. Please contact us no later than (date) at (telephone) so we can tell you the information we need.

[ ] Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.

INSTRUCTIONS: The first box under 'Pended' should be checked when the client needs to provide the agency with additional information to decide eligibility for Medical Assistance.

The second box under 'Pended' should be checked when the agency has the required information and is in the process of re-evaluating Medical Assistance eligibility.

2. DSS-4014: ACTION TAKEN ON YOUR RECERTIFICATION: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES

(ATTACHMENT 2)

This notice is used to inform recipients of the result of their recertification.

a. Public Assistance Section

When the recertification results in a negative action for any of the programs, this notice must be postmarked at least 10 days prior to the effective date of the action.

In addition to the actions that result in change, the action continue your regular monthly public assistance grant unchanged is included. Previously it was not necessary to send a letter to inform the client of the result of a recertification if there was no change in the Public Assistance grant. Clients must now be notified of the result of their recertification, even if there is no change in the grant amount.

If the client reports a change which results in a different budget calculation, even if it results in no change in the benefit amount, a copy of the budget and the ABEL budget narrative must be sent with the notice.

This section has space to inform the client of other amounts which s/he can expect to receive during the certification period. For example, if a household receives a recurring visitor's allowance, the amount, reason and dates can be entered in this space.

The recoupment section, if applicable, must be completed.

b. Food Stamp Section

In addition to the actions that result in change, the action CONTINUE your monthly food stamp benefit unchanged is included. If the benefits will continue unchanged, and recertification requirements for Public Assistance have been met, the worker checks the **CONTINUE** box, completes the first line and crosses out the subsequent lines under **CONTINUE**. If the benefits will continue unchanged, and recertification requirements for Public Assistance have not been met, the worker checks the **CONTINUE** box and completes all lines. See the Food Stamp Source Book section VI.A and B and Section G of this Directive regarding the DSS-3153: "Continuing Your Food Stamps" for important information about PA/FS recertification requirements, certification periods and notice requirements.

The next version of this notice will be modified to provide two separate boxes for continue, one for when Public Assistance recertification requirements have been met and one for when Public Assistance requirements have not been met.

If a **RECOUPMENT** is currently in place for Food Stamps, the worker checks the box indicating that a recoupment is being taken against the Food Stamp benefits. The worker should not fill in the blank percent, but rather cross out "at the rate of _____ percent (%)". The next version of this notice will delete these words.

When a household is not participating in the Food Stamp Program, a notation must be made on the reason line in the Food Stamp section indicating why the household is not participating.

For examples of completed notices see attachments 3 and 4.

c. Medical Assistance Section

Medical Assistance messages for PA Combined Notices: DSS-4014, DSS-4015 and DSS-4016 and Employment Notices: DSS-4003 and DSS-4004 are as follows:

(1) MESSAGE [ ] CONTINUE the Medical Assistance coverage for (name(s)) unchanged. You will continue to receive a Medical Assistance authorization entitling the eligible individual(s) to full services.

INSTRUCTIONS: This box should be checked when the agency has determined that the change in PA has no impact on Medical Assistance eligibility.

(2) MESSAGE [ ] CONTINUE the Medical Assistance coverage for (name(s)) pending the receipt of information necessary to decide continued eligibility. Please contact us no later than (date) at (telephone) so we can tell you the information we need.

INSTRUCTIONS: This box should be checked when it is unknown at the time that the Public Assistance decision is made whether or not the change will affect MA eligibility. In these situations the client is being requested to produce additional information necessary in order for the agency to make its eligibility determination.

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

INSTRUCTIONS: This box should be checked when it is unknown at the time that the PA decision is made whether or not the change will affect MA eligibility. In these situations the agency has the necessary information and is in the process of making a decision.

(4) MESSAGE [ ] REDUCE the Medical Assistance coverage effective (date) for (name(s)) from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $_____. Your total monthly deductions are $_____. The difference between those is your monthly NET income for Medical Assistance. This is $_____. The allowable income standard for a family household your size is $_____. The difference between your net income and this standard ($_____) is your excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

INSTRUCTIONS: This box should be checked when the change results in the recipient's coverage being reduced from full coverage to coverage with a spenddown. This will occur primarily as a result of increased income or a reduction in the family household composition.

(5) MESSAGE [ ] REDUCE the Medical Assistance for (name(s)). We have determined that you transferred $_____ in resources on (date). Because you transferred these

resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until (date). You will be eligible for all other Medical Assistance services effective (date). You will have to meet a spenddown requirement for these services if there is a [✓] in the box above.

INSTRUCTIONS: This box should not be used at this time.

(6) MESSAGE [ ] DISCONTINUE Medical Assistance for (name) effective (date) because _____

_____

_____.

INSTRUCTIONS: This box should be checked when the agency has determined that the recipient is not eligible for Medical Assistance. This determination of ineligibility may be for the same reason as the Public Assistance discontinuance or for a separate reason. It may be for financial (i.e., excess resources) or non-financial (failure to comply) reasons.

3. DSS-4015: NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY AND ADEQUATE)

(ATTACHMENT 5)

This notice supersedes DSS-3514 - Notice of Intent to Change or Discontinue the Public Assistance Grant and Status of Medical Assistance Coverage introduced in 85 ADM-29. This form is used to tell a Public Assistance recipient of changes to eligibility or benefit amounts during the certification period - reductions, discontinuations, suspensions, increases, or continuation of assistance unchanged (when an action has been taken which did not affect the amount of the benefit).

a. Public Assistance/Food Stamp Sections

This notice is used to provide timely notice to a recipient (i.e., notice at least ten days before the action will take effect) and must be used if the change requires timely notice for any program area covered by the notice. For example, an increase in the Public Assistance grant which does not require timely notice results in a decrease to Food Stamp benefits. This notice must be used because the adverse Food Stamp action requires timely notice. In this situation, the effective date of the Public Assistance change may be different (earlier) than the effective date of the Food Stamp change.

The recoupment section, if applicable, must be completed.

Additionally, for Food Stamps, if a recoupment is currently in place, the RECOUPMENT box must be checked. The blank percent should not be filled out but rather crossed out. The next version will delete the words "at the rate of __ percent %".

When a household is not participating in the Food Stamp Program, a notation must be made on the reason line in the Food Stamp section indicating why the household is not participating.

b. Medical Assistance Section

See VI D.2, Medical Assistance section

4. DSS-4016: NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY)

(ATTACHMENT 6)

This notice is used to tell a recipient of changes to eligibility or benefit amounts during the certification period, when timely notice is not required.

Section 358-3.3(d) of the Fair Hearing regulations specify when an adequate only notice may be sent for Public Assistance or Medical Assistance. Federal Food Stamp requirements permit adequate notice to be used only when the change is the result of information reported on the monthly report. However, Federal Food Stamp requirements do permit situations in which no notice at all is required. These Food Stamp situations are specified in Section 358-3.3(e) of the Fair Hearing regulations. Based on the different program requirements, this adequate - only notice can be used for Public Assistance households under the following circumstances:

- the conditions for adequate - only notice for PA and MA apply and no notice is required for Food Stamps. Even though notice is not required, the appropriate FS boxes on the combined notice must be completed to avoid confusing the recipients about their Food Stamp eligibility and benefits;

- the condition for adequate - only notice for PA and MA apply and the household does not receive PA Food Stamps;

- the action being taken is based on information reported on a monthly report;

- the action being taken is an increase for both Public Assistance and Food Stamps or an increase in either program that does not adversely affect the other program.

a. Public Assistance Section

The recoupment section, if applicable, must be completed.

b. Food Stamp Section

If a recoupment is currently in place for Food Stamps, the worker should check the box indicating that a recoupment is being taken against the Food Stamp benefits. The worker should not fill in the blank percent, but rather cross out "at the rate of _____ percent (%)". The next version of this notice will delete these words.

c. Medical Assistance Section

See VI.D.2, - Medical Assistance Section

5. DSS-4017: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE)

(ATTACHMENT 7)

Food Stamps Section

This notice is used to tell a Public Assistance recipient of a Food Stamp change during the certification period that does not have any effect on Public Assistance, Medical Assistance or Services benefits. For example, a change in Food Stamp Program regulations that results in decreased Food Stamp benefits but has no effect on the Public Assistance grant.

6. DSS-4018: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (ADEQUATE ONLY)

(ATTACHMENT 8)

This notice is used to tell a Public Assistance recipient of a change to Food Stamp benefits during the certification period that does not have any effect on Public Assistance, Medical Assistance or Services benefits and which does not require timely notice. For example, an increase in the Thrifty Food Plan levels results in increased Food Stamp benefits.

This notice will be used mostly to inform recipients of increase and continue actions. The only other time adequate-only notice can be given for a Food Stamp action is when the action is the result of information reported on the monthly report. Since monthly reporting changes will most likely affect both the Public Assistance and Food Stamps, a DSS-4015 (Timely and Adequate) or DSS-4016 (Adequate) notice of change would be used. The DISCONTINUE box may be used at local district option in situations where no notice is required

under federal requirements. These situations are specified in Part 358 - 3.3(e) of the Fair Hearing regulations.

7. DSS-3152: ACTION TAKEN ON YOUR FOOD STAMP CASE and DSS-3153: CONTINUING YOUR FOOD STAMPS (See Section VI.G.1)

(ATTACHMENT 14 and ATTACHMENT 16)

Under certain circumstances these notices must be used by the Public Assistance worker for a Public Assistance household. See section G of this directive about Food Stamp Only Notices for information regarding when and how these notices are used for a Public Assistance case.

E. Employment Combined Notices (Upstate Only)

1. DSS-4003: NOTICE OF INTENT TO CHANGE PUBLIC ASSISTANCE GRANT AND/OR FOOD STAMPS BENEFITS AND/OR MEDICAL ASSISTANCE COVERAGE OR NONCOMPLIANCE WITH EMPLOYMENT RELATED REQUIREMENTS - Notice A

(ATTACHMENT 9)

a. Public Assistance Section

This notice combines the model notice of the same title with the "Notice of Employment Program Sanction," both of which are described in 86 ADM-10, "Revision of Public Assistance Sanction Procedures". In addition, DSS-4003 incorporates Food Stamp language so that the notice can be used for Public Assistance/Food Stamp recipient noncompliance with either PA or Food Stamp employment program requirements.

b. Food Stamp Section

If a Food Stamp sanction is proposed due to the Public Assistance/Food Stamp recipient's failure to comply with a Food Stamp or comparable Public Assistance employment - related requirement, the appropriate sanction box (whole household or individual) must be checked.

For a Food Stamp sanction, the DSS-4003 ("Notice A") serves as a good cause inquiry letter and, for households which do not respond to "Notice A", also fulfills requirements for timely and adequate notice to impose the sanction.

c. Medical Assistance Section

See VI-D.2. - Medical Assistance Section

NOTE: On the reverse side of DSS-4003, language pertaining to recovery of aid-continuing was erroneously included. On both client copies of DSS-4003 (Reverse), Continuing Your

Benefits section, workers must strike out everything which follows the first sentence. This correction will be made in the next reprinting of DSS-4003.

2. DSS-4004: NOTICE OF INTENT TO CHANGE PUBLIC ASSISTANCE GRANT AND/OR FOOD STAMP BENEFITS AND/OR MEDICAL ASSISTANCE COVERAGE FOR NON-COMPLIANCE WITH EMPLOYMENT RELATED REQUIREMENTS - Notice B

(ATTACHMENT 10)

a. Public Assistance/Food Stamp Sections

As with DSS-4003, this form combines two previous PA notices and adds Food Stamp language so that it can be used in cases of non-compliance with either PA or Food Stamps employment program requirements. The DSS-4004 is used when an individual has responded to the DSS-4003 and the local district has determined, based on the individual's response and any other evidence it has, that the noncompliance with employment programs is willful and without good cause.

For a Food Stamp sanction, the appropriate sanction box (whole household or individual) must be checked.

b. Medical Assistance Section

See VI.D.2 - Medical Assistance Section

NOTE: On the reverse side of DSS-4004, language pertaining to recovery of aid-continuing was erroneously included. On both client copies of DSS-4004 (Reverse), Continuing Your Benefits section, workers must strike out everything which follows the first sentence. This correction will be made in the next reprinting of DSS-4004.

3. DSS-4005 NOTIFICATION OF EMPLOYABILITY AND THE RIGHT TO CONTEST (TIMELY AND ADEQUATE)

(ATTACHMENT 11)

This notice replaces the model notice contained in 85 ADM-45, "Fair Hearings to Contest Determinations of Employability". It must be prepared , and a copy issued to the applicant or recipient, every time an employability determination is made and the individual is determined to be employable. An individual determined employable for the first time must receive a copy of the form before he/she is assigned to any employment related activity, including registration at Job Service or the WIN office for work rules or WIN services. An individual being redetermined employable must receive a copy of the form before that person is reassigned to employment related activities.

F. Public Assistance Only Notices

1. DSS-2425: REPAYMENT OF INTERIM ASSISTANCE NOTICE

(ATTACHMENT 12)

In addition to the change to the uniform heading which includes "Notice Date", there are other significant changes to this notice.

a. The third sentence of the paragraph headed "Dear Sir/Madam:" has been changed. (Brackets [ ] show new language).

The sentence now reads, "We have deducted the amount of Public Assistance you received beginning with the [date] SSI determined you [became] eligible for benefits and ending with the month after the month in which the initial payment is received".

This language reflects the Department policy that the recovery of Home Relief assistance granted should be calculated from the first day of the client's eligibility for SSI. Consequently, it is sometimes necessary to prorate the Home Relief amount to be recovered for the initial month of SSI eligibility.

b. The regulatory citation has been added.

2. DSS-4002: NOTICE OF ACCEPTANCE/DENIAL OF REQUEST FOR ASSISTANCE TO MEET AN IMMEDIATE NEED OR A SPECIAL ALLOWANCE

(ATTACHMENT 13)

This notice combines the contents of and supersedes, "Notice of Acceptance/Denial of Request for Assistance to Meet an Immediate Need" introduced in 86 ADM-7 and DSS-3813: "Notice of Acceptance/Denial of Request for an Additional Allowance to Meet a Special or Immediate Need" introduced in 87 ADM-18 and included in 89-ADM-6.

a. Public Assistance section:

This new, combined notice is to be used whenever an applicant requests assistance to meet an immediate need or when a recipient requests an additional allowance to meet a special or immediate need.

A decision on a request for an additional allowance must be made within 30 days of the local district's receipt of a completed request form DSS-3815: "Request For An Additional Allowance By A Public Assistance Recipient", unless there is an immediate need.

In the case of an immediate need of an applicant or recipient, notice must be provided in accordance with 86 ADM-7..

b. Food Stamps section:

Self-explanatory

c. Medical Assistance section:

(1) MESSAGE [ ] If you are in need of assistance to help with your medical bills, you must apply separately for Medical Assistance. If you wish to receive further information about eligibility under the Medical Assistance Program, contact the agency at the phone number listed above.

INSTRUCTIONS: This box should be checked unless the client is an active PA or MA-Only recipient or has requested Medical Assistance. Persons determined eligible for immediate need or a special allowance only (i.e., are not also eligible for a recurring cash grant) are not automatically entitled to Medical Assistance. As such, they must file and be found eligible by a separate determination.

(2) MESSAGE [ ] Your Medical Assistance coverage remains unchanged.

INSTRUCTIONS: Self-explanatory

(3) MESSAGE [ ] Your application for Medical Assistance is being reviewed. We will send you our decision within 30 days.

INSTRUCTIONS: This box should be checked when the client has requested the agency to determine his/her eligibility for Medical Assistance and the agency is in the process of evaluating the information submitted.

G. Food Stamps Only Notices

1. General Notices

These notices are sent to Non-Public Assistance (NPA) Food Stamp households. Also, the DSS-3152: "Action Taken on Your Food Stamp Case" and the DSS-3153: "Continuing Your Food Stamps" are used for Public Assistance recipients under certain circumstances.

a. DSS-3152: ACTION TAKEN ON YOUR FOOD STAMP CASE

(ATTACHMENT 14)

This notice is used to inform NPA Food Stamp households of the decision made regarding an application or recertification for Food Stamps. It is also used when a household which is applying for Public Assistance and Food Stamps is determined eligible for Food Stamps before eligibility for Public Assistance is determined. This situation is most likely to occur when the household is entitled to expedited processing for Food Stamps.

The first **ACCEPTED** box is used to accept a Food Stamp application at application or recertification when all verification requirements have been completed. This includes situations where a case has been processed under expedited standards and all verification requirements have been completed.

The second **ACCEPTED** box is used to accept a Food Stamp application that was processed under expedited standards and there are still verification requirements which must be completed. (See attachment 15 for an example.)

This notice informs the household that if the Food Stamp application is accepted before the amount of a Public Assistance grant is determined, the Food Stamp benefit may be changed without further notice. This is included because federal regulations state that no additional notice is required in this situation. However, this State's practice is to give as much information as possible to applicant/recipient households. Therefore, the Food Stamp section of the **DSS-4013** combined PA/FS/MA notice must be completed even if this notice has previously been sent to a Public Assistance household.

The **Recoupment** box is checked if a recoupment is going to be taken against Food Stamps when the case is opened. However, a recoupment cannot be taken and this box checked unless all appropriate procedures and notices have been used regarding claims establishment. (See Section VI.G.2 of this Directive.)

b. DSS-3153: CONTINUING YOUR FOOD STAMPS

(ATTACHMENT 16)

This notice is used to inform a household in receipt of NPA Food Stamp benefits that the certification period is due to expire and that the household must take action as indicated in order to continue to receive Food Stamps and avoid interruption in benefits.

This notice is also used for PA/FS households under two circumstances. First, if the Public Assistance certification period is less than twelve months and the Food Stamp certification period is one month longer than the Public Assistance period, this notice must be sent to the household if it fails to recertify for Public Assistance. It must be sent when the DSS-4014: "Action Taken On Your Recertification" is sent informing the household that the Public Assistance grant is being discontinued.

