Date: _____

Case Number: _____

Case Name: _____

Center: _____

Caseload: _____

Mail-in Recertification/Eligibility Questionnaire

To determine your continued eligibility for Cash Assistance (CA) and Supplemental Nutrition Assistance Program (SNAP), you must answer every question, sign, date, and return this form in the enclosed postage-paid envelope to the **Family Independence Administration, P.O. Box 637, Canal Street Station, New York, NY 10213-0195** by: _____.
(Return Date)

For CA, this form is considered a mail-in recertification form. For SNAP, this is an Eligibility Questionnaire.

- You must enclose copies of letters or documents that verify the changes you report. In addition, if you or your family member has a job (earned income), you must submit the last four paystubs *or other proof of gross income earned and the number of hours worked during the last 30 days* even if the wages have not changed.
- Failure to return the form or returning it without the required verification may result in the closing of your case or reduction of benefits.

1. Do you still need: Cash Assistance? ☐ Yes ☐ No
   SNAP? ☐ Yes ☐ No Medical Assistance? ☐ Yes ☐ No
   If you check ☑ No, your benefit will be stopped.

2. Did anyone **move into** or **out of** your household since the last time you reported the number of persons in your household (including births)? ☐ Yes ☐ No
   - If Yes, provide the information requested below.
   - If they want to apply for assistance an application must be completed.
   - If you are reporting a newborn enclose a copy of a birth certificate for verification.

Social Security Number	Name	Relationship to You	Moved In	Moved Out	Date

(Turn Page)

Case Number: _____

3. Other than Cash Assistance, did you, or anyone in your household, have a change in income? Has anyone begun receiving any new or increased income or lost income from any of the following sources since the last time you reported your income?

   If you check ☑ Yes, indicate the amount you receive and whether this amount is new, more, or less. If you or a family member has a job (earned income) you must fill in part B, Employment, and submit photocopies of the last 4 paystubs *or other proof of gross income earned and number of hours worked during the last 30 days* even if the wages have not changed.

Source of Income		Amount	New	More	Less
A. Contributions	☐Yes ☐No	$_____			
B. Employment (whether new or not and whether more or less than previously reported) Please indicate the number of hours you work per week_____.	☐Yes ☐No	$_____			
C. Unemployment Insurance Benefits (UIB)	☐Yes ☐No	$_____			
D. Supplemental Security Income (SSI)	☐Yes ☐No	$_____			
E. Social Security Income other than SSI	☐Yes ☐No	$_____			
F. Child Support (including court-ordered payments)	☐Yes ☐No	$_____			
G. Veterans or other military benefits	☐Yes ☐No	$_____			
H. Other Income	☐Yes ☐No	$_____			

4. Have there been any changes in the following since you last reported to us?
   A. Rent costs: ☐ Yes ☐ No
      If Yes, Increase ☐ Decrease ☐ New amount $_____
      (Enclose proof of change).
   B. Do you now pay separately from your rent for:
      ☐Heat or Air Conditioning ☐ Yes ☐ No
      ☐Other Utilities (electricity, cooking gas, water, sewer, trash, etc.) ☐ Yes ☐ No
   C. Is someone pregnant, disabled or 60 years of age or older? ☐ Yes ☐ No
      If Yes, provide name (enclose medical proof): _____

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Case Number: _____

4. Have there been any changes in the following since you last reported to us? *(continued)*

   D. Resources (e.g., motor vehicle, bank account, etc.): ☐ Yes ☐ No
   If Yes, explain (enclose photocopy of car title, bank statement, etc.):
   _____

   E. Child support you pay to someone outside your household: ☐ Yes ☐ No
   If Yes, Increase ☐ Decrease ☐ New amount $_____
   (Enclose proof of court order).

   F. Medical expenses paid by household member who is disabled or who is 60 years old or older: ☐ Yes ☐ No
   If Yes, explain change: _____

   G. Other changes: ☐ Yes ☐ No
   If Yes, explain: _____

   H. Have any medical conditions that limit their ability to work or the type of work they can perform? ☐ Yes ☐ No
   If Yes, Name: _____

Able Bodied Adult Without Dependents (ABAWDs) - If anyone in your SNAP household is an Able-Bodied Adult Without Dependents ("ABAWD"), you must report when that individual's monthly participation in employment, or other work activities, falls below 80 hours.

Supplemental Nutrition Assistance Program (SNAP)

In order to determine if you can still get SNAP benefits, you must complete this Eligibility Questionnaire and return it by the date on **page 1** of this form. If you do not complete and return the Eligibility Questionnaire by the due date, your SNAP benefits will be reduced or stopped. We will send you another notice if this happens. This decision is based on Regulation 18 NYCRR 387.17.

List of changes you must report for SNAP at this time:

- Changes in any **source of income** for anyone in your household.
- Changes in your household's total **earned income** when it goes up or down by more than $100 a month.

