LDSS-4013A NYC (Rev. 7/06)

ACTION TAKEN ON YOUR APPLICATION: PART A

PA, MA, FS App

PUBLIC ASSISTANCE, FOOD STAMP BENEFITS AND MEDICAL ASSISTANCE COVERAGE (NYC)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____

OR

Agency Conference _____

Fair Hearing information and assistance _____

Record Access _____

Legal Assistance information _____

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

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

SEE PART B FOR FOOD STAMP BENEFITS AND FAIR HEARING INFORMATION.

PUBLIC ASSISTANCE

☐ **ACCEPTED** for the period from _____ to _____. You will get $_____, which will cover the period from _____ to _____. After this you will get $ _____.

☐ The above grant is based on a reduced budget because:

☐ _____ failed without good cause to cooperate with the Office of Child Support Enforcement (OCSE) on _____ by _____ [18NYCRR 352.3(d)]:

To lift this sanction, call (_____)_____. **Read the detailed instructions on the back of this notice.**

☐ _____ failed to comply with the following drug/alcohol treatment requirement(s) [18NYCRR 351.2(i)]:

☐ screening ☐ assessment ☐ rehabilitation

☐ or, has not provided consent or revoked consent to disclose treatment information to the agency.

☐ A RECOUPMENT at the rate of _____ percent (%) is being taken against your Public Assistance. The reason for this recoupment is: _____.

If you believe the recoupment at this rate will cause your family an undue hardship, you should contact your worker to explain your reason. An undue hardship means that a person does not have enough income to eat, to pay for shelter or utilities, to get necessary clothing, to buy general items of need, or to pay for medical needs not covered by Medical Assistance. Your worker will let you know what kind of proof you will need to show that the recoupment at this rate will cause an undue hardship. If we decide that the recoupment will cause an undue hardship, the recoupment rate will be changed to a rate between 5 and 10%. The recoupment rate must be at least 5%. This decision is based on 18 NYCRR 352.31(d).

☐ **DENIED** for [name(s)]_____ because_____

_____

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

MEDICAL ASSISTANCE

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

_____

☐ **ACCEPTED** for Medical Assistance with a SPENDDOWN, effective _____ for [name(s)] _____

Your total monthly income is $ _____. Your total monthly deductions are $ _____.

The difference between these figures is your monthly net income for Medical Assistance. This is $ _____. The allowable income standard for a family household your size is $ _____. The difference between your net income and this standard ($_____) is your monthly excess income (18 NYCRR 360-4.8). The enclosed letter explains eligibility under the Excess Income Program and Optional Pay-In Program.

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

_____

_

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

☐ **PENDED**

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

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

☐ Not applying for Medical Assistance. You did not indicate on the application that you wanted to apply for Medical Assistance.

☐ **OTHER**_____

This above decision(s) is based on _____.

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

Enclosure

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

To Lift a Sanction for Non-cooperation with a Child Support Requirement

A sanction for non-cooperation with a child support requirement is open-ended and will continue until _____contacts the Child Support Enforcement Unit and cooperates.
When _____ contacts the Child Support Enforcement Unit, he or she will be told what action(s) must be taken to end the sanction. The sanction will end when he or she takes the required actions(s). If _____ did not cooperate but now wants to report a good reason for not cooperating with child support he or she should call (_____)_____.

Some examples of a good reason for not cooperating with child support are:

- fear of emotional or physical harm to you or the children in your family; or,
- the child was born due to rape or incest; or,
- the child is freed for adoption; or, you are now being assisted by an agency to determine whether to put the child up for adoption and discussions have not gone on for more than three months.

To find out more information about how to end the sanction, call (_____)_____.

☑ Social Services can give you education and counseling about birth control and can assist you in getting medical care to help you plan for your desired family or to prevent unwanted pregnancies.

Even if you are no longer eligible for Public Assistance or Medical Assistance, you may get information and education about family planning for up to 90 days from the date of your application.

For further information, please contact your services worker or call the general phone number on the front of this notice.

☑ If you know of children under the age of 19 who do not have health care coverage, call 1-800-698-4543 to learn about Child Health Plus coverage.

☑ Regulations require that you immediately notify this Department of any changes in needs, income, resources, living arrangements or address.

☑ Although you may no longer be able to get Public Assistance, Food Stamp Benefits or Medical Assistance, you still may be able to get help with your heating costs by applying for the Home Energy Assistance Program (HEAP). You can get more information on HEAP by calling the general telephone number on the front page of this notice.

☑ **Animal Population Control Program (APCP)** - If you have been approved to receive Public Assistance, Medical Assistance Coverage and/or Food Stamp Benefits, the New York State Department of Agriculture and Markets has a program that can help pay to have your dog or cat spayed/neutered. Through the animal population control program, eligible people can have their cat or dog spayed/neutered for $20.00. This notice entitles you to participate in the program. To receive an application voucher for this program, call 1-866-402-0666.

SEE THE BACK OF PART B

FOR YOUR CONFERENCE AND FAIR HEARING RIGHTS.