The second circumstance is when the Food Stamp certification period is the same as the Public Assistance period. In this situation, this Food Stamp notice must be sent to the household at the same time as the Public Assistance notification to recertify. The most common situation where the Food Stamp and Public Assistance certification periods are the same is when the household is authorized for a twelve month certification period.

If a household receives this notice and fails to fulfill the Food Stamp recertification requirements, no further notice is sent (i.e., no additional notification that benefits have been discontinued is required). However, if this notice is sent at the same time as the PA notice to recertify and a PA notice is being sent to discontinue the PA case, the Food Stamp portion of the combined notice must be completed to avoid confusing the recipient.

c. DSS-3620: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE)

(ATTACHMENT 17)

This notice is an adverse action notice used to inform a recipient of Food Stamp benefits of the determination to reduce, discontinue or suspend such recipient's Food Stamp benefits within the certification period.

If a recoupment is currently in place for Food Stamps, the worker should check the box indicating that a recoupment is being taken against Food Stamp benefits.

d. DSS-3621: NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (ADEQUATE ONLY)

(ATTACHMENT 18)

This notice is used to inform a Food Stamp recipient of a change in benefits, during the certification period, when timely notice is not required.

This notice includes the action **INCREASE** and should also include the action **CONTINUE**. A new requirement of Part 358 of Department Regulations is that Food Stamp recipients be provided adequate notice of any increases in benefits, or of any changes in the amount of one of the items used in the calculation of his/her Food Stamp benefits although there is no change in the amount of Food Stamp benefits.

A new box for **CONTINUE** will be added in the next revision of this form. In the interim, workers should utilize the **DISCONTINUE** box, crossing out the "DIS" of discontinue and making other appropriate changes to adequately explain the action.

The only situation which permits adequate - only notice of reduction or suspension for Food Stamps is when a reduction or suspension occurs as a result of information reported on the monthly report. New York State does not have an NPA monthly reporting requirement at this time.

The **DISCONTINUE** box may be used at local district option in situations where no notice is required under federal requirements. These situations are specified in Section 358 - 3.3(e) of the Fair Hearing regulations.

2. Food Stamp Overissuance, Disqualification and Repayment Notices

These notices are used for both Public Assistance and Non-Public Assistance households.

a. Overissuance Notices

(1) DSS-3156: NOTICE OF FOOD STAMP OVERISSUANCE

(ATTACHMENT 19)

This notice informs an individual or household of an overissuance of Food Stamps resulting from agency error or inadvertent household error and the amount of the overissuance.

The DSS-4053: "Food Stamp Repayment Agreement" must be sent with this notice.

(2) DSS-4052: NOTICE OF FOOD STAMP OVERISSUANCE - INTENTIONAL PROGRAM VIOLATION

(ATTACHMENT 20)

This notice informs an individual or household of an overissuance of Food Stamps and the amount resulting from an intentional program violation.

The following notices must be sent with this notice, as appropriate:

The DSS-4051: "Food Stamp Notice To Disqualified Individual" must be issued for a single person household.

The DSS-4050: "Food Stamp Notice to Household of Disqualified Individual" and DSS-4051: "Food Stamp Notice to Disqualified Individual(s)" must be issued for a multiperson household.

See Disqualification Notices(VI.G.2.b)

The DSS-4053: "Food Stamp Repayment Agreement" must accompany this notice if a "Disqualification Consent Repayment Agreement" or court order on repayment has not been signed.

b. Disqualification Notices

(1) DSS-4050: FOOD STAMP NOTICE TO HOUSEHOLD OF DISQUALIFIED INDIVIDUAL

(ATTACHMENT 21)

This notice informs the household that a household member has been disqualified from receiving Food Stamps, the period of the disqualification, how the disqualification was determined and the benefits to which the household is entitled as a result of the disqualification.

The following notices must be sent with this form:

(a) DSS-4053: "Food Stamp Repayment Agreement" must accompany this notice if a "Disqualification Consent Agreement" or court order on repayment has not been signed.

(b) DSS-4051: "Food Stamp Notice to Disqualified Individual(s)"

(c) DSS-4052: "Notice of Food Stamp Overissuance - Intentional Program Violation"

(2) DSS-4051: FOOD STAMP NOTICE TO DISQUALIFIED INDIVIDUAL(S)

(ATTACHMENT 22)

This notice informs an individual(s) that she/he has been disqualified from receiving Food Stamps, how the disqualification was determined and the period of disqualification.

The following notices must be sent with this notice, as appropriate:

(a) The DSS-4053: "Food Stamp Repayment Agreement" must accompany this notice if a "Disqualification Consent Repayment Agreement" or a court order on repayment has not been signed.

(b) The DSS-4052: "Notice of Food Stamp Overissuance - Intentional Program Violation" must be issued for a single person household being disqualified.

(c) The DSS-4050: "Food Stamp Notice to Household of Disqualified Individual" and DSS-4052: Notice of Food Stamp Overissuance - Intentional Program Violation" must be issued for a multiperson household containing a disqualified individual.

c. DSS-4053: FOOD STAMP REPAYMENT AGREEMENT

(ATTACHMENT 23)

This form is used to negotiate repayment of Food Stamp overissuances.

The section on repayment by allotment reduction method has been modified to allow the worker to indicate the type of allotment reduction by checking the appropriate box.

H. Medical Assistance Only Notices

1. General Instructions:

   a. Local districts must indicate the specific details regarding the reason(s) for the action(s).

   b. Except in the case of denials, local districts must indicate effective date(s) for the action(s).

   c. Local districts must specify the name(s) of the individual(s) affected.

   d. Local districts must specify **ALL** of the appropriate laws and/or regulations upon which the action is based.

   e. Local districts must specify the budgetary method used to determine eligibility whenever the notice provides space for calculations. In addition a copy of the budget must be enclosed with the letter if the reason for the action is based on financial reasons. This includes all notices of acceptance.

   f. A notice of increase/decrease in benefits must specify both the new and former benefit coverage (i.e., full coverage to $20/mo. spenddown, spenddown change from $20/mo. to $50/mo.).

   g. If more than one reason exists the local social services district must state as many reasons for the action(s) as are applicable.

2. Eligibility

   a. Revised Notices

      (1) FORM DSS-3622: NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION

      (ATTACHMENT 24)

      This form supersedes the 1/85 version of the DSS-3622, as contained in 84 ADM-41.

      REQUIREMENT: Department Regulation section 360-2.5 requires that all applicants for Medical Assistance be sent a written notification of acceptance or denial. A copy of the notice must also be sent to the medical provider, as appropriate.

      WHEN TO USE: The revised notice must be used to notify **applicants** when the application for an individual or family is accepted for full or emergency only coverage, denied, or withdrawn.

Excess Income, Catastrophic or Chronic Care situations are dealt with in separate notices. The DSS-3622 may be used in combination with these separate notices, when the household circumstances warrant different treatment of income/resources for individual case members.

The section regarding emergency medical care and services is used in situations when coverage must be restricted due to an individual's alien status, e.g., illegal/undocumented, students and visitors, or IRCA aliens restricted to emergency services. When this section is completed, the information contained in the DSS-3622A: "Notice of Eligibility for Coverage of an Emergency Medical Condition", Attachment 26 of this Administrative Directive, must also be attached to the DSS-3622.

NOTE: Attachment 26 supersedes the notice contained in Administrative Directive 88 ADM-4, and must be reproduced without modification until a supply is available from this Department.

When an individual/family is denied for excess resources and also has excess income, the excess income amount must be indicated on the notice and the DSS-4038: "Explanation of the Excess Income Program" (Attachment 25) shall be enclosed with the Notice of Decision. (The "Explanation of the Excess Income Program" was previously mandated by Administrative Directive 87 ADM-4 and is now available as form DSS-4038.)

(2) FORM DSS-3623: NOTICE OF INTENT TO DISCONTINUE/ CHANGE MEDICAL ASSISTANCE

(ATTACHMENT 27)

This notice supersedes the 1/85 version of the DSS-3623 as contained in 84 ADM-41.

REQUIREMENT: Department Regulation section 360-2.6 requires that all recipients of Medical Assistance be sent a written notification whenever a change in circumstances causes an increase or reduction in coverage and/or liability or a discontinuance of eligibility. A copy of the decision must also be sent to the medical provider, as appropriate.

In addition, changes to the Fair Hearing regulations, 18 NYCRR 358-3.3, require that adequate notice be provided to recipients when a social services agency determines to change the amount of one of the items used in the calculation of the Medical Assistance spenddown, even if there is no change in the amount of the Medical Assistance spenddown.

WHEN TO USE: This notice must be used to notify recipients of changes in the Medical Assistance eligibility for an individual or family, i.e., change from full coverage to spenddown; increase or decrease in the amount of spenddown; when deleting/discontinuing an individual or the whole case. As with the DSS-3622, the DSS-4038: "Explanation of the Excess Income Program," must be enclosed, when appropriate.

(3) FORM DSS-3868: NOTICE OF MEDICAL ASSISTANCE REVIEW

(ATTACHMENT 28)

This notice supersedes the 10/87 version of the DSS-3868, as contained in Administrative Directive 87 ADM-48. There are no significant changes to this form.

REQUIREMENT: Department Regulation section 360-7.5(a)(1) requires that, under certain circumstances, direct reimbursement may be made to recipients or their representatives for paid medical services which should have been paid by the Medical Assistance Program. This will occur primarily as a result of fair hearing decisions, agency reconsiderations and litigation.

WHEN TO USE: This notice must be used to notify applicants/recipients or their representatives that the agency has reevaluated eligibility and that Medical Assistance coverage may be available for benefits previously denied.

This notice should not be used when the fair hearing decision directs that Medical Assistance be provided (i.e. a determination of eligibility has been made in the decision). The notice should be used in response to a reevaluation by the district of the appellant's eligibility where the hearing decision has directed the district to redetermine the appellant's eligibility.

(4) FORM DSS-3869: NOTICE OF DECISION ON REIMBURSEMENT OF MEDICAL BILLS BY THE MEDICAL ASSISTANCE PROGRAM

(ATTACHMENT 29)

This notice supersedes the 10/87 version of the DSS-3869, as contained in Administrative Directive 87 ADM-48. There are no significant changes to this form.

REQUIREMENT: Department Regulation section 360-7.5(a)(1) requires that, under certain circumstances, direct reimbursement may be made to recipients or their representatives for paid medical services which

should have been paid by the Medical Assistance Program. This will occur primarily as a result of fair hearing decisions, agency reconsiderations and litigation.

WHEN TO USE: This notice must be used to notify **applicants/recipients** of the agency's decisions regarding reimbursement of medical bills. When this notice is used, form DSS-3870 "Medical Assistance Reimbursement Detail Form" must always be enclosed. The DSS-3870 (10/87) can be found in 87 ADM-48.

b. New Notices

(1) FORM DSS-3935: NOTICE OF DECISION TO ACCEPT - DENY - CHANGE YOUR MEDICAL ASSISTANCE COVERAGE (CATASTROPHIC ILLNESS PROGRAM)

(ATTACHMENT 30)

REQUIREMENT: Department Regulation sections 360-2.5 and 358-3.3 require that all applicants for Medical Assistance be provided a written notice of acceptance or denial. The notice must specify any limitations in coverage. A copy of the notice must also be sent to the medical provider, as appropriate.

WHEN TO USE: This notice must be used to notify **federally non-participating applicants** who are not otherwise eligible under Home Relief rules, and who have incurred or expect to incur inpatient hospital expenses, of the decision on their application. The DSS-3935 must also be used to notify a **recipient** of catastrophic coverage of a change in his/her contribution to the cost of care, due to some change in the individual's circumstances. This notice must be used whether or not a client liability exists unless the client is eligible for full coverage, in which case the DSS-3622 is used.

(2) FORM DSS-3973: NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION (EXCESS INCOME)

(ATTACHMENT 31)

REQUIREMENT: Department Regulation sections 360-2.5 and 358-3.3 require that all applicants for Medical Assistance be provided a written notice of acceptance or denial. The notice must specify any limitations in coverage. A copy of the notice must be sent to the medical provider, as appropriate.

WHEN TO USE: This notice must be used in all situations in which **federally-related applicants** have excess income. (See form DSS-3622 for situations involving both excess income and excess resources.)

Following the guidelines issued in Administrative Directive 87 ADM-4, a decision must be made as to the existence of sufficient allowable medical expenses to offset an income overage, and the appropriate coverage to be authorized. In all situations involving excess income, the DSS-4038: "Explanation of the Excess Income Program" must be enclosed with the DSS-3973. The DSS-3973 may be used in combination with other decision notices when household circumstances warrant different treatment of income/resources for individual case members.

NOTE: The DSS-3973 is intended to notify applicants of the eligibility decision. Local districts must continue to use whatever method is currently in place to inform a recipient when a monthly spenddown has been met and the appropriate coverage authorized.

(3) FORM DSS-4021: NOTICE OF INTENT TO CHANGE THE CONTRIBUTION TOWARD CHRONIC CARE COSTS

(ATTACHMENT 32)

REQUIREMENT: Department Regulation section 360-2.6 requires that all recipients of Medical Assistance be sent a written notification whenever a change in circumstances causes an increase or reduction in coverage and/or liability or a discontinuance of eligibility. A copy of the decision must also be sent to the medical provider, as appropriate.

WHEN TO USE: This notice must be used to notify a chronic care recipient of a change in the required contribution to the cost of care in the institution. Proper procedures for the notice to a spouse, if applicable, must be followed, as outlined in Administrative Directive 85 ADM-37.

(4) FORM DSS-4022: NOTICE OF INTENT TO ESTABLISH A LIABILITY TOWARD CHRONIC CARE

(ATTACHMENT 33)

REQUIREMENT: Department Regulation sections 360-2.5 and 358-3.3 require that all applicants for Medical Assistance be provided a written notice of acceptance or denial. The notice must specify any limitations in coverage. A copy of the notice must also be sent to the medical provider, as appropriate.

WHEN TO USE: This notice must be used whenever an applicant/recipient is determined to be residing in a medical institution on a permanent basis. (Procedures for determining temporary/permanent absence status, budgeting, and appropriate notices to

legally responsible relatives, as required in the settlement in Brill v. Perales, are found in Administrative Directive 85 ADM-37 and are in no way changed by the use of this notice.) In the case of a recipient who was previously eligible for Medical Assistance with a spenddown requirement, the amount of the previous spenddown must be indicated in the space provided, in order to comply with Department Regulation 358-2.2(a)(2). The INCOME section of the DSS-4022 provides space to accommodate the various budgeting methodologies which may be applicable to an individual entering a chronic care situation. In situations in which a contribution to the cost of care is being made by an LRR, the amount of the contribution may be added to the gross monthly income of the institutionalized individual, or it may be identified as a separate amount elsewhere on the DSS-4022.

If there is an applying spouse and/or other dependents residing in the community, a DSS-3622 must be sent to the applicant(s) in the community to notify him/her of the agency's decision on the application for Medical Assistance.

(5) FORM DSS-4023: NOTICE OF INTENT TO DISCONTINUE FOR FAILURE TO COMPLY WITH RECERTIFICATION PROCEDURES

(ATTACHMENT 34)

REQUIREMENT: Department Regulation 360-2.2 and Social Services Law section 366-a require a redetermination of a Medical Assistance recipient's eligibility at least once every 12 months. The recipient must recertify on the State prescribed form.

WHEN TO USE: This notice must be used when a recipient is to be discontinued for failure to appear for a face-to-face interview, or when an interview has been held but the recipient has failed to return the required form/documents. In the section regarding failure to return documents, the district has the option of listing the specific documents on the DSS-4023, or of attaching a separate sheet listing the required documents, such as the DSS-2642 - "Documentation Requirements", or similar local equivalent.

3. Long Term Care

FORM DSS-4006: NOTIFICATION OF ADVERSE UTILIZATION REVIEW DECISION AND FAIR HEARING RIGHTS

(ATTACHMENT 35)

This notice supersedes the notice of the same name which is Attachment #1 to Administrative Directive 80 ADM-12, "Revised Policy and Procedure Regarding Adverse Utilization Review Determination in a Residential Health Care Facility (Yaretsky v. Blum et al)".

REQUIREMENTS: The partial final judgement in the Yaretsky v. Blum case requires, in part, that all Medical Assistance recipients who are residents of Skilled Nursing Facilities (SNFs) and Health Related Facilities (HRFs) be notified when a utilization review committee determines that a lower level of care is required, of their right to veto an out-of-facility transfer and their right to a fair hearing.

WHEN TO USE: The revised notice must be used when a utilization review committee determines that a resident of a residential health care facility (SNF or HRF) requires a lower level of care. The policy and procedure of 80 ADM-12 remain in effect and unchanged.

4. Personal Care Services

a. Revised Notices

(1) FORM DSS-4007: NOTICE OF DECISION OF INITIAL AUTHORIZATION/REAUTHORIZATION/OR DENIAL PERSONAL CARE SERVICES

(ATTACHMENT 36)

This notice supersedes the 7/83 version of the "Initial Authorization/Reauthorization/ or Denial of Personal Care Services" notice transmitted to the local social services districts in a "Dear Commissioner" letter dated July 13, 1983.

REQUIREMENT: Department Regulation section 505.14(b)(5)(v) requires that all applicants/recipients of personal care services be sent a written notification of acceptance, reacceptance or denial.

WHEN TO USE: The revised notice must be used to notify applicants/recipients of personal care services of the decision of initial authorizations, reauthorizations that remain unchanged, or an initial denial of services.

(2) FORM DSS-4008: NOTICE OF INTENT TO INCREASE, REDUCE OR DISCONTINUE PERSONAL CARE SERVICES

(ATTACHMENT 37)

This notice supersedes the 7/83 version of the "Notice of Intent to Increase, Reduce or Discontinue Personal Care Services" transmitted to the local social services districts in a "Dear Commissioner" letter dated 7/13/83.