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Case Number: _____

List of changes you must report for SNAP at this time:

- Changes in your household's total **unearned income from a public source** such as Social Security Benefits or Unemployment Insurance Benefits when it goes up or down by more than $100 a month.
- Changes in your household's total **unearned income from a private source** such as child support payments or private disability insurance when it goes up or down by more than $100 a month.
- Changes in the amount of court-ordered **child support you pay** to a child outside of your SNAP household.
- Changes in **who lives with you**.
- **If you move,** your new address and your new rent or mortgage costs, heat/air conditioning costs, and utility costs.
- **A new or different car,** or other vehicle.
- Increases in your household's **cash, stocks, bonds, money in the bank** or savings institution if the total cash and savings of all household members now amounts to more than $2,250 for a household without an elderly or permanently disabled household member or $3,500 for a household with an elderly or permanently disabled household member.
- If anyone in your SNAP household is an Able-Bodied Adult Without Dependents (ABAWD), they MUST tell the district if their participation in employment or other work activities falls below 80 hours each month within 10 days after the end of that month. The ABAWD can request a qualifying work activity from the district to help them meet the federal ABAWD requirement. If anyone in your SNAP household is an ABAWD, they should also report if your household has moved to an area with a federally approved ABAWD waiver or if the ABAWD believes they should be exempt from the ABAWD requirement.

MEDICAL ASSISTANCE – You must immediately report any changes in your address, income, resources or household size to this agency. You will be notified if your Medical Assistance coverage changes.

You must enclose copies of letters or documents that verify the changes you report. In addition, if you or your family member has a job (earned income), you must submit the last four paystubs *or other proof of gross income earned and the number of hours worked during the last 30 days* even if the wages have not changed.

If anyone in your SNAP household is an Able Bodied Adult Without Dependents (ABAWD), you must tell us if that individual's participation in employment or other work activities falls below 80 hours a month within 10 days after the end of that month.

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Authorization To Repay Public Assistance Benefits From Retroactive SSI

I authorize the Commissioner of the Social Security Administration (SSA) to use my first payment of SSI (i.e. my retroactive SSI payment) to reimburse the local Social Services District (SSD) for Public Assistance (PA) the SSD pays me from State or local funds while SSA decides if I am eligible for Supplemental Security Income (SSI). SSA will not reimburse the SSD for PA that was paid using any federal funds.

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

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

SSA can reimburse the SSD in two situations:

(1) It will repay the SSD if I apply for SSI and SSA finds me eligible.

(2) It will repay the SSD if my SSI benefits are reinstated after termination or suspension.

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

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

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

This authorization applies to any SSI application or appeal I now have pending before SSA.

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

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Case Number: _____

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

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

I swear (or) affirm that the information on this form is true and correct.

Name (please print): _____

Signature: _____ Date: _____

Spouse or Authorized Representative Signature: _____

Date: _____

WARNING: Federal and State law provides for penalties of fine, imprisonment or both if you do not tell the truth or if you conceal or fail to disclose facts regarding your continuing eligibility for assistance. Regulations require that you immediately notify this Agency of any changes in needs, income, resources, living arrangements or address.

Worker Signature: _____ Date: _____

NOTE: The last part of this form is an application to register to vote. If you would like help filling out the voter registration application form, ask your Worker. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency. Return this form to the Agency whether it has been completed or not.

LDSS-5084 (Rev. 11/17)

ACCESSING APPLICANT/RECIPIENT INFORMATIONAL BOOKS

If you are blind or seriously visually impaired and need this form or the three informational books in an alternative format (large print, audio, data CD, or Braille) contact your social services district. Large print, audio and data files are also available for download at http://otda.ny.gov/ under "Forms". If you require another accommodation, please contact your local social services district office.

This form and the three informational books are offered in multiple languages and are available online at http://otda.ny.gov/ under "Forms". To view the books follow the link provided, click "Forms" and scroll down until you see the titles of the books. The book titles are listed below.

You may also pick up printed books at your local District Offices or have them mailed to you at any time upon request.

Book1: What You Should Know About Your Rights and Responsibilities (LDSS-4148A)

This book informs you about your rights and responsibilities when applying for and receiving benefits.

Book 2: What You Should Know About Social Services Programs (LDSS-4148B)

This book gives information about the different programs available - such as Temporary Assistance (TA), Supplemental Nutrition Assistance Program (SNAP) as well as Medical Assistance (MA) (which includes Medicaid, Family Health Plus, and Family Planning Benefit Program). It also provides information on other services including child care, foster care, child welfare, adoption and other available programs.

Book 3: What You Should Know If You Have an Emergency (LDSS-4148C)

This book tells you what to do in case you have an emergency - such as needing immediate help with shelter, food, utility, fuel expenses, or medical attention.

You are entitled to information about your rights and responsibilities as an applicant or recipient of services and benefit programs.

The valuable information in these books can help you in applying for and receiving benefits. It is very important that you read these books and understand the information. If you have any questions after reading the books, or need help accessing the information, you may contact your district office for assistance.

Hearing impaired callers can use the New York State Relay service by dialing 711 or
TTY phone numbers of 1-800-421-1220 or 1-800-662-1220