REQUIREMENT: Department Regulation section 505.14 (b)(5)(viii) requires that recipients be sent a written notification of intended changes to his/her personal care services authorizations.

WHEN TO USE: The revised notice must be used to notify recipients of intended changes to his/her personal care services authorizations, i.e., increase or reduction in the personal care services authorization; when discontinuing a recipient's personal care services authorization.

b. New Notice

(1) FORM DSS-4009: NOTICE OF DECISION TO SUSPEND THE AUTHORIZATION FOR PERSONAL CARE SERVICES

(ATTACHMENT 38)

REQUIREMENT: Department Regulation section 505.14(b)(5)(x)(c) requires that the local social services district reassess a recipient's need for personal care services when there is a change in that individual's medical condition. The notice informs the recipient of the need to reassess the personal care services need and the suspension of the personal care services authorization.

WHEN TO USE: This notice must be used to notify recipients of personal care services of the decision to suspend an authorization due to hospitalization. The recipient is informed that a new assessment of personal care services needs is necessary prior to a reauthorization of service. The recipient is instructed to notify the case manager when the date of discharge is known. A new physician's order for home care must be completed reflecting his/her current medical needs of the recipient.

5. Recipient Restriction

a. Revised Notices

(1) FORM DSS-4024: NOTICE OF INTENT TO RESTRICT YOU TO A PRIMARY MEDICAID PROVIDER (INITIAL RESTRICTION)

(ATTACHMENT 39)

This notice supersedes the 5/84 version of letter of intent (a), "Letter of Intent to Restrict You To a Primary Medicaid Provider", found in the Restricted Recipient Procedure Manual.

REQUIREMENT: Department Regulation section 360-6.4 requires that all restriction candidates be sent a written notification of the State's intention to restrict Medicaid services.

WHEN TO USE: The revised notice must be used to inform the client that because of his/her abuse or misuse of the Medicaid system, an initial restriction will be placed on his/her Medicaid benefits for a fifteen month period. The client must choose and obtain Medicaid services, with some exceptions, from a primary provider in the restriction type assigned.

(2) FORM DSS-4025: NOTICE OF INTENT TO RESTRICT YOU TO A PRIMARY MEDICAID PROVIDER (RE-RESTRICTION)

(ATTACHMENT 40)

This notice supersedes the 5/84 version of letter of intent (b), "Letter of Intent to Restrict You to a Primary Medicaid Provider", found in the Restricted Recipient Procedural Manual.

REQUIREMENT: Department Regulation section 360-6.4 requires that all re-restriction candidates be sent a written notification of the State's intention to again restrict Medicaid services.

WHEN TO USE: The revised notice must be used to inform clients, who have previously been restricted, that a subsequent restriction period will be imposed. This period will be for three years.

(3) FORM DSS-4028: NOTICE OF INTENT TO CONTINUE YOUR RESTRICTION TO A PRIMARY MEDICAID PROVIDER (ADMINISTRATIVE CONTINUATION)

(ATTACHMENT 41)

This notice supersedes letter of intent (c), "Letter of Intent To Continue Your Restriction To a Primary Medicaid Provider", found in the Restricted Recipient Procedural Manual.

REQUIREMENT: Department Regulation section 360-6.4 requires that all restricted recipients be sent a written notification of the State's intention to continue to restrict Medicaid services.

WHEN TO USE: The revised notice must be used to inform currently restricted Medicaid recipients that because of their non-compliance with the restriction program, their restriction period will continue for an additional three years. The initial and subsequent restriction will be continuous.

VII. SERVICES

Since services categorical related eligibility is based on current receipt of Public Assistance and/or Medical Assistance, an initial PA/MA eligibility decision would not impact on the client's services eligibility. Consequently, there is no need for services input on notices which inform the client of the determination on his/her initial application. However, a services section is included on the PA combined notices of intent to change or discontinue benefits and on the notice of action or recertification. This section informs the client that a loss of Public Assistance benefits will require a service redetermination within 30 days of the decision to reduce or discontinue PA benefits.

Please note that a telephone number must be entered in that section for the client to call for information.

VIII. ADDITIONAL INFORMATION

A. Your district will automatically receive a supply of these forms based on past ordering practices or an estimate of a three-month supply. Spanish versions of the notices will also be available. Requests for additional supplies or Spanish versions of the notices must be submitted on Form WMS-47 (Rev. 3/81): "WMS Order Form", and should be sent to:

New York State Department of Social Services
Welfare Management System
P.O. Box 1990
Albany, New York 12201
Attention: Don Guinane

Questions concerning ordering forms should be addressed to Mr. Guinane by calling 1-800-342-3715, extension 6-6223.

B. HEAP will have revised notices for heating season 1989-90. These will be sent to you under separate cover.

C. Department Regulation 381 is likely to change in the near future regarding mismanagement of the ADC cash grant.

For that reason two Public Assistance notices, "NOTICE OF INTENT TO RESTRICT RENT PAYMENT" and "DETERMINATION OF RENT PAYMENT STATUS" (introduced in 80 ADM-98) were not included in the notices project. Until the expected changes to Section 381 are finalized and new notices are developed to reflect the changes, districts must use DSS-4015 "NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE AND SERVICES (TIMELY AND ADEQUATE) and shall send the "NOTICE OF INTENT TO RESTRICT RENT PAYMENT" or the

locally developed equivalent as an addendum. When a determination of mismanagement has been made, districts must use DSS-4016: "NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE AND SERVICES (ADEQUATE ONLY)" and shall send the "DETERMINATION OF RENT PAYMENT STATUS" or the locally developed equivalent as an addendum.

IX. EFFECTIVE DATE

The effective date of this directive is:

June 1, 1989 for use of manual notices

October 1, 1989 for use of automated notices.

Oscar R. Best, Jr.
Deputy Commissioner
Division of Income Maintenance

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

ACTION TAKEN ON YOUR APPLICATION: PUBLIC ASSISTANCE, FOOD STAMPS AND MEDICAL ASSISTANCE COVERAGE

NOTICE DATE:

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE

CASE NUMBER | CIN RID NUMBER

CASE NAME and C/O Name / Present AND ADDRESS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

The action(s) taken on your application dated _____ are explained below next to the boxes that have been checked ☑

ATTENTION: If you are accepted for Public Assistance, Food Stamps, or Medical Assistance, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

PUBLIC ASSISTANCE

☐ ACCEPTED for the period _____ to _____ You will receive $ _____ which will cover the period _____ to _____ After this you will receive $ _____ a month.

☐ A RECOUPMENT at the rate of 10 percent (%) is being taken against your grant. If you believe that this reduction will cause your family an undue hardship you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase personal incidentals, or to pay for extraordinary medical needs that are not covered by medical assistance. Your worker will let you know what kind of evidence you will need to support your undue hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction between 5 and 10 percent (%). The regulation which allows us to do this is 18 NYCRR 352.31(d). The reason for this recoupment is explained below

_____

_____

☐ DENIED because _____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

FOOD STAMPS

☐ ACCEPTED for the period _____ to _____ You will receive $ _____ which will cover the period _____ to _____ This amount will be available to you on _____ After this you will receive $ _____ a month.

☐ A RECOUPMENT is being taken against your food stamp benefits.

☐ DENIED because _____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

☐ PENDED because _____

_____

MEDICAL ASSISTANCE

☐ ACCEPTED for Medical Assistance effective _____ for (name(s)) _____ You will be issued a Medical Assistance authorization entitling all eligible applicants to full services. The enclosed letter will clarify coverage under the Medical Assistance Program.

☐ ACCEPTED for Medical Assistance with a SPENDDOWN, effective _____ for (name(s)) _____ . Your total monthly income is $ _____ . Your total monthly deductions are $ _____ . The difference between these figures is your monthly net income for Medical Assistance. This is $ _____ The allowable income standard for a family household your size is $ _____ . The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

☐ ACCEPTED effective _____ for (name(s)) _____

We have determined that you transferred $ _____ in resources on _____ . Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until _____ . You will be eligible for all other Medical Assistance services effective _____ You will have to meet a spenddown requirement for these services if there is an ✓ in the box above.

☐ DENIED Medical Assistance effective _____ for (name(s)) _____

because _____

_____

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

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

☐ PENDED

☐ We do not have enough information to decide your eligibility under the Medical Assistance Program. Please contact us no later than _____ at _____ so we can tell you the information we need.

☐ Your application for Medical Assistance is being reviewed. We will send you our decision within thirty days.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: *You may have a conference to review these actions.* If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 847-3877

If you live in **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County:** (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, *Tompkins* or *Tioga* County:** (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___

___ I want a fair hearing. The Agency's action is wrong because

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing, you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, *you have a right to bring witnesses to speak in your favor.* You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have *the right to free copies of documents* which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ACTION TAKEN ON YOUR RECERTIFICATION: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES

NOTICE DATE:

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE

CASE NUMBER | CIN / RID NUMBER

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

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

The action(s) taken on your recertification are explained below next to the boxes that have been checked ☑:

PUBLIC ASSISTANCE

☐ REDUCE your regular monthly public assistance grant for the period _____ to _____ You will receive $ _____ a month beginning _____

☐ DISCONTINUE your public assistance grant effective _____

☐ INCREASE your regular monthly public assistance grant for the period _____ to _____ You will receive $ _____ a month beginning _____ The amount of your previous monthly grant was $.

☐ CONTINUE your regular monthly public assistance grant unchanged at $ _____ for the period _____ to _____

☐ If this box is checked, during your eligibility period you will receive the following amounts for the indicated time periods which are different from your regular monthly grant _____

☐ A RECOUPMENT at the rate of 10 percent (%) is being taken against your grant. If you believe that this reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase personal incidentals, or to pay for extraordinary medical needs that are not covered by medical assistance. Your worker will let you know what kind of evidence you will need to support your undue hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction between 5 and 10 percent (%). The regulation which allows us to do this is 18 NYCRR 352.31(d). The reason for this recoupment is explained below.

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

FOOD STAMPS

☐ REDUCE your monthly food stamp benefit for the period _____ to _____ You will receive $ _____ a month beginning _____. The amount of your previous monthly benefit was $.

☐ DISCONTINUE your monthly food stamp benefit effective _____ .

☐ INCREASE your monthly food stamp benefit for the period _____ to _____ You will receive $ _____ a month beginning _____. The amount of your previous monthly benefit was $ _____ .

☐ CONTINUE your monthly food stamp benefit unchanged at $ _____ for the period _____ to _____ .
You failed to meet recertification requirements for public assistance but can still be recertified for food stamps. You will receive your monthly food stamp benefit of $ _____ for ONLY one additional month. To have your food stamp benefits continued you must reapply. We will send you a separate notice advising you of how to continue your food stamp benefits. If this box is checked, during your eligibility period you will receive the following amounts for the indicated time periods which are different from your regular monthly benefit _____

☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your food stamp benefits.

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

MEDICAL ASSISTANCE

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ unchanged.
You will continue to receive a medical assistance authorization entitling the eligible individual(s) to full services.

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

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

☐ REDUCE the Medical Assistance coverage effective _____ for (name(s)) _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____ Your total monthly deductions are $ _____ . The difference between these is your monthly net income for Medical Assistance. This is $ _____ . The allowable income standard for a family household your size is $ _____ . The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

☐ REDUCE the Medical Assistance for (name(s)) _____ . We have determined that you transferred $ _____ in resources on _____ . Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until _____ .
You will be eligible for all other Medical Assistance services effective _____ . You will have to meet a spenddown requirement for these services if there is an ✓ in the box above.

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

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

SERVICES - Recipients of Social Services - A loss of Public Assistance and Medical Assistance benefits will require a redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact Services at _____ for further information.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will **not** result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed* to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___

__ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice and our action affects your Public Assistance, Medical Assistance or Social Services, you will continue to receive your Public Assistance, Medical Assistance and any Social Services at the same amount as before your recertification until the fair hearing decision is issued. However, if you request a fair hearing on your food stamp case, your food stamp benefits **cannot** be continued at the same amount as before your recertification, but will be in the amount indicated on the first page of the notice. If you lose the fair hearing, you will owe any Public Assistance money that you should not have received. In addition, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box or boxes below to indicate the program(s) for which you do **not** want your aid continued, and send this page along with your hearing request. If you do check the box or boxes, the action(s) described above will be taken on the effective date listed above as identified under the appropriate program.

I do **not** want the following benefits continued at the same amount as before my recertification until the fair hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ Social Services

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ATTACHMENT 3

DSS-4014 (2/89) Recertification-PA

ACTION TAKEN ON YOUR RECERTIFICATION: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES

NOTICE DATE: 5/20/89

CASE NUMBER: P623

CIN / RID NUMBER: My ID Number

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

K.C. Smith
Y Street
Combine, New York 12221

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE:

X County
Y Street
Combine, New York 12221

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP

OR Agency Conference 555-4444
Fair Hearing information and assistance 555-4443
Record Access 555-4442
Legal Assistance information 555-7122

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO
1	03	02	Tom Jones	555-4445

The action(s) taken on your recertification are explained below next to the boxes that have been checked ☑:

PUBLIC ASSISTANCE

☐ REDUCE your regular monthly public assistance grant for the period _____ to _____ will receive $ _____ a month beginning _____ The amount of your previous monthly grant was $.

☐ DISCONTINUE your public assistance grant effective _____

☐ INCREASE your regular monthly public assistance grant for the period _____ to _____ You will receive $ _____ a month beginning _____ The amount of your previous monthly grant was $ _____.

☒ CONTINUE your regular monthly public assistance grant unchanged at $ 216.50 s/m for the period 6/1/89 to 11/30/89

☐ If this box is checked, during your eligibility period you will receive the following amounts for the indicated time periods which are different from your regular monthly grant _____

☐ A RECOUPMENT at the rate of 10 percent (%) is being taken against your grant. If you believe that this reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase personal incidentals, or to pay for extraordinary medical needs that are not covered by medical assistance. Your worker will let you know what kind of evidence you will need to support your undue hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction between 5 and 10 percent (%). The regulation which allows us to do this is 18 NYCRR 352.31(d). The reason for this recoupment is explained below.

The REASON for this action is your circumstances are unchanged

The LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 351.20

FOOD STAMPS

☐ REDUCE your monthly food stamp benefit for the period _____ to _____ You will receive $ _____ a month beginning _____

☐ DISCONTINUE your monthly food stamp benefit effective _____

☐ INCREASE your monthly food stamp benefit for the period _____ to _____ You will receive $ _____ a month beginning _____ The amount of your previous monthly benefit was $ _____.

☒ CONTINUE your monthly food stamp benefit unchanged at $ 90 for the period 6/1/89 to 12/31/89

~~You failed to meet recertification requirements for public assistance but can still be recertified for food stamps. You will receive your monthly food stamp benefit of $ _____ for ONLY one additional month. To have your food stamp benefits continued you must reapply. We will send you a separate notice advising you of how to continue your food stamp benefits. If this box is checked, during your eligibility period you will receive the following amounts for the indicated time periods which are different from your regular monthly benefit _____~~

☒ A RECOUPMENT at the rate of _____ percent (%) is being taken against your food stamp benefits.

The REASON for this action is your circumstances are unchanged

The LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 387.17(f)

MEDICAL ASSISTANCE

☒ CONTINUE the Medical Assistance coverage for (name(s)) Katherine and Rose unchanged. You will continue to receive a medical assistance authorization entitling the eligible individual(s) to full services.

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

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

☐ REDUCE the Medical Assistance coverage effective _____ for (name(s)) _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____. Your total monthly deductions are $ _____. The difference between these is your monthly net income for Medical Assistance. This is $ _____. The allowable income standard for a family household your size is $ _____. The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

☐ REDUCE the Medical Assistance for (name(s)) _____ We have determined that you transferred $ _____ in resources on _____. Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until _____. You will be eligible for all other Medical Assistance services effective _____. You will have to meet a spenddown requirement for these services if there is an ✓ in the box above.

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

AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 360-6.2

SERVICES - Recipients of Social Services - A loss of Public Assistance and Medical Assistance benefits will require a redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact Services at 555-4421 for further information.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

ATTACHMENT 4

DSS-4014 (2/99) Recertification-PA

ACTION TAKEN ON YOUR RECERTIFICATION: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES

NOTICE DATE: 5/3/89

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE

X County
Y Street
Combine , New York 12221

CASE NUMBER: P624

CIN / RID NUMBER: My ID Number

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

Elvira Smith
Y Street
Combine, New York 12221

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP: _____

OR Agency Conference: 555-4444
Fair Hearing information and assistance: 555-4443
Record Access: 555-4442
Legal Assistance information: 555-7122

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO
3	01	05	Harry Hendrick	555-4448

The action(s) taken on your recertification are explained below next to the boxes that have been checked ☑:

PUBLIC ASSISTANCE

☐ REDUCE your regular monthly public assistance grant for the period _____ to _____. You will receive $ _____ a month beginning _____. The amount of your previous monthly grant was $.

☒ DISCONTINUE your public assistance grant effective 5/13/89.

☐ INCREASE your regular monthly public assistance grant for the period _____ to _____. You will receive $ _____ a month beginning _____. The amount of your previous monthly grant was $.

☐ CONTINUE your regular monthly public assistance grant unchanged at $ _____ for the period _____ to _____.

☐ If this box is checked, during your eligibility period you will receive the following amounts for the indicated time periods which are different from your regular monthly grant _____

☐ A RECOUPMENT at the rate of 10 percent (%) is being taken against your grant. If you believe that the reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase personal incidentals, or to pay for extraordinary medical needs that are not covered by medical assistance. Your worker will let you know what kind of evidence you will need to support your undue hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction between 5 and 10 percent (%). The regulation which allows us to do this is 18 NYCRR 352.31(d). The reason for the recoupment is explained below.

The REASON for this action is You failed to keep your appointment for a face-to-face recertification interview scheduled for May 2, 1989 at 9am

The LAW(S) AND/OR REGULATION(S) which allows us to do this is NYCRR 351.20

FOOD STAMPS

☐ REDUCE your monthly food stamp benefit for the period _____ to _____. You will receive $ _____ a month beginning _____. The amount of your previous monthly benefit was $ _____.

☐ DISCONTINUE your monthly food stamp benefit effective _____.

☐ INCREASE your monthly food stamp benefit for the period _____ to _____. You will receive $ _____ a month beginning _____. The amount of your previous monthly benefit was $ _____.

☒ CONTINUE your monthly food stamp benefit unchanged at $ 90 for the period 6/1/89 to 6/30/89. You failed to meet recertification requirements for public assistance but can still be recertified for food stamps. You will receive your monthly food stamp benefit of $ _____ for ONLY one additional month. To have your food stamp benefits continued you must reapply. We will send you a separate notice advising you of how to continue your food stamp benefits. If this box is checked, during your eligibility period you will receive the following amounts for the indicated time periods which are different from your regular monthly benefit _____

☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your food stamp benefits.

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 387.17(a)

MEDICAL ASSISTANCE

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ unchanged. You will continue to receive a medical assistance authorization entitling the eligible individual(s) to full services.

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

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

☐ REDUCE the Medical Assistance coverage effective _____ for (name(s)) _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____. Your total monthly deductions are $ _____. The difference between these is your monthly net income for Medical Assistance. This is $ _____. The allowable income standard for a family household your size is $ _____. The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

☐ REDUCE the Medical Assistance for (name(s)) _____. We have determined that you transferred $ _____ in resources on _____. Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until _____. You will be eligible for all other Medical Assistance services effective _____. You will have to meet a spenddown requirement for these services if there is an ✓ in the box above.

☒ DISCONTINUE Medical Assistance for (name(s)) Elvira and Chester effective 5/13/89 because you failed to keep your appointment for a face-to-face recertification interview scheduled for May 2, 1989 at 9am

The LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 360-2.2(e), SSL 366-a(5)

SERVICES - Recipients of Social Services - A loss of Public Assistance and Medical Assistance benefits will require a redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact Services at 555-4421 for further information.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

DSS-4015 7 89 Change-P4

NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE COVERAGE AND SERVICES (TIMELY AND ADEQUATE)

NOTICE DATE	NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER / DIN RID NUMBER	
CASE NAME AND C/O Name - Present AND ADDRESS	GENERAL TELEPHONE NO FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This NOTICE is to tell you that this agency intends to CHANGE YOUR BENEFIT(S). The changes are explained below next to the boxes that have been checked ☑

PUBLIC ASSISTANCE

__ REDUCE your public assistance grant from $ _____ to $ _____ effective _____

__ DISCONTINUE your public assistance grant effective _____

__ SUSPEND your public assistance grant for the month of _____

__ INCREASE your public assistance grant from $ _____ to $ _____ effective _____

__ CONTINUE your public assistance grant unchanged at $ _____

__ A RECOUPMENT at the rate of 10 percent (%) is being taken against your grant. If you believe that this reduction will cause your family an undue hardship you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat to pay for shelter or utilities to clothe and purchase general incidentals or to pay for extraordinary medical needs that are not covered by medical assistance. Your worker will let you know what kind of evidence you will need to support your undue hardship claim. If it is determined that the recoupment will cause an undue hardship the recoupment may be changed to a reduction of between 5 and 10%. The regulation which allows us to do this is 18 NYCRR 352.31 c. The reason for the recoupment is explained below

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

FOOD STAMPS

__ REDUCE your food stamp benefit from $ _____ to $ _____ effective _____

__ DISCONTINUE your food stamp benefit effective _____

__ SUSPEND your food stamp benefit for the month of _____

__ INCREASE your food stamp benefit from $ _____ to $ _____ effective _____

__ CONTINUE your food stamp benefit unchanged at $ _____

__ A RECOUPMENT at the rate of _____ percent (%) is being taken against your food stamp benefits

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

MEDICAL ASSISTANCE

__ CONTINUE the Medical Assistance coverage for (name(s)) _____ unchanged. You will continue to receive a medical assistance authorization entitling the eligible individual(s) to full services

__ CONTINUE the Medical Assistance coverage for (name(s)) _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need

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

__ REDUCE the Medical Assistance coverage effective _____ for (name(s)) _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $. _____ Your total monthly deductions are $ _____ The difference between these is your monthly net income for Medical Assistance. This is $ _____ The allowable income standard for a family household your size is $ _____ The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program

__ REDUCE the Medical Assistance for (name(s)) _____

We have determined that you transferred $ _____ in resources on _____ Because you transferred these resources for less than they were worth you are ineligible for nursing home level of care health related facility and long term home health care program services until _____ You will be eligible for all other Medical Assistance services effective _____ You will have to meet a spenddown requirement for these services if there is an ✓ in the box above

__ DISCONTINUE Medical Assistance for (name(s)) _____ effective _____ because _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

SERVICES - Recipients of Social Services - A loss of Public Assistance and Medical Assistance benefits will require a redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact Services at _____ for further information

ATTENTION: If you are receiving Public Assistance, Food Stamps, or Medical Assistance, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

ure BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island) (212) 488-6550

If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___

__ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing, you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice and our action affects your Public Assistance, Medical Assistance, Food Stamp benefits or Social Services, you will continue to receive your benefits and any social services unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, you will owe any Public Assistance money and Food Stamp benefits that you should not have received. In addition, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box or boxes below to indicate the program(s) for which you do not want your aid continued, and send this page along with your hearing request. If you do check the box or boxes, the action(s) described above will be taken on the effective date listed above as identified under the appropriate program.

I do not want the following benefits continued unchanged until the fair hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Social Services

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

LDSS-4058 (1-89) ATTACHMENT 6 Change-P4

NOTICE OF INTENT TO CHANGE BENEFITS: PUBLIC ASSISTANCE. FOOD STAMPS. MEDICAL ASSISTANCE COVERAGE AND SERVICES (ADEQUATE ONLY)

NOTICE DATE

NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE

CASE NUMBER | SSN OR MCI NUMBER

CASE NAME AND C/O Name - Present AND ADDRESS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP

OR Agency Conference

Fair Hearing information and assistance

Record Access

Legal Assistance information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This NOTICE is to tell you that this agency intends to CHANGE YOUR BENEFITS. The changes are explained below next to the boxes that have been checked ☑

PUBLIC ASSISTANCE

☐ REDUCE your public assistance grant from $ _____ to $ _____ effective _____

☐ DISCONTINUE your public assistance grant effective _____

☐ SUSPEND your public assistance grant for the month of _____

☐ INCREASE your public assistance grant from $ _____ to $ _____ effective _____

☐ CONTINUE your public assistance grant unchanged at $ _____

☐ A RECOUPMENT at the rate of 10 percent (10%) is being taken against your grant. If you believe that this reduction will cause your family an undue hardship, you may contact your worker to explain your reasons. An undue hardship occurs when a person does not have enough income to eat, to pay for shelter or utilities, to clothe and purchase general incidentals, or to pay for extraordinary medical needs that are not covered by medical assistance. Your worker will let you know what kind of evidence you will need to support your undue hardship claim. If it is determined that the recoupment will cause an undue hardship, the recoupment may be changed to a reduction of between 5 and 10%. The regulation which allows us to do this is 18 NYCRR 352.31(d). The reason for the recoupment is explained below.

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

FOOD STAMPS

☐ REDUCE your food stamp benefit from $ _____ to $ _____ effective _____

☐ DISCONTINUE your food stamp benefit effective _____

☐ SUSPEND your food stamp benefit for the month of _____

☐ INCREASE your food stamp benefit from $ _____ to $ _____ effective _____

☐ CONTINUE your food stamp benefit unchanged at $ _____

☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your food stamp benefits

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

MEDICAL ASSISTANCE

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ unchanged. You will continue to receive a medical assistance authorization entitling the eligible individuals to full services.

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

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

☐ REDUCE the Medical Assistance coverage effective _____ for (name(s)): _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____. Your total monthly deductions are $ _____. The difference between these is your monthly net income for Medical Assistance. This is $ _____. The allowable income standard for a family household your size is $ _____. The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

☐ REDUCE the Medical Assistance for (name(s)) _____

We have determined that you transferred $ _____ in resources on _____. Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until _____. You will be eligible for all other Medical Assistance services effective _____. You will have to meet a spend-down requirement for these services if there is an ✓ in the box above.

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

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

SERVICES - Recipients of Social Services - A loss of Public Assistance and Medical Assistance benefits will require a redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact Services at _____ for further information.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

DSS-4016 (REVISED)

ATTENTION: If you are receiving Public Assistance, Food Stamps, or Medical Assistance, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County**: (716) 847-3877

If you live in **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County**: (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County**: (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County**: (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___

__ I want a fair hearing. The Agency's action is wrong because

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing within ten days of the date of the postmark of the mailing of this notice and our action affects your Public Assistance, Medical Assistance, Food Stamp benefits or Social Services, your assistance, benefits and any social services will be reinstated (aid continuing) and will remain unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, you will owe any Public Assistance money and Food Stamp benefits that you should not have received. In addition, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box or boxes below to indicate the program(s) for which you do not want your aid continued, and send this page along with your hearing request. If you do check the box or boxes, the action(s) described above will be taken on the effective date listed above as identified under the appropriate program.

I do not want the following benefits continued unchanged until the fair hearing decision is issued:

☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Social Services

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your *local Legal Aid Society or other legal advocate group*. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, *how to gain access to your case file* and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS
(TIMELY AND ADEQUATE)

NOTICE DATE		NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RIC NUMBER	
CASE NAME (AND C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
— —		OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information
— —		

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This agency is sending you this NOTICE to tell you we are CHANGING YOUR FOOD STAMP BENEFITS. The changes are explained below next to the boxes that have been checked ☑

FOOD STAMPS

☐ REDUCE your food stamp benefit from $ _____ to $ _____ effective _____

☐ DISCONTINUE your food stamp benefit effective _____.

☐ SUSPEND your food stamp benefit for the month(s) of _____.

☐ INCREASE your food stamp benefit from $ _____ to $ _____ effective _____

☐ CONTINUE your food stamp benefit unchanged at $ _____.

The REASON for this action is _____

_____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

PUBLIC ASSISTANCE

☑ This change does NOT affect your public assistance benefits.

MEDICAL ASSISTANCE

☑ This change does NOT affect your medical assistance coverage.

SERVICES

☑ This change does NOT affect your eligibility for services.

ATTENTION: If you are receiving Food Stamps, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free, at 1-800-555-5000

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** *(PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)*

- If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island) (212) 488-6550
- If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877
- If you live in **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282
- If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117
- If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed* to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date of the action in this notice you will continue to receive your food stamp benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, you will owe any Food Stamp benefits that you should not have received. If you want to avoid this possibility, check the box ☐ below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action(s) described above will be taken on the effective date listed on the first page of this notice.

☐ I do not want my Food Stamp benefits continued unchanged until the fair hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-4018 (1-89) Food Stamp Action-PA

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS
(ADEQUATE ONLY)

NOTICE DATE	NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN / RID NUMBER	
CASE NAME AND ID Name - Street AND ADDRESS	GENERAL TELEPHONE NO FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information

CASE ID NO / UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This agency is sending you this NOTICE to tell you we are CHANGING YOUR FOOD STAMP BENEFITS.
The changes are explained below next to the boxes that have been checked ☑

FOOD STAMPS

☐ REDUCE your food stamp benefit from $ _____ to $ _____ effective _____

☐ DISCONTINUE your food stamp benefit effective _____

☐ SUSPEND your food stamp benefit for the month(s) of _____

☐ INCREASE your food stamp benefit from $ _____ to $ _____ effective _____

☐ CONTINUE your food stamp benefit unchanged at $

The REASON for this action is _____

_____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

PUBLIC ASSISTANCE

☑ This change does NOT affect your public assistance benefits.

MEDICAL ASSISTANCE

☑ This change does NOT affect your medical assistance coverage.

SERVICES

☑ This change does NOT affect your eligibility for services.

ATTENTION: If you are receiving Food Stamps, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free, at 1-800-555-5000

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. It is not the way you request a fair hearing. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 847-3877

If you live in **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County:** (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County:** (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing within ten days of the date of the postmark of the mailing of this notice, your Food Stamp benefits will be reinstated (aid continuing) and will remain unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, you will owe any Food Stamp benefits that you should not have received.

If you want to avoid this possibility, check the box ☑ below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action(s) described above will be taken on the effective date listed on the first page of this notice.

☐ I do not want my Food Stamp benefits continued unchanged until the fair hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ATTACHMENT 9 Employment Action Taken - A

NOTICE OF INTENT
TO CHANGE PUBLIC ASSISTANCE GRANT AND/OR FOOD STAMP BENEFITS AND/OR MEDICAL ASSISTANCE COVERAGE FOR NON-COMPLIANCE WITH EMPLOYMENT RELATED REQUIREMENTS (TIMELY AND ADEQUATE)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN - AID NUMBER	
CASE NAME And C/O Name If Present; AND ADDRESS		

GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This NOTICE is to tell you that this agency intends to CHANGE YOUR BENEFIT(S). Although the change(s) are explained below next to the box(es) that have been checked ☑, you should read ALL the information on both sides of this notice.

You should contact this agency by phone _____ or in person to see _____ before the effective date of this notice. If you do not contact the agency, your failure will be considered a willful violation and your benefits will be reduced or discontinued. If you do contact this agency, your assistance will continue unchanged until you have had the chance to explain the circumstances of your non-compliance. It is your responsibility to give reasons why we should not take this action. We will then review your explanation, along with any other relevant information and make a final determination. You will be notified in writing of the results of the review.

If we determine that you did not willfully and without good cause fail or refuse to comply with employment requirements, this notice will be nullified and no action will be taken to reduce or discontinue your benefits.

If we determine that you did willfully and without good cause fail or refuse to comply with employment related requirements, you will receive another notice and can request a fair hearing at that time to review the proposed change.

PUBLIC ASSISTANCE

☐ REDUCE your public assistance grant from $ _____ to $ _____ effective _____

☐ DISCONTINUE your public assistance grant effective _____

The REASON for this action is that on _____ you failed to _____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is ☐ SSL 131-5 / 18 NYCRR 385.14 ☐ SSL 350-e/-g / 18 NYCRR 392.10

This Public Assistance sanction will begin on _____ and will last for _____ days and until such time as you are willing to comply.

During the sanction period you will receive no public assistance. You have the right to reapply at any time before the end of the sanction but we strongly recommend that you contact this agency on or before _____ to insure timely processing of your new application. At that time you must show that you are willing to comply with employment program requirements to meet this eligibility requirement for assistance. You may reapply after this date but if you do so there may be delays in your getting public assistance.

FOOD STAMPS

☐ REDUCE your food stamp benefit from $ _____ to $ _____ effective _____

☐ DISCONTINUE your food stamp benefit effective _____

☐ INCREASE your food stamp benefit from $ _____ to $ _____ effective _____

☐ CONTINUE your food stamp benefit unchanged at $ _____

The REASON for this action is _____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

☐ Your entire food stamp household will be sanctioned for two months, because the head of your household failed to comply.
You may reapply for food stamps at any time either during or after the sanction period. If you reapply during the sanction period, you may re-establish your eligibility for food stamps if the individual who failed to comply either complies with the requirement, is found to be exempt from work registration, leaves the household, or a new principal wage earner joins your household.

☐ You will be sanctioned for two months.
Your household may request to have you added back into your food stamp case at any time, either during or after the sanction period. If they request to have you added during the sanction period, you may re-establish your eligibility for food stamps if you either comply with the requirement or are found to be exempt from work registration.

MEDICAL ASSISTANCE

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ unchanged. You will continue to receive a medical assistance authorization entitling the eligible individual(s) to full services.

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need.

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

☐ REDUCE the Medical Assistance coverage effective _____ for (name(s)) _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____ Your total monthly deductions are $ _____ The difference between these is your monthly net income for Medical Assistance. This is $ _____ The allowable income standard for a family household your size is $ _____ The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program.

☐ REDUCE the Medical Assistance for (name(s)) _____

We have determined that you transferred $ _____ in resources on _____ Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until _____ You will be eligible for all other Medical Assistance services effective _____ You will have to meet a spenddown requirement for these services if there is an ✓ in the box above.

☐ DISCONTINUE Medical Assistance for (name(s)) _____

effective _____ because _____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

SERVICES - Recipients of Social Services - A loss of Public Assistance and Medical Assistance benefits will require a redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact Services at _____ for further information.

Enclosure

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE FOLLOWING INFORMATION ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice and our action affects your Public Assistance, Medical Assistance, Food Stamp benefits or Social Services, you will continue to receive your benefits and any social services unchanged until the fair hearing decision is issued. ~~However, if you lose the fair hearing, you will owe any Public Assistance money and Food Stamp benefits that you should not have received. In addition, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box or boxes below to indicate the program(s) for which you do not want your aid continued, and send this page along with your hearing request. If you do check the box or boxes, the action(s) described above will be taken on the effective date listed above as identified under the appropriate program.~~

~~I do not want the following benefits continued unchanged until the fair hearing decision is issued:~~

~~☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Social Services~~

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF INTENT
TO CHANGE PUBLIC ASSISTANCE GRANT AND/OR FOOD STAMP BENEFITS AND/OR MEDICAL ASSISTANCE COVERAGE FOR NON-COMPLIANCE WITH EMPLOYMENT RELATED REQUIREMENTS (TIMELY AND ADEQUATE)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN RID NUMBER	
CASE NAME And C/O Name if Present AND ADDRESS		
		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This NOTICE is to tell you that this agency intends to CHANGE YOUR BENEFIT(S). Although the change(s) are explained below next to the boxes that have been checked ☑ you should read ALL the information on both sides of this notice

PUBLIC ASSISTANCE

☐ REDUCE your public assistance grant from $ _____ to $ _____ effective _____

☐ DISCONTINUE your public assistance grant effective _____

The REASON for this action is that after a review of your case as well as the explanation which you provided to us, it has been determined that on _____ you willfully and without good cause failed or refused _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is ☐ SSL 131.5 / 18 NYCRR 385.14 ☐ SSL 350-a/-g / 18 NYCRR 392.10

This Public Assistance sanction will begin on _____ and will last for _____ days and until such time as you are willing to comply

During the sanction period you will receive no public assistance. You have the right to reapply at any time before the end of the sanction but we strongly recommend that you contact this agency on or before _____ to insure timely processing of your new application. At that time you must show that you are willing to comply with employment program requirements to meet this eligibility requirement for assistance. You may reapply after this date but if you do so there may be delays in your getting public assistance

FOOD STAMPS

☐ REDUCE your food stamp benefit from $ _____ to $ _____ effective _____

☐ DISCONTINUE your food stamp benefit effective _____

☐ INCREASE your food stamp benefit from $ _____ to $ _____ effective _____

☐ CONTINUE your food stamp benefit unchanged at $ _____

The REASON for this action is _____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

☐ Your entire food stamp household will be sanctioned for two months, because the head of your household failed to comply

You may reapply for food stamps at any time either during or after the sanction period. If you reapply during the sanction period, you may re-establish your eligibility for food stamps if the individual who failed to comply either complies with the requirement, is found to be exempt from work registration, leaves the household, or a new principal wage earner joins your household

☐ You will be sanctioned for two months

Your household may request to have you added back into your food stamp case at any time, either during or after the sanction period. If they request to have you added during the sanction period, you may re-establish your eligibility for food stamps if you either comply with the requirement or are found to be exempt from work registration

MEDICAL ASSISTANCE

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ unchanged. You will continue to receive a medical assistance authorization entitling the eligible individual(s) to full services

☐ CONTINUE the Medical Assistance coverage for (name(s)) _____ pending the receipt of information necessary to decide continued eligibility. Please contact us no later than _____ at _____ so we can tell you the information we need

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

☐ REDUCE the Medical Assistance coverage effective _____ for (name(s)) _____ from full coverage to coverage with a SPENDDOWN. Your total gross monthly income is $ _____ Your total monthly deductions are $ _____ The difference between these is your monthly net income for Medical Assistance. This is $ _____ The allowable income standard for a family household your size is $ _____ The difference between your net income and this standard ($ _____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the *Excess Income Program*

☐ REDUCE the Medical Assistance for (name(s)) _____

We have determined that you transferred $ _____ in resources on _____ Because you transferred these resources for less than they were worth, you are ineligible for nursing home level of care, health related facility and long term home health care program services until _____ You will be eligible for all other Medical Assistance services effective _____ You will have to meet a spenddown requirement for these services if there is an ☑ in the box above

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

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

SERVICES - Recipients of Social Services - A loss of Public Assistance and Medical Assistance benefits will require a redetermination of your eligibility for social services within 30 days of such a decision. This does not necessarily mean that these services will be terminated. It means that your continuing eligibility for these services will have to be redetermined. Please contact Services at _____ for further information

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: *You may have a conference to review these actions. If you want a conference, you should* ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are *still entitled to a fair hearing. If you want* to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___

___ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: *If you request a fair hearing before the effective date stated in this notice and our action* affects your Public Assistance, Medical Assistance, Food Stamp benefits or Social Services, you will continue to receive your benefits and any social services unchanged until the fair hearing decision is issued. ~~However, if you lose the fair hearing, you will owe any Public Assistance money and Food Stamp benefits that you should not have received. In addition, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box or boxes below to indicate the program(s) for which you do not want your aid continued, and send this page along with your hearing request. If you do check the box or boxes, the action(s) described above will be taken on the effective date listed above as identified under the appropriate program.~~

~~I do not want the following benefits continued unchanged until the fair hearing decision is issued:~~

~~☐ Public Assistance ☐ Medical Assistance ☐ Food Stamps ☐ Social Services~~

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ATTACHMENT 11

NOTIFICATION OF EMPLOYABILITY AND THE RIGHT TO CONTEST (TIMELY AND ADEQUATE)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME And C O Name / Present AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

YOU HAVE BEEN DETERMINED TO BE EMPLOYABLE

☐ This is to notify you that the _____ Department of Social Services has determined that you are employable effective as of the notice date above. The attached form (DSS-1653, Certificate of Employability or DSS-2612, WIN Referral/Registration) advises the NYS Employment Service of this determination.

☐ At your request, the _____ Department of Social Services has reviewed your status as an employable recipient and has determined that you continue to be employable.

This Action is being taken pursuant to Social Services Law Section(s) ☐ 131.5 ☐ 350-e.

You have been determined to be employable, or you continue to be employable because you are not:

Aged, as defined by Social Services Regulations
A full-time caretaker relative of children under the age of 6
Employed full-time or part-time to capacity
Ill or injured
Incapacitated
In full-time training/rehabilitation
In need of child care (non-WIN only)
Needed in the home due to illness of another household member
A parent or other caretaker when another adult relative is complying with employment requirements
A person 16-19 (ADC) or 16-21 (HR) in school full-time
A person under 16 years of age

DUTIES OF AN EMPLOYABLE PERSON

As an employable person you are expected to meet one or more of the requirements listed below as assigned by this Agency. The purpose of these requirements is to assist you in finding and keeping a job so that you will no longer be in need of public assistance.

The legal basis for these requirements may be found in Social Services Law Sections 131.5 through 131.7-a; Sections 164 and 164-b; Sections 350-b, 350-e, 350-g, 350-k and 350-l. Further details may be found in 18 NYCRR Parts 385, 388, and 392.

- You must register with the New York State Job Service and report, as scheduled by this Agency or the Job Service, for manpower services and certification.
- You must enroll in, accept referral to, and take part in the WIN Demonstration Program when appropriate.
- You must conduct an active job search and give evidence of such efforts when requested.
- You must accept referral to or offer of any employment in which you are able to engage.
- You must provide medical verification and/or undergo a medical examination or other diagnostic assessment necessary for the purpose of determining limitations on your employment or suitability for training or rehabilitation.
- You must accept referral to or enrollment in appropriate programs of vocational rehabilitation or training, or other employment related training programs if necessary to improve your employability.
- You must accept referral to and participate in work experiences on a public work project or community work experience project when appropriate.
- You must participate in the development of a child care plan when necessary.

If you willfully choose not to comply with the above listed requirements, you may be disqualified from receiving public assistance and/or medical assistance for a period of time from 30 days to six months.

If you continue to refuse, you will remain disqualified until you agree to comply with the requirements.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will **not** result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

__ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing within ten (10) days of the effective date of this notice **you will not have to comply** with the employment *related requirements outlined above even if these requirements were* assigned to you before you decided to request a hearing, unless and until a fair hearing decision is issued which finds you employable.

If you request a hearing **after more than ten days have passed** from the effective date of this notice, you must comply with the employment related assignments given you by this Agency and continue to perform them unless and until a fair hearing decision is issued which finds you unemployable.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

REPAYMENT OF INTERIM ASSISTANCE NOTICE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/ RIC NUMBER	
[illegible]		

GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____

OR Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

Dear Sir/Madam:

In accordance with your authorization to the Secretary of Health and Human Services, your retroactive Supplemental Security Income (SSI) payment has been sent to this department. This payment includes benefits for the period during which you received public assistance. We have deducted the amount of public assistance you received beginning with the date SSI determined you became eligible for benefits and ending with the month after the month in which the initial payment was received.

The REGULATION that allows us to do this is 18 NYCRR 370.7.

The amount of public assistance received during this period is shown below.

Our Calculations Show That:

☐ There is no balance due you ☐ There is a balance due of $ _____

PUBLIC ASSISTANCE BENEFITS CALCULATION

MONTH	19	19	19	19	19
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					
TOTAL	$	$	$	$	$

GRAND TOTAL $

REMARKS

I certify that the above is a true statement of receipts and disbursements under our agreement with the Secretary of Health and Human Services for the purpose of furnishing interim assistance to individuals as established by P.L. 93 - 368, as amended.

_____ Worker's Signature _____ Title

Amount of SSI Check	$	Date of SSI Check	
Less Amount of Home Relief Benefits	$	Date SSI Check Received By Department of Social Services	
Refund Due	$	Date Reimbursement Check Sent To You	
TOTAL AMOUNT OF AGENCY REIMBURSEMENT	$		

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island) (212) 488-6550

If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P O Box 1930 Albany, New York 12201. Please keep a copy for yourself.

___

___ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF ACCEPTANCE/DENIAL OF REQUEST FOR ASSISTANCE TO MEET AN IMMEDIATE NEED OR A SPECIAL ALLOWANCE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

On _____, you requested assistance to meet a special or immediate need of

_____

_____

This is to inform you that assistance to meet your ☐ special or ☐ immediate need will be provided by:

☐ an additional allowance of _____ effective _____.

☐ an emergency pre-investigation grant to meet your immediate need in the amount of _____ effective _____

☐ other action _____

_____

_____

☐ DENIAL REASON _____

_____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

PUBLIC ASSISTANCE

If you are an applicant for public assistance, this notice does not affect your application for on-going public assistance. You will also receive a notice advising you of the local agency decision on your application for assistance.

If you are a recipient and your request for an additional allowance is denied, your ongoing public assistance case will not be affected.

FOOD STAMPS

Your entitlement to the above grant may affect your household's Food Stamp benefits. If this occurs, you will receive a separate notice telling you of this effect and explaining it.

MEDICAL ASSISTANCE

☐ If you are in need of assistance to help with your medical bills, you must apply separately for Medical Assistance. If you wish to receive further information about eligibility under the Medical Assistance Program, contact the agency at the phone number listed above.

☐ Your medical assistance coverage remains unchanged.

☐ Your application for medical assistance is being reviewed. We will send you our decision within 30 days.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action(s) are wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

You have the following number of days from the date of this notice to request a fair hearing:

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-3152 (Rev. 2/89) Application/Recertification-FS

ACTION TAKEN ON YOUR FOOD STAMP CASE

NOTICE DATE		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN RIC NUMBER	
CASE NAME (And C/O Name) PRESENT AND ADDRESS		
		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

The action(s) taken on your application/recertification request for Food Stamps dated _____ is explained below next to the box(es) checked ☑ :

☐ ACCEPTED for the period from _____ to _____. You will receive a benefit amount of $_____ which will cover the period _____ to _____. This amount will be available to you on _____. After this you will receive

_____

_____

NOTE: If you are receiving Food Stamps while your application for public assistance (PA) is pending and public assistance is granted which increases your household's income, this may result in your Food Stamp benefits being reduced or terminated without further notice.

☐ ACCEPTED under expedited processing standards for the period from _____ to _____. You will receive a benefit amount of $ _____ which will cover the period from _____ to _____. This amount will be available to you on _____. Since you qualified for expedited application processing, we postponed certain verification and documentation requirements in order to issue your initial months benefit right away. However, your monthly benefit of $ _____ for the period _____ to _____ cannot be issued until you bring or mail in the following information:

_____

_____

In addition, you will not be eligible to receive expedited service in the future until the requested information is provided. If this verification changes your eligibility or benefit amount, we will make these changes without further notice. If you are receiving Food Stamps while your application for public assistance (PA) is pending and public assistance is granted which increases your household's income, this may result in your Food Stamp benefits being reduced or terminated without further notice.

☐ DENIED because _____

_____

_____

☐ You didn't do everything required for us to find out if you are eligible to receive Food Stamps. Here's what you still need to do: _____

_____

_____

If you do this by _____ you will not have to reapply. After that date, you will have to reapply in order for us to find out if you are eligible to receive Food Stamps.

☐ A RECOUPMENT is being taken against your Food Stamp benefits.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____.

NOTICE

If you were denied Food Stamps, please inform this office if you are later approved for Supplemental Security Income (SSI) or Aid to Dependent Children (ADC) since this may mean you are eligible for Food Stamps.

ATTENTION: If you are accepted for Food Stamps, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free, at 1-800-555-5000

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island) (212) 488-6550

If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed* to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE **90** DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-3152 (Rev. 2-89) Application/Recertification-FS

ACTION TAKEN ON YOUR FOOD STAMP CASE

NOTICE DATE 6/3/89

CASE NUMBER: F632

CIN / RIC NUMBER: My ID Number

CASE NAME AND RIC Name / Present AND ADDRESS

Maro Smith
Y Street
Food Stamps, New York 12222

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE

X County
Y Street
Food Stamps, New York 12222

GENERAL TELEPHONE NO FOR QUESTIONS OR HELP: 555-4444

OR Agency Conference: _____

Fair Hearing information and assistance: _____

Record Access: _____

Legal Assistance information: _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO
1	02	03	Mary Jones	555-4225

The action(s) taken on your application/recertification request for Food Stamps dated 6/3/89 is explained below next to the box(es) checked ☑ :

☐ ACCEPTED for the period from _____ to _____. You will receive a benefit amount of $_____ which will cover the period _____ to _____ This amount will be available to you on _____. After this you will receive

_____

_____

NOTE: If you are receiving Food Stamps while your application for public assistance (PA) is pending and public assistance is granted which increases your household's income, this may result in your Food Stamp benefits being reduced or terminated without further notice.

☒ ACCEPTED under expedited processing standards for the period from 6/3/89 to 11/30/89. You will receive a benefit amount of $ 81. which will cover the period from 6/3/89 to 6/30/89. This amount will be available to you on 6/4/89. Since you qualified for expedited application processing, we postponed certain verification and documentation requirements in order to issue your initial months benefit right away. However, your monthly benefit of $ 90. for the period 7/1/89 to 11/30/89 cannot be issued until you bring or mail in the following information:

bank statement from XYZ Savings Bank which shows the account balance on 6/3/89

In addition, you will not be eligible to receive expedited service in the future until the requested information is provided. If this verification changes your eligibility or benefit amount, we will make these changes without further notice. If you are receiving Food Stamps while your application for public assistance (PA) is pending and public assistance is granted which increases your household's income, this may result in your Food Stamp benefits being reduced or terminated without further notice.

☐ DENIED because _____

_____

_____

☐ You didn't do everything required for us to find out if you are eligible to receive Food Stamps. Here's what you still need to do: _____

_____

_____

If you do this by _____ you will not have to reapply. After that date, you will have to reapply in order for us to find out if you are eligible to receive Food Stamps.

☐ A RECOUPMENT is being taken against your Food Stamp benefits.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 387.8(a)(3).

NOTICE

If you were denied Food Stamps, please inform this office if you are later approved for Supplemental Security Income (SSI) or Aid to Dependent Children (ADC) since this may mean you are eligible for Food Stamps.

ATTENTION: If you are accepted for Food Stamps, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free, at 1-800-555-5000

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

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If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed* to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE **90** DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ATTACHMENT 16

DSS-3153 Rev. 2 89 — Recertification-FS

CONTINUING YOUR FOOD STAMPS

NOTICE DATE	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN, AID NUMBER	
CASE NAME AND C/O NAME (Please print)	GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
	OR Agency Conference _____
	Fair Hearing information and assistance _____
	Record Access _____
	Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

We are writing to tell you that your Food Stamps will end on_____. This action is taken in accordance with New York State Department of Social Services Regulation 387.17. In order to continue receiving Food Stamps, your household must now reapply. No further benefits will be issued unless you reapply. To reapply and prevent an interruption of Food Stamp benefits, a member of your household must complete the enclosed Recertification form and complete the action(s) explained next to the box(es) checked ☑ below:

☐ You must be interviewed again. We have scheduled an interview for_____ _____at_____o'clock at_____. If you cannot keep this appointment, or missed your scheduled appointment, it is your responsibility to reschedule this appointment by calling_____.

☐ You must be interviewed again. You must appear for the interview no later than_____15th to prevent a possible delay in processing your applicaion. Telephone the following number as soon as possible for an interview time_____

☐ You must mail in your completed recertification form with the documentation data listed below that applies to you to_____. You should mail it back as soon as possible, but we must receive it by_____. If it is not received by this date, your food stamps will not be continued. Also, mail back any documentation that is required.

DOCUMENTATION DATA: When you come for the interview or mail in your recertification form, whichever applies to you, please provide the following items (if they apply to you):

- Documentation of any change (since the last time it was verified) in the amount of your household's income, if it has changed by $25 or more, or the source of your household's income.
- Documentation of any change (since the last time it was verified) in actual claimed heating/utility expenses.
- If anyone in your household is 60 years of age or older, or receives SSI or Social Security disability benefits, bring or send in proof of their medical expenses that were incurred since you applied or since your last recertification, whichever is later.
- Documentation of any change in your living situation which includes but is not limited to changes in income, resources, shelter (rent, utilities, heat, etc.), family size, child care costs, etc.

If you, a member of your household, or an authorized representative fails to submit your recertification application form, appear for an interview (if required), or provide any required documentation, you will not receive Food Stamps after the end date above unless you reapply and are determined eligible.

If any verification is still required after the interview (or after the recertification form is received by this agency when no interview is required), you will be notified about what you need to provide and will be allowed at least ten days to provide it.

You may mail or bring the recertification form into this agency/center prior to your scheduled interview to the Food Stamp Office located at_____. We must receive your recertification form by_____15th to insure that you are entitled to receive Food Stamp benefits without a break should you continue to be eligible. The recertification form should be as complete as possible, but must be accepted by the district if at a minimum it contains your name, address, and your signature. In addition, if you file a recertification form by the 15th of the month, you must be interviewed (if an interview is required) by the end of that month in order to receive Food Stamp benefits without a break.

APPLICATION RIGHTS

- You have the right to request an application for Food Stamp benefits. This office must accept the application provided the application is signed and contains a legible name and address.
- You have the right to apply for Food Stamp benefits in person, by mail or through an authorized representative. An interview may be required.

NOTICE

If all members of your household are now receiving Supplemental Security Income (SSI) or plan to apply for SSI, you may reapply for Food Stamps at the Social Security office instead of filing your recertification application at the Food Stamp office.

If you choose to do this, the Social Security office must also receive your application by the date shown in the above paragraph. They will interview you and send your application with supporting documents to the Food Stamp office for recertification processing.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

__ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date

YOU HAVE 90 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by *checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.*

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ATTACHMENT 17

DSS-3620 Rev. 2-89 Change-FS

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (TIMELY AND ADEQUATE)

NOTICE DATE		NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RIC NUMBER	
CASE NAME And C/O Name - Present AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This agency is sending you this NOTICE to tell you we are CHANGING YOUR FOOD STAMP BENEFITS. The changes are explained below next to the boxes that have been checked ☑.

☐ REDUCE your Food Stamp benefits from $ _____ to $ _____ effective _____. The specific reason for this change in your Food Stamp benefits is as follows

_____

_____

_____

☐ DISCONTINUE your Food Stamp benefits as of _____. The specific reason for this change in your Food Stamp benefits is as follows.

_____

_____

_____

☐ SUSPEND your Food Stamp benefits for the month of _____. The specific reason for this change in your Food Stamp benefits is as follows:

Your household's income for the month of _____ exceeds the allowable limit for your size household. Since this increase in income was for one month only, your Food Stamp eligibility will be reinstated effective _____, providing this income increase does not continue and you continue to be otherwise eligible. You do not have to reapply; however, you MUST continue to complete and return ALL Monthly Reports.

☐ A RECOUPMENT is being taken against your Food Stamp benefits.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

The enclosed budget worksheet for your case explains the action (reduce, discontinue or suspend) checked above.

ATTENTION: *If you are receiving Food Stamps, you may be eligible for a discount on your telephone service. For information on LIFELINE, call New York Telephone, toll-free, at 1-800-555-5000.*

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

DSS 3620 Fe

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may do this conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County**: (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County**: (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, *Jefferson*, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County**: (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County**: (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 90 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date of the action in this notice, your Food Stamps will be continued unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, you will owe any Food Stamps that you should not have received. We are required by Federal Law to recover any Food Stamp overpayments. We must make a claim against you for any Food Stamps you receive that you were not entitled to, which may be collected by reduction of future Food Stamp allotments, lump sum installment payments, or through legal action. If you want to avoid this possibility you can check the box below. You can also indicate over the telephone or in a letter that you do not want reinstatement of your Food Stamps. If you check the box ☑, we will take the action(s) described above on the effective date listed above.

☐ I do not want my benefits reinstated and continued unchanged until the hearing decision is issued

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF INTENT TO CHANGE FOOD STAMP BENEFITS (ADEQUATE ONLY)

NOTICE DATE		NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / ID NUMBER	
CASE NAME AND ID Name(s) Present AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This agency is sending you this NOTICE to tell you we are CHANGING YOUR FOOD STAMP BENEFITS. The changes are explained below next to the boxes that have been checked ☑.

☐ REDUCE your Food Stamp benefits from $ _____ to $ _____ effective _____. The specific reason for this change in your Food Stamp benefits is as follows:

_____

_____

_____

☐ DISCONTINUE your Food Stamp benefits as of _____. The specific reason for this change in your Food Stamp benefits is as follows:

_____

_____

_____

☐ INCREASE your Food Stamp benefits from $ _____ to $ _____ effective _____. The specific reason for this change in your Food Stamp benefits is as follows:

_____

_____

_____

☐ SUSPEND your Food Stamp benefits for the month of _____. The specific reason for this change in your Food Stamp benefits is as follows:

Your household's income for the month of _____ exceeds the allowable limit for your size household. Since this increase in income was for one month only, your Food Stamp eligibility will be reinstated effective _____, providing this income increase does not continue and you continue to be otherwise eligible. You do not have to reapply; however, you MUST continue to complete and return ALL Monthly Reports.

☐ A RECOUPMENT is being taken against your Food Stamp benefits.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____.

The enclosed budget worksheet for your case explains the action (reduce, discontinue, suspend or increase) checked above.

ATTENTION: If you are receiving Food Stamps, you may be eligible for a discount on your telephone. For information on LIFELINE, call New York Telephone, toll-free, at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in	**New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island) (212) 488-6550
If you live in	**Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877
If you live in	**Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282
If you live in	**Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117
If you live in	**Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 90 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing **within ten days** of the date of the postmark of the mailing of this notice, your Food Stamps will be reinstated and will be unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, you will owe any Food Stamps that you should not have received. We are required by Federal Law to recover any Food Stamp overpayments. We must make a claim against you for any Food Stamps you receive that you were not entitled to, which may be collected by reduction of future Food Stamp allotments, lump sum installment payments, or through legal action. If you want to avoid this possibility you can check the box below. You can also indicate over the telephone or in a letter that you do not want reinstatement of your Food Stamps. If you check the box ☑, we will take the action(s) described above on the effective date listed above.

☐ I do not want my benefits reinstated and continued unchanged until the hearing decision is issued

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF FOOD STAMP OVERISSUANCE

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO

IT HAS BEEN DETERMINED that you or your household received an overissuance of food stamps during the months of _____ to _____ in the total amount of $ _____ for the following reason:

☐ AGENCY ERROR; specifically: _____

Calculation of the amount of this type of overissuance is limited to a period of twelve (12) months from the date of the discovery of the overissuance.

The amount of food stamps owed by you or your household is:

☐ $ _____.

☐ $ _____. This amount is different from the $ _____ indicated above because you already repaid $ _____.

☐ $ _____. This amount is different from the $ _____ indicated above because we have subtracted $ _____ in food stamps that we owed you and/or your household for the month(s) of _____ due to _____

You may choose to repay this Agency in one of the two methods provided in the enclosed "Food Stamp Repayment Agreement." If you decide to repay, please review the terms of the Agreement, sign and date the appropriate portion of the Agreement and return it to this Agency.

If you do not sign and return the enclosed Agreement, we may contact you again to ask for repayment. This AGENCY WILL NOT REDUCE YOUR FOOD STAMPS by allotment reduction without your agreement to such a reduction. However, any future restored food stamps owed may be applied toward reducing the amount of the overissuance.

The REGULATION which allows us to do this is 18 NYCRR 387.19.

☐ INADVERTENT HOUSEHOLD ERROR; specifically: _____

Calculation of the amount of this type of overissuance is initially limited to a period of twelve (12) months from the date of the discovery of the overissuance. *(IMPORTANT - SEE NOTE BELOW)*

The amount of food stamps owed by you or your household is:

☐ $ _____.

☐ $ _____. This amount is different from the $ _____ indicated above because you already repaid $ _____.

☐ $ _____. This amount is different from the $ _____ indicated above because we have subtracted $ _____ in food stamps that we owed you and/or your household for the month(s) of _____ due to _____

You **MUST** repay this Agency by choosing one of the two methods provided in the enclosed "Food Stamp Repayment Agreement." You **MUST** choose a repayment method, sign and date the appropriate portion of the Agreement and return it within thirty (30) days to this Agency. If you fail to sign and return the Agreement within thirty (30) days and you currently receive food stamps, we will begin collecting the overissuance by reducing your food stamps by allotment reduction of 10% of your household's monthly benefit, or $10, whichever is greater. Your household will receive a separate notice before this reduction can occur. If you currently do not receive food stamps and fail to return the Agreement, we may contact you again to ask for repayment or other collection actions may be taken. If you or any member of your household receive food stamps in the future, this Agency may reduce your food stamps at that time. Any future restored food stamps owed may be applied toward reducing the amount of the overissuance.

NOTE: Pursuant to Federal and State Regulations (18 NYCRR Part 399), this Agency may investigate this overissuance to determine if the acts that resulted in the overissuance constitute an intentional violation of the Food Stamp Program. If it is determined that you and/or a member of your household committed an Intentional Program Violation, you or your household member will be sanctioned from the Program for a specified period of time. The amount of the overissuance may be increased to include the total amount of Food Stamp overissuance received for the entire overissuance period up to a maximum of six (6) years from the date of discovery. In addition, the amount of the overissuance may be increased if you failed to report earned income. If it is determined that an Intentional Program Violation has occurred, you will be receiving a separate notice informing you of the determination and the new overissuance amount.

We advise you to keep this Notice as a reference in the event that an Intentional Program Violation is found.

The REGULATION which allows us to do this is 18 NYCRR 387.19.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Even if you ask for a conference, you still have only 90 days from the date of this notice to request a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE **90** DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-1052 2.89)

ATTACHMENT 20

NOTICE OF FOOD STAMP OVERISSUANCE
INTENTIONAL PROGRAM VIOLATION

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
	OR Agency Conference _____
	Fair Hearing information and assistance _____
	Record Access _____
	Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

SECTION I — AMOUNT AND REASON FOR OVERISSUANCE

It has been determined that you or your household received an overissuance of food stamps in the amount of $ _____ because of an Intentional Program Violation committed by _____. Specifically, _____

The disqualified person(s):

☐ Was *determined to have committed* an intentional violation of the Food Stamp Program after an administrative disqualification hearing held on _____, which resulted in a decision dated _____.

☐ Waived the right to an administrative disqualification hearing by signing a waiver on _____.

☐ Was found guilty of a crime or offense by a court of law on _____ for committing an intentional violation of the Food Stamp Program.

☐ Signed a disqualification consent agreement on _____.

☐ If this box is checked, you were informed by notice dated _____ that you or your household had received an overissuance in food stamps in the amount of $ _____. You were further informed that if it was later determined that you or a member of your household committed an intentional violation of the Food Stamp Program, the amount of the overissuance might increase.

Since Intentional Program Violation was found, this Agency has taken the following steps:

☐ Increased the period and the amount of the food stamp overissuance from a one year total to a total based on the entire overissuance period (up to a maximum of six years from the date that the overissuance was discovered) as set forth in the decision, waiver, court order, or consent agreement.

☐ Increased the amount of the food stamp overissuance because you or your household were not entitled to an earned income deduction for that portion of earned income which you or your household intentionally failed to report.

The REGULATION which allows us to do this is 7 CFR 273.18(c)(2).

If you require clarification of the above actions, please contact your caseworker.

SECTION II - AMOUNT OF FOOD STAMPS YOU OWE

The amount of food stamp benefits owed by you or your household is:

☐ $ _____.

☐ $ _____. This amount is different from the $ _____ indicated in Section I because you have already repaid $ _____.

☐ $ _____. This amount is different from the $ _____ indicated in Section I because we have subtracted $ _____ in food stamps that we owed you and/or your household for the month(s) of _____ due to _____.

SECTION III - REPAYMENT INFORMATION

You must repay the amount of food stamps owed in the manner indicated next to the box checked below:

☐ You have already signed a "DISQUALIFICATION CONSENT REPAYMENT AGREEMENT" or have been given a COURT ORDER on repayment. Therefore, you must make repayment as follows: _____.

☐ You MUST sign the enclosed "FOOD STAMP REPAYMENT AGREEMENT" and return it to this Agency by the date specified in the agreement. IF YOU DO NOT SIGN THE AGREEMENT, AN ALLOTMENT REDUCTION OF 20% of the amount your household would have received if the household member(s) had not been disqualified, or $10, whichever is greater, will BE TAKEN from your food stamp allotment.

The REGULATION which allows us to do this is 18 NYCRR Part 399.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO A FAIR HEARING ON THE AMOUNT OF THE OVERISSUANCE UNLESS THIS AMOUNT HAS BEEN ESTABLISHED AT AN ADMINISTRATIVE DISQUALIFICATION HEARING, BY A COURT OF APPROPRIATE JURISDICTION, IS SET FORTH ON A DISQUALIFICATION CONSENT AGREEMENT, OR AS A RESULT OF A WAIVER OF AN ADMINISTRATIVE HEARING.

BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review the amount of the overissuance. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Even if you ask for a conference, you still have only 90 days from the date of this notice to request a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 90 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-4050 2:89)

ATTACHMENT 21

FOOD STAMP NOTICE
TO HOUSEHOLD OF DISQUALIFIED INDIVIDUAL

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
\SE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

It has been determined that _____ committed an intentional violation of the Food Stamp Program and will be disqualified from receiving food stamps

☐ for a period of _____ months ☐ permanently

effective _____. This determination was made as a result of:

☐ An administrative disqualification hearing held on _____, which resulted in a decision dated _____.

☐ A waiver to an administrative disqualification hearing signed on _____.

☐ The individual(s) being found guilty of a crime or offense by a court of law on _____ for committing an intentional violation of the Food Stamp Program.

☐ A disqualification consent agreement signed on _____.

It was also determined that, as a result of this violation, your household received an overissuance of food stamps in the amount of $ _____. *(IMPORTANT - SEE NOTE BELOW)*

We have reviewed your food stamp case to determine the amount of food stamps that your household is entitled to receive during this disqualification period. The total income of the disqualified individual(s) is included in the food stamp budget calculation.

As a result of this disqualification, your household's food stamp entitlement will be as follows:

☐ Your household will receive a monthly allotment of $ _____ in food stamps for the months of _____ to _____.
(The allotment may be further reduced if your household agrees to repay the overissuance by allotment reduction. Your household will receive a separate notice before this reduction would occur.)

☐ Although your household's certification period expired on _____, your household still may be eligible for food stamps. To see if you are, please contact the Food Stamp Office to find out how to reapply.

☐ You are no longer eligible for food stamps as of _____, because

_____

_____

The REGULATION which allows us to do this is 18 NYCRR Part 399.

NOTE: If the disqualified individual does not agree to repay the overissuance, this Agency may take appropriate action against you to recover the overissuance. The REGULATION which allows us to do this is 18 NYCRR 399.9(f).

Enclosed is a budget worksheet which explains how we reduced or terminated your food stamps as described above.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU MAY ASK FOR A FAIR HEARING IF YOU ARE NOT SATISFIED WITH THE DECISION ON THE AMOUNT OF FOOD STAMPS YOU WILL RECEIVE OR IF THE DISQUALIFIED INDIVIDUAL HAS REQUESTED TO BE BUT IS NOT RESTORED TO THE HOUSEHOLD'S FOOD STAMP BUDGET AFTER THE END OF THE DISQUALIFICATION PERIOD.

BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review the benefits to be provided to the remaining household members during the disqualification period, or the district's failure to restore the disqualified individual upon request to the household's food stamp budget after the end of the disqualification period indicated. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Even if you ask for a conference, you still have only 90 days from the date of this notice to request a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: You may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, He Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Office of Administrative Hearings, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 90 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice. or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-4051 (2/89)

ATTACHMENT 22

FOOD STAMP NOTICE TO DISQUALIFIED INDIVIDUAL(S)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____ Record Access _____ Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

You are being disqualified from receiving food stamps because of the reason checked below:

☐ You were determined to have committed an intentional violation of the Food Stamp Program after an administrative disqualification hearing held on _____, which resulted in a decision dated _____ .

☐ You waived your right to an administrative disqualification hearing by signing a Waiver on _____

☐ You were found guilty of a crime or offense by a court of law on _____ for committing an intentional violation of the Food Stamp Program.

☐ You signed a disqualification consent agreement on . _____

Based on the above, you are subject to disqualification from the Food Stamp Program for the period of time checked below:

☐ For 6 months because this was your first intentional program violation.

☐ For 12 months because this was your second intentional program violation.

☐ For _____ months as contained in the sentencing by the court.

At the end of your disqualification period you must contact the Food Stamp Office if you want to reapply for food stamps. You will not be automatically restored to the Food Stamp Program.

☐ If this box is checked, you are permanently disqualified from receiving food stamps because this was your third intentional program violation.

THE ACTION BEING TAKEN AT THIS TIME IS CHECKED BELOW:

☐ If you are currently getting food stamps, beginning on _____ you will not receive any food stamps for the period identified above.

☐ If you are not getting food stamps now, you will be subject to the above disqualification penalties whenever you apply and are eligible for food stamps again.

The REGULATION which allows us to do this is 18 NYCRR 399.6.

If you do not agree with this decision, you can appeal this decision in an appropriate court of law.

If you have any questions, please call the Food Stamp Office at _____.

ATTACHMENT 23

FOOD STAMP REPAYMENT AGREEMENT

NOTICE DATE:

NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE

CASE NUMBER

CIN / RID NUMBER

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

GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Record Access _____

Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

SECTION I - INSTRUCTIONS

It has been determined that you or your household received $ _____ more food stamps than you were eligible to receive. The reason you owe benefits and the method of repayment is explained below next to the box that has been checked ☑:

☐ **AGENCY ERROR**

You may choose to repay us by selecting one of the two methods in Section II below. If you decide to repay, please carefully review the terms of this Agreement, sign and date the Agreement under the method you wish to repay and return it to this Agency by _____

_____

If you do not sign and return this Agreement, we may contact you again to ask for repayment. We will not reduce your food stamps by allotment reduction without your agreement to such a reduction. However, any future restored food stamps owed may be applied toward reducing the amount of the overissuance.

☐ **INADVERTENT HOUSEHOLD ERROR** ☐ **INTENTIONAL PROGRAM VIOLATION**

You must repay us by selecting one of the two methods in Section II below. SIGN and date this Agreement under the method you wish to repay us by and return it to this Agency by _____.

If you fail to sign and return this Agreement by this date and you currently receive food stamps, we will begin collecting the overissuance by reducing your food stamps by allotment reduction. Your household will receive a separate notice before this reduction would occur. If you currently do not receive food stamps and you fail to sign and return this Agreement, we may contact you again to ask for repayment or other collection actions may be taken. Also, please note any future restored food stamps owed may be applied toward reducing the amount of the overissuance.

SECTION II - METHODS OF PAYMENT

1. REPAYMENT BY CASH AND/OR FOOD STAMPS METHOD

You may repay the entire amount of the overissuance in cash or food stamps all at once, or you may use cash or food stamps to repay part of the claim now and then repay the rest in installments. You may choose to repay the entire amount of the overissuance in installments.

Please check the repayment method you wish to use and sign your agreement:

☐ All at once ☐ Part now, the rest in monthly payments ☐ Part now, the rest in quarterly payments (if you receive your food stamps quarterly)

☐ Monthly Payments only ☐ Quarterly Payments only (if you receive your food stamps quarterly)

Type of Repayment: ☐ Cash ☐ Food Stamps

I agree to repay by this method.

Signature of disqualified individual if in the household _____ Date _____

Signature of head of household _____ Date _____
(If not the same as the disqualified individual)

- We will contact you to discuss the repayment method you have chosen and give you a written statement showing how much you will be repaying (and how long your payments will continue should you choose to repay through monthly/quarterly payments).
- If you fail to make payments as agreed, you will be contacted to discuss a new repayment schedule or, if a participating household, your benefits may be reduced by allotment reduction.
- If your household's financial circumstances change, you may contact this Agency at the telephone number above to renegotiate your repayment agreement.

OR

2. REPAYMENT BY ALLOTMENT REDUCTION METHOD

Should you choose this repayment method, the amount of food stamps we will keep from your household's monthly/quarterly allotment is explained next to the box checked below:

☐ AGENCY ERROR - The amount will be discussed with you and will be the amount you agree to pay each month/quarter.

☐ INADVERTENT HOUSEHOLD ERROR NOT CAUSED BY THE AGENCY - 10% of your household's monthly benefit, or $10, whichever is greater.

☐ INTENTIONAL PROGRAM VIOLATION - 20% of the amount your household would have received if the household member(s) had not been disqualified, or $10, whichever is greater.

We will send you a notice to explain the method used to determine the amount of your food stamp allotment reduction and tell you the amount of food stamps you will get while you are repaying with this method. This repayment schedule may change without notice if your food stamp allotment amount changes.

I agree to repay by this method.

Signature of disqualified individual if in the household _____ Date _____

Signature of head of household _____ Date _____
(If not the same as the disqualified individual)

If your household's financial circumstances change, you may contact this agency at the telephone number above to renegotiate your repayment agreement.

IF YOU NEED HELP IN COMPLETING THIS AGREEMENT, PLEASE CALL US AT THE TELEPHONE NUMBER ABOVE.

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This Department has made a decision concerning eligibility under the Medical Assistance Program. We are sending this notice to tell you that this Department will:

☐ ACCEPT the Medical Assistance application dated _____, with coverage as follows:

☐ All covered care and services effective _____, for (name(s)) _____. If the eligible individual(s) does not already have a valid Medical Assistance Identification Card(s) and is entitled to receive one, one will be sent within 15 days. This card must be shown to the Medical Assistance provider whenever care is needed.

☐ Emergency medical care and services only, for (name(s)) _____, from _____ to _____.

☐ The applicant(s) may be eligible for direct reimbursement of medical expenses paid on or after _____. We will notify you of our decision.

☐ DENY the Medical Assistance application dated _____ for (name(s)) _____ because:

☐ The applicant(s) has RESOURCES totaling $ _____. The allowable Medical Assistance resource standard is $ _____. The difference between these ($ _____) is the EXCESS RESOURCE amount.

☐ In addition to excess resources, the applicant(s) has EXCESS INCOME in the amount of $ _____/month. The enclosed information explains how individuals may become eligible under the EXCESS INCOME PROGRAM.

☐ Other: _____

☐ TAKE NO ACTION on the Medical Assistance application dated _____ for (name(s)) _____ since it was withdrawn.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____.

If any of these actions were taken because of financial circumstances, we have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

Limited to illegal and/or undocumented aliens.

ATTENTION: Persons accepted for Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE **60** DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ATTACHMENT 25

EXPLANATION OF THE EXCESS INCOME PROGRAM

The following is an explanation of how you may become eligible for Medical Assistance and receive help with your medical bills even though your income may be over the limit. Please contact your social services worker if you need help understanding this letter.

If you have applied for Medical Assistance, our written notice to you will tell you if you have income over the Medical Assistance income level and the amount by which your income is over. This amount is also called excess income. If your net income is over (in excess of) the Medical Assistance level for your family size for a period in which you want help with your medical bills, you may receive Medical Assistance coverage only if either of the following conditions are met.

A. **Outpatient Care and Service (One Month Eligibility)**

You can become eligible for Medical Assistance for outpatient care and services if in any month you have medical bills that are equal to or more than the amount of your excess income.

This is possible under the **Excess Income Program** which provides outpatient coverage on a month-to-month basis for people who become eligible by bringing us their paid or unpaid medical bills which add up to at least the amount of their monthly excess income. You must present these medical bills to the agency when they add up to at least the amount of your excess income.

When you incur (owe) or have paid the amount of your monthly excess income and have submitted these bills and/or receipts to the agency, you may receive Medical Assistance coverage for all other eligible outpatient services for that month.

OR

B. **Outpatient and Inpatient/Hospital Care and Services (Six Month Eligibility)**

You can become eligible for Medical Assistance for all appropriate medical care and services (inpatient and outpatient) if you become hospitalized and/or are seeking help with your inpatient hospital bills, and if you incur (owe) or have paid an amount of medical bills equal to your monthly excess income for six months. Once you have medical bills (paid or unpaid), including any other medical bills besides your hospital bill that equal this six months' figure and present them to the agency, you will then receive Medical Assistance coverage each month for these six months for all other covered medical expenses (whether in-hospital or not).

C. **Medicare, Private Insurance and Use of Bill**

If a bill or service is covered in full by **Medicare** or private insurance, it cannot count as a medical expense to meet your monthly excess. If only part of a bill is covered by **Medicare** or private insurance, then that portion which remains (not covered by Medicare or private insurance) can count toward reducing or eliminating your monthly excess.

Bills for your care, your spouse's care if you live with your spouse or your children under 21 may be counted toward your monthly excess within the following guidelines. Medical bills of a child living with you will be considered if the child is included in the case. Medical bills of a child who is not part of your household may also be considered so long as you are providing medical support for the child. Bills for your parents care if you are under 21 and live with your parents may also be counted toward meeting your monthly excess. Unpaid bills from prior months may be counted toward meeting your monthly excess. Once unpaid bills, whether old or current, are credited toward meeting your monthly excess, they cannot be counted again.

After you have enrolled in the **Excess Income Program**, you must arrange to either bring in or mail in your bills and receipts each month once you have accumulated medical expenses equal to or greater than your excess income.

Continued on Reverse

We suggest that you make any necessary doctors appointments or fill prescriptions in the early part of each month so that, after you have met your excess amount, you can have the benefit of a Medical Assistance card to use for the payment of other medical expenses for that month. Medical Assistance may also be available for unpaid and certain paid bills for services and supplies received in the three calendar months prior to the month you applied.

D. **Payment of Medical Bills**

It is important to check to see if your doctor or other medical person accepts Medical Assistance payments. Medical Assistance will only pay bills from a doctor, druggist or other provider who accepts payments under New York's Medical Assistance Program. However, even if the doctor or other medical person does not accept Medical Assistance payments, you may still use bills from that person, whether paid or unpaid, to meet your excess income amount to qualify under the **Excess Income Program** *(See below).*

E. **Allowable Medical Expenses**

You should note that when meeting your excess amount, you can use doctor bills as well as medical expenses such as:

— Transportation expenses to obtain necessary medical services (in most cases).

— Medical expenses or payments made to therapists, nurses, personal care attendants and home health aides (as required by a physician).

— Prescription drug bills.

— Payments made toward surgical supplies, medical equipment, prosthetic devices, hearing aids and eye glasses (as ordered by a doctor).

You can also use medical expenses which are not covered by the Medical Assistance Program such as:

— Chiropractor's service (and other non-covered services).

— Services from non-participating providers (people who provide medical services but do not accept Medical Assistance payments).

— Some over-the-counter drugs and medical supplies such as bandages and dressings may be applied toward reduction of your excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items are not acceptable.

Certain of these bills can be counted only if required by a physician. Some of these services and supplies can also be paid for with your Medical Assistance card, but may have some restrictions.

Should there be a change in your circumstances (financial, household size, etc.), your eligibility in the **Excess Income Program** could be affected. All changes must be reported to your local social services office.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR MEDICAL ASSISTANCE ELIGIBILITY EXAMINER FOR DETAILS.

SS-3622A (2/89) MA-Only

NOTICE OF ELIGIBILITY FOR COVERAGE FOR THE TREATMENT OF AN EMERGENCY MEDICAL CONDITION

CASE NAME	CASE NUMBER	DATE

he applicant(s) indicated on the attached DSS-3622 has been determined to be eligible for Medical Assistance overage for emergency medical care and services only, for the reason indicated below:

☐ Section 1903(v) of the Social Security Act provides that aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law may only be provided Medical Assistance coverage for treatment received as a result of an emergency medical condition.

☐ The Immigration Reform and Control Act of 1986 (P.L. 99-603) provides that aliens whose status has been adjusted to that of Lawful Temporary Resident (LTR) are limited to Medical Assistance coverage for emergency services only, unless the alien is: a Cuban-Haitian entrant; aged, or certified blind/disabled; under 18 years of age; or a pregnant woman.

he care/services provided to (name(s)) _____

n _____ by _____ has been etermined necessary for the treatment of an emergency medical condition. Therefore, coverage will be provided or this treatment as follows:

☐ Full coverage

☐ Coverage with a SPENDDOWN requirement.

Gross monthly income		$ _____
Total monthly deductions	—	$ _____
Net monthly income		$ _____
Allowable income standard	—	$ _____
Monthly excess income		$ _____

Based on these calculations, the liability toward the cost of care for the period of treatment is

$ _____ . (See the enclosed "Explanation of the Excess Income Program" for information on how this liability may be met.)

☐ Coverage will be provided for inpatient hospital expenses which exceed $ _____ , the total amount for which you are responsible under the Catastrophic Illness Program. To determine this amount, we use the lesser of 25% of your annualized net income or the difference between your annualized net income and the Public Assistance standard for a household your size.

he provider(s) of medical care/services has been notified of your eligibility for Medical Assistance coverage.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

BE SURE TO READ THE ATTACHED NOTICE ON HOW TO APPEAL THIS DECISION

LDSS-3623 (rev. 2/91) MA Only

NOTICE OF INTENT TO DISCONTINUE/CHANGE MEDICAL ASSISTANCE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / AID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This is to advise you that this Department intends to take the action(s) indicated on your Medical Assistance case:

☐ CHANGE

☐ We will ☐ Increase ☐ Decrease the amount the Medical Assistance household must spend or incur on medical expenses each month in order to receive Medical Assistance coverage, based on the following calculations:

Gross Monthly Income	$ _____
Total Deductions	$ _____
Balance	$ _____
Allowable Income Standard	$ _____
New Monthly Excess Income	$ _____
New Excess Income (six months)	$ _____

The former monthly excess income amount was $ _____

The former excess income amount for six months was $ _____

☐ We will change the manner in which we compute the Medical Assistance spenddown as follows:

Gross Monthly Income	$ _____
Total Deductions	$ _____
Balance	$ _____
Allowable Income Standard	$ _____
Excess Income (monthly)	$ _____
Excess Income (six months)	$ _____

These calculations **do not** result in any change in the amount you must spend or incur on medical expenses each month in order to receive Medical Assistance coverage for the eligible individuals.

This change is effective _____ and is being made as a result of

☐ Change in income as follows: _____

_____

☐ Other (non-financial) change in circumstances: _____

_____

Please read the enclosed explanation of the EXCESS INCOME PROGRAM.

☐ DISCONTINUE the Medical Assistance coverage for (name(s)) _____

_____ effective _____ because:

_____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is _____

If any of these actions were taken because of financial circumstances, we have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do **not** want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-3868 Rev. 2.89

MA Only

NOTICE OF MEDICAL ASSISTANCE REVIEW

NOTICE DATE:	NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN / AID NUMBER	
CASE NAME And C/O Name (Present) AND ADDRESS	GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
— —	OR Agency Conference _____
	Fair Hearing information and assistance _____
	Record Access _____
— —	Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This notice is to advise you that the eligibility of (name(s)) _____

_____ for the Medical Assistance Program has been reevaluated as a result of your:

- ☐ Fair Hearing decision, dated _____
- ☐ Agency reconsideration
- ☐ Being a class member in the _____ court case.

Therefore:

- ☐ See attached Notice of Decision (DSS-3622) for details of your eligibility.
- ☐ We have determined eligibility as follows:

_____

_____

_____

_____

_____

Since we have determined eligibility as shown above, you may now be eligible for payment of certain medical bills. Please send or bring to us any medical bills for medical care, services or supplies that you have for the stated time period. Please send us these bills within 30 days from the date of this notice.

New York State Regulations, Part 500, only allows us to pay these bills for you if they are for services covered under the Medical Assistance Program. If you have already paid these bills, we can only reimburse you at the Medical Assistance rate. We will notify you when we have determined which bills are payable and how much we are going to pay.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF DECISION ON REIMBURSEMENT OF MEDICAL BILLS BY THE MEDICAL ASSISTANCE PROGRAM

NOTICE DATE:		NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name, if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This notice is to advise you of this Department's decision regarding reimbursement of medical bills.

☐ The provider(s) listed on the enclosed DSS-3870 (Medical Assistance Reimbursement Detail Form) is (are) to be paid for services to you or your dependents for the amount(s) shown. That form details the bill(s) you sent us.

☐ A check for $ _____ is being mailed to you. This represents a reimbursement (payment) to you for medical services which you paid. The enclosed form details these reimbursement amounts.

These payments are being made as a result of your fair hearing, agency (re)consideration, or as a result of a court case, pursuant to the notice(s) dated _____.

In computing the amount of these checks, the Department reviewed the bill(s) sent to us. These bills totaled $ _____. Denied bills, if any, are listed along with the reason(s) for denial on the enclosed DSS-3870 (Medical Assistance Reimbursement Detail Form).

The remaining bills are to be paid at the Medical Assistance rate in effect at the time the services were rendered (less your excess income, if any).

☐ The bills submitted are not reimbursable by the Medical Assistance Program. The reason(s) for denial are listed on the enclosed DSS-3870 (Medical Assistance Reimbursement Detail Form).

The LAW(S) AND/OR REGULATION(S) which allows us to do this is Section 365(a) of Social Services Law and 18 NYCRR 360-7.5(a)(1).

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF DECISION TO ACCEPT/DENY/CHANGE YOUR MEDICAL ASSISTANCE COVERAGE (CATASTROPHIC ILLNESS PROGRAM)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This Department has made a decision concerning your eligibility for Medical Assistance coverage of Inpatient Hospital Care and Services Only based on the following calculations:

For the 12 month period from to we estimated your income and deductions to be as follows:

Income	$
Deductions	— $
Annualized Net Income	$

You are responsible for paying the lesser of the following toward your inpatient hospital care:

(a) 25% of your annualized net income $ _____ ***OR***

(b) the difference between your annualized net income and the Public Assistance standard. The Public Assistance standard for a household your size is $ _____. The difference between your annualized net income and the Public Assistance standard is $ ___.

You are also responsible for spending your excess resources, if any, toward your inpatient hospital care. Your excess resources are calculated by determining the difference between your resources and the Medical Assistance resource exemption standard.

Your Resources	$
Medical Assistance Exemption	— $
Excess Resources	$

BASED ON THE ABOVE CALCULATIONS, THIS DEPARTMENT WILL:

☐ ACCEPT your application dated _____ for the Catastrophic Illness Program from _____ to _____. Before the Medical Assistance Program can help pay your hospital expenses you must first verify spending your excess resource amount (if any), on your hospital bill. Once verified, we will pay those covered expenses that exceed $ _____, the total amount for which you are responsible. **Provided your circumstances remain unchanged**, you are eligible for Medical Assistance for any other inpatient care and services for one year beginning _____.

☐ DENY your application dated _____ for the Catastrophic Illness Program because:

_____

_____

_____

☐ CHANGE (☐ Reduce ☐ Increase) your contribution as follows:

You were previously informed that you were responsible for $ _____ toward your hospital bill(s). Based on a change in your income, resources or other change, you are now responsible for $ _____ toward your hospital bill(s).

☐ TAKE NO ACTION on your application dated _____ for the Catastrophic Illness Program since it was withdrawn.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is Section 366.2 of the Social Services Law and 18 NYCRR 360-3.8 _____.

The enclosed budget worksheet(s) explains these calculations.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will **not** result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: *If you believe that the above action is wrong, you may request a State fair hearing by:*

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE **60** DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do **not** want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

ATTACHMENT 31

LDSS-3973 Rev. 2/89

MA Only

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION (EXCESS INCOME)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER / CIN / RID NUMBER	
CASE NAME And C/O Name / Present AND ADDRESS	GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
	OR Agency Conference - Fair Hearing information and assistance - Record Access - Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This Department has made a decision concerning your eligibility for Medical Assistance coverage under the EXCESS INCOME PROGRAM.

The total gross monthly INCOME is $_____. The total monthly deductions are $_____. The difference between these is the net monthly income. This is $_____. The allowable income standard for a family household your size is $_____. The difference between the monthly net income and this standard ($_____) is the monthly spenddown or excess income amount. The excess income for six months is $_____.

BASED ON THE ABOVE CALCULATIONS, THIS DEPARTMENT WILL:

☐ ACCEPT the application dated _____ for (name(s)) _____ with a SPENDDOWN requirement for:

☐ **Outpatient Medical Care Only** - You have verified paid or unpaid medical expenses (outpatient or inpatient) which equal $ _____, (the excess income for the month(s) of _____. The Medical Assistance Program will pay those **covered** outpatient expenses which **exceed** the monthly spenddown for the month(s) noted. The applicant(s) noted above may become eligible for Medical Assistance for outpatient care and services in any month by submitting to this Department bills or receipts for medical expenses equal to the monthly spenddown amount indicated above.

☐ **Outpatient and Inpatient Hospital Medical Care** (all covered care and services) - You have verified paid or unpaid medical expenses which equal $ _____ (the excess income for the six month period from _____ to _____). The Medical Assistance Program will pay any additional **covered** medical expenses incurred during this six month period.

☐ The applicant(s) anticipates meeting the excess income amount on a month-to-month and/or six month basis. When medical bills and/or receipts have been submitted to the Department for the appropriate amount, the eligible individual(s) will receive the corresponding Medical Assistance coverage.

☐ DENY the application dated _____ for (name(s)) _____ because you have indicated in the application that the applicant(s) does not have any unpaid medical bills, or any paid medical bills for services received within three months prior to the month of application which equal or exceed the monthly spenddown, nor does the applicant(s) anticipate incurring bills in this amount. Should this situation change, you may reapply.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is **Section 366.2(b) of the** Social Services Law and 18 NYCRR 360-4.8 _____.

The enclosed budget worksheet(s) explains these calculations.

PLEASE READ THE ENCLOSED EXPLANATION OF THE EXCESS INCOME PROGRAM. IF THE APPLICATION HAS BEEN ACCEPTED AND THE ELIGIBLE INDIVIDUAL(S) DOES NOT ALREADY HAVE A VALID MEDICAL ASSISTANCE IDENTIFICATION CARD(S) AND IS ENTITLED TO RECEIVE ONE, ONE WILL BE SENT WITHIN 15 DAYS.

ATTENTION: Persons accepted for Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: *You may have a conference to review these actions. If you want a conference, you should* ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have *the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself.* At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents *from your case record which you need for your fair hearing.* To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-[illegible]

ATTACHMENT 32

MA Only

NOTICE OF INTENT TO CHANGE THE CONTRIBUTION TOWARD CHRONIC CARE COSTS

NOTICE DATE	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN RID NUMBER	
CASE NAME And C/O Name + Present AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
— — — —		OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This notice is to inform you that this Department has recalculated the contribution required toward the cost of care for the individual named above. Effective _____, this Department will:

☐ INCREASE the monthly contribution required toward the cost of this individual's care from $ _____ to $ _____.

The total available income each month (including any support from the recipient's spouse) is $ _____.

The total monthly deductions (including the appropriate income standard/personal needs allowance) equal $ _____. The contribution toward the cost of care is the difference, or $_____.

☐ REDUCE the monthly contribution required toward the cost of this individual's care from $ _____ to $_____.

The total available income each month (including any support from the recipient's spouse) is $ _____.

The total monthly deductions (including the appropriate income standard/personal needs allowance) equal $_____. The contribution toward the cost of care is the difference, or $ _____.

This change is being made as a result of: _____

_____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is Section 366 of the Social Services Law and 18 NYCRR 360-4.9 and 360-4.3(f).

The enclosed budget worksheet(s) explains these calculations.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

cc: _____
NAME OF MEDICAL FACILITY

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will **not** result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF INTENT TO ESTABLISH A LIABILITY TOWARD CHRONIC CARE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/MID NUMBER	
CASE NAME And C/O Name (Present) AND ADDRESS		
		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This Department has made a decision concerning eligibility under the Medical Assistance Program of the individual named above, who has been determined to be residing in a medical institution on a permanent basis. (If the individual was previously in receipt of full Medical Assistance coverage or Medical Assistance coverage subject to a spenddown amount of $ _____ , the required contribution towards institutional costs is explained below.)

Date of Application: _____

Date of Institutionalization: _____

Date of Chronic Care Status: _____

We have calculated the total monthly contribution toward the cost of this individual's care for the periods indicated, as follows:

INCOME

From: _____ To: _____	____ To: .	From: _____ To: _____
Gross monthly income $_____	Gross monthly income $_____	Gross monthly income $_____
Deductions —_____	Deductions —_____	Deductions —_____
Income Standard/ Personal Incidental Allowance —_____	Income Standard/ Personal Incidental Allowance —_____	Income Standard/ Personal Incidental Allowance —_____
Contribution per mo. $_____	Contribution per mo. $_____	Contribution per mo. $_____
Payable to:_____	Payable to:_____	Payable to:_____

RESOURCES

Resources, if any, must also be considered in calculating your eligibility.

From _____ To _____		From _____ To _____	
Your total resources equal	$ _____	Your total resources equal	$ _____
Medical Assistance exemption —	$ _____	Medical Assistance exemption —	$ _____
Excess Resources	$ _____	Excess Resources	$ _____

Any excess resources must be contributed toward the cost of care during the period _____.

The Medical Assistance Program will pay any additional covered institutional costs during the authorized period.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is Section 366 of the Social Services Law and 18 NYCRR 360-4.9 and 360-4.3(f).

The enclosed budget worksheet(s) explains these calculations.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

_____
NAME OF MEDICAL FACILITY

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will **not** result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do **not** want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF INTENT TO DISCONTINUE FOR FAILURE TO COMPLY WITH RECERTIFICATION PROCEDURES

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This notice is to advise you that this Department will discontinue the Medical Assistance coverage of (name(s))

_____

effective _____ because:

☐ You or your representative failed to appear for a face-to-face interview on _____ at this office in order to determine continued eligibility for Medical Assistance.

If you believe that Medical Assistance should not be discontinued, you or your representative must recertify for eligibility. You may do this by appearing at this office on or before the effective date specified above.

If you or a representative were unable to appear for the scheduled interview but do wish to continue receiving Medical Assistance, you must contact this Department at the telephone number listed above before the effective date of this Department's intended action to discontinue coverage.

If you or your representative have had your face-to-face interview and/or rescheduled the date of the original interview please contact this office.

☐ You or your representative failed to return the recertification form and/or all of the documents necessary to determine continued eligibility of (name(s) _____

_____ for Medical Assistance. The following items are needed:

☐ Recertification Form ☐ Documentation ☐ See Attached

_____

_____

_____

If you wish Medical Assistance to continue, you must return the completed recertification statement and/or all of the required documents, to this office on or before the effective date noted above.

If you have submitted the completed recertification form and all of the required documents, please call this office at the number listed above to confirm that we have received the information.

If you need a new recertification information packet, you or your representative may obtain one by calling or writing to this office (numbers and address listed at the top of this notice). If coming to our office in person, please bring this notice with you.

The LAW(S) AND/OR REGULATION(S) which allows us to do this is 18 NYCRR 360-2.2.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE **60** DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do **not** want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-4006 (2-89) MA Only

NOTIFICATION OF ADVERSE UTILIZATION REVIEW DECISION AND FAIR HEARING RIGHTS

ICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
MEDICARE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

On _____ the Utilization Review Committee at your facility decided that you do not require (skilled nursing, health related) facility level of care which you have been receiving. As soon as arrangements are made, you should be (transferred to a _____ facility, discharged).

The reason for this decision and a copy of your Long-Term Care Placement Form (PRI or equivalent) which gives an evaluation of your present condition are attached.

As a result of this decision, this Department of Social Services intends to stop Medicaid payment for your present level of care on _____. If you require placement in another level of care facility, Medicaid payments may continue beyond this date until a transfer can be made.

A transfer cannot be approved or implemented to a location outside your present facility unless you voluntarily agree to specifically identified facilities or locations. If you now object to such a transfer, you should immediately contact the social worker in your facility and your social services district representative identified below. A transfer from one level of care to another level of care within a two level facility (combined SNF-HRF, or combined HRF-Domiciliary Care Facility, etc.) can be approved and implemented without your voluntary consent.

The REGULATIONS upon which this action is based are as follows:

18 NYCRR 505.9(B), 358.3, 358.4, 360-2.8, 360-2.9, 360-6.5, 505.20 AND
10 NYCRR 416.9, 421.13, 85.14-85.17, 414.14, 730.17, 731.11, 740.14, 741.14.

NAME OF AUTHORIZED DEPARTMENT REPRESENTATIVE	TITLE	TELEPHONE NUMBER

SIGNATURE OF AUTHORIZED DEPARTMENT REPRESENTATIVE

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

cc: Patient's Physician
Patient's Relative, Sponsor, Representative
Facility Administrator

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will **not** result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

Please note that the Fair Hearing will be held at your nursing home or health related facility upon your request. When making your request, by whichever method, it is important that you state that you are appealing a utilization review decision.

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed on the first page of this notice.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

MA Only

NOTICE OF DECISION OF INITIAL AUTHORIZATION/ REAUTHORIZATION/OR DENIAL PERSONAL CARE SERVICES

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This is to inform you of the following action taken on your request for personal care services effective _____ : ***(Please read carefully)***

☐ INITIALLY AUTHORIZED

Personal Care Services have been initially authorized for _____ hours per day, _____ days per week. The personal care services has been determined to be:

☐ Level I (Environmental and Nutritional Functions)

☐ Level II (Personal Care, Environmental and Nutritional Functions)

☐ Level III (Personal Care, Environmental and Nutritional Functions, and Health Related Tasks)

Your authorization period is from _____ to _____

☐ REAUTHORIZED

Personal Care Services have been reauthorized for _____ hours per day, _____ days per week. The personal care services have been determined to be:

☐ Level I (Environmental and Nutritional Functions)

☐ Level II (Personal Care, Environmental and Nutritional Functions)

☐ Level III (Personal Care, Environmental and Nutritional Functions, and Health Related Tasks)

Your authorization period is from _____ to _____ .

☐ DENIED

We intend to take this action because: _____

_____

_____

_____

The REGULATION which allows us to do this is 18 NYCRR 505.14.

SIGNATURE OF WORKER

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF INTENT
TO INCREASE, REDUCE OR DISCONTINUE PERSONAL CARE SERVICES

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This is to advise you that effective _____, this agency intends to:

☐ INCREASE YOUR PERSONAL CARE SERVICES

Your personal care services have been increased *from:*

_ hours per day, _____ days per week *to:*

_ hours per day, _____ days per week.

The personal care services have been determined to be:

☐ Level I (Environmental and Nutritional Functions)

☐ Level II (Personal Care, Environmental and Nutritional Functions)

☐ Level III (Personal Care, Environmental and Nutritional Functions, and Health Related Tasks)

Your authorization period is from _____ to _____.

We intend to take this action because: _____

_____

_____

_____.

☐ REDUCE YOUR PERSONAL CARE SERVICES

Your personal care services have been reduced *from:*

_ hours per day, _____ days per week *to:*

_ hours per day, _____ days per week.

The personal care services have been determined to be:

☐ Level I (Environmental and Nutritional Functions)

☐ Level II (Personal Care, Environmental and Nutritional Functions)

☐ Level III (Personal Care, Environmental and Nutritional Functions, and Health Related Tasks)

Your authorization period is from _____ to _____.

We intend to take this action because: _____

_____

_____

_____

☐ DISCONTINUE YOUR PERSONAL CARE SERVICES

We intend to take this action because: _____

_____

_____

_____.

The REGULATION which allows us to do this is 18 NYCRR 505.14.

SIGNATURE OF WORKER

X _____

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will **not** result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

   If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

   If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

   If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

   If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

   If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE **60** DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box below to indicate that you do **not** want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed on the first page of this notice.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-4005 (c 89)

ATTACHMENT 38

MA Only

NOTICE OF DECISION TO SUSPEND THE AUTHORIZATION FOR PERSONAL CARE SERVICES

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
ASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

This is to advise you that your authorization for personal care services has been **suspended** due to your hospitalization. A new assessment of your personal care services needs will be necessary prior to the reauthorization of services.

As soon as you know the date when you will be discharged from the hospital, please call your case manager, _____ at _____ , to inform him/her of your discharge date. At the same time, your physician should complete a new physician's order for home care reflecting your current medical needs.

The REGULATION which allows us to do this is 18 NYCRR 505.14.

SIGNATURE OF WORKER

X

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF INTENT TO RESTRICT YOU TO A PRIMARY MEDICAID PROVIDER (INITIAL RESTRICTION)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / AID NUMBER	
CASE NAME And C O Name if Present AND ADDRESS		
		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference Fair Hearing information and assistance Record Access _____ Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

A review of your Medicaid record indicates that you have used an excessive and/or potentially hazardous number of medical services. Attached are copies of your Summary Medical and Pharmacology Assessments which describe your excessive use of Medicaid services. The Medical Assistance Program intends to limit your care to a provider of your choice. A primary provider is the single _____ from which you will be able to receive services.

As of _____ your Medical Assistance Authorization will be restricted to the following:

☐ a primary pharmacy

☐ a primary physician/clinic
When necessary your primary physician/clinic will make referrals to other physicians/clinics for you.

In an emergency any doctor or clinic enrolled in the Medicaid Program will serve you. Dentists, optometrists, podiatrists, methadone maintenance treatment and certain other Medicaid services are not restricted.

You should be aware that you have the right to request a change of your primary provider every three months or sooner when there is good cause. These circumstances include, but are not limited to, the following:

- A change in residence
- Provider withdrawal from the Restriction Program

You must contact this office with the specific information and your request for a provider change will be considered. The final determination as to whether a request will be approved is the responsibility of this office. After 15 months, your records will be reviewed to determine if the restriction should be continued.

Please enter the names of:

_____

on the enclosed selection form and mail it to us in the enclosed return envelope. We are asking you to select three (3) choices so that the consent of one provider is assured. We will contact providers in the order you give us. You will receive a letter from us confirming the name of your primary provider. Failure to choose providers within two weeks of the date of this letter will allow the agency to select your primary providers based on the names of providers found in your record.

The REGULATION which allows us to do this is 18 NYCRR 360-6.4.

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box below to indicate that you do **not** want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed on the first page of this notice.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-4.25 (__/__)

ATTACHMENT 40

MA Only

NOTICE OF INTENT TO RESTRICT YOU TO A PRIMARY MEDICAID PROVIDER (RE-RESTRICTION)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY CENTER OR DISTRICT OFFICE
SE NUMBER	CIN RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____
		OR Agency Conference _____
		Fair Hearing information and assistance _____
		Record Access _____
		Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

A review of your Medicaid record indicates that you have used an excessive and/or potentially hazardous number of medical services. Attached are copies of your Summary Medical and Pharmacology Assessments which describe your excessive use of Medicaid services. The Medical Assistance Program intends to limit your care to a provider of your choice. A primary provider is the single _____ from which you will be able to receive services.

As of _____ your Medical Assistance Authorization will be restricted to the following:

☐ a primary pharmacy

☐ a primary physician/clinic
When necessary your primary physician/clinic will make referrals to other physicians/clinics for you.

In an emergency any doctor or clinic enrolled in the Medicaid Program will serve you. Dentists, optometrists, podiatrists, methadone maintenance treatment and certain other Medicaid services are not restricted.

You should be aware that you have the right to request a change of your primary provider every three months or sooner when there is good cause. These circumstances include, but are not limited to, the following:

- A change of residence
- Provider withdrawal from the Restriction Program

You must contact this office with the specific information and your request for a provider change will be considered. The final determination as to whether a request will be approved is the responsibility of this office. Since you were restricted before and your Medicaid usage subsequent to the restriction has again shown misuse, this new restriction period will be for three years. After three years, your records will be reviewed to determine if the restriction should be continued.

Please enter the names of:

_____

on the enclosed selection form and mail it to us in the enclosed return envelope. We are asking you to select three (3) choices so that the consent of one provider is assured. We will contact providers in the order you give us. You will receive a letter from us confirming the name of your primary provider. Failure to choose providers within two weeks of the date of this letter will allow the agency to select your primary providers based on the names of providers found in your record.

The REGULATION which allows us to do this is 18 NYCRR 360-6.4.

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

___

___ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover Medical Assistance benefits. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed on the first page of this notice.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

DSS-4028 (rev.)

ATTACHMENT 41

MA Only

NOTICE OF INTENT TO CONTINUE YOUR RESTRICTION TO A PRIMARY MEDICAID PROVIDER
(Administrative Continuation)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN / RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO FOR QUESTIONS OR HELP _____ OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO	UNIT NO	WORKER NO	UNIT OR WORKER NAME	TELEPHONE NO

A review of your Medicaid record while you were restricted indicates that the restriction should be continued. Attached is a summary of why your restriction is being continued. The Medical Assistance Program will continue to limit your care to a primary _____ for an additional three-year period.

A primary provider is the single _____ from which you will be able to receive service.

For the three-year period beginning _____, your Medical Assistance Authorization will continue to be restricted to the following:

- ☐ a primary pharmacy
- ☐ a primary physician/clinic
  When necessary your primary physician/clinic will make referrals to other physicians/clinics for you.

In an emergency any Medicaid doctor or hospital will serve you. Dentists, optometrists, podiatrists, methadone maintenance treatment and certain other Medical services are not restricted.

You should be aware that you have the right to request a change of your primary provider every three months or sooner when there is good cause. These circumstances include, but are not limited to, the following:

- A change in residence
- Provider withdrawal from the Restriction Program

You must contact this office with the specific information and your request for a provider change will be considered. The final determination as to whether a request will be approved is the responsibility of this office. After three years, your records will be reviewed to determine if the restriction should be continued.

According to our records, you are currently restricted to the primary provider(s) listed on the attached sheet, and these assignments will be continued.

The REGULATION which allows us to do this is 18 NYCRR 360-6.4.

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call New York Telephone, toll-free at 1-800-555-5000.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) ***Telephoning:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans** or **Wyoming County:** (716) 847-3877

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne** or **Yates County:** (716) 238-8282

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins** or **Tioga County:** (315) 428-4117

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington** or **Westchester County:** (518) 474-8781

OR

(2) ***Writing:*** By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.