

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES

**NOTICE OF INTENT TO CHANGE CHILD CARE BENEFITS AND FAMILY SHARE PAYMENTS**

NOTICE DATE:		EFFECTIVE 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	WORKER TELEPHONE NO.

This notice is to inform you that this agency intends to change your Child Care benefits.  
The changes are: \_\_\_\_\_

Comments: \_\_\_\_\_

**BENEFITS:**

Child(ren):	For this provider:	For the amount of:*	Full Time or Part Time:

\*Payment may vary based on fluctuations in your approved activity and/or absences.

**FAMILY SHARE. You are responsible for paying the following fees:**

- Effective \_\_\_\_\_, a **Weekly Family Share** must be paid to \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ per week.
- Effective \_\_\_\_\_, an **Additional Family Share** must be paid to \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ per week.
- Effective \_\_\_\_\_, a **Court Ordered Family Share** must be paid to \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ per week, for the child(ren) \_\_\_\_\_

**The following information is an explanation of how your weekly family share was determined.**

Family's annual gross income	\$ _____
Minus 100% annual state income standard for a family size of _____	\$ _____
Remaining income	\$ _____
Remaining income	\$ _____ X family share % _____ % = \$ _____
\$ _____ / 52 weeks =	\$ _____ weekly family share.

All family share amounts are rounded to the nearest \$0.50. There is a minimum fee of \$1 per week for all families not receiving TA.

The reason for this action is: \_\_\_\_\_

The LAW(S) AND/OR REGULATION(S) that allows us to do this is: \_\_\_\_\_

**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 front 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. Requesting an agency conference does not affect your right to also 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) **1-800-342-3334. OR**
- (2) **Writing:** Complete the information below, sign and mail to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201-1930. **Please keep a copy for yourself. OR**
- (3) **FAX:** Complete the information, sign and fax both sides of this form for your fair hearing request to (518) 473-6735. **OR**
- (4) **Online:** To send your fair hearing request online, go to <http://www.otda.ny.gov/oah>, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

**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, pay-stubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

**Check one:**

- KEEP MY CHILD CARE BENEFITS THE SAME.** If you request a fair hearing before the effective date of this notice, your child care benefits 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 child care benefits that you should not have received. We are required to recover any child care overpayments. We must make a claim against you for any child care benefits you receive that you were not entitled to, which may be collected by reduction of future child care 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 child care benefits.
- I do not want my child care benefits continued 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.

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**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you may need to prepare for your fair hearing. If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you **only** if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page one of this notice or write to us at the address printed at the top of page one of this notice.

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**REQUEST FOR A FAIR HEARING**

I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

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Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

District: \_\_\_\_\_  
 Case Number: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

**ADDENDUM TO NOTICE OF INTENT TO CHANGE CHILD CARE BENEFITS AND FAMILY SHARE PAYMENTS-FINANCIAL ELIGIBILITY CALCULATION**

Effective Date: \_\_\_\_\_  
 Case Name: \_\_\_\_\_  
 Case Number: \_\_\_\_\_

The amount that you pay for your family share has changed from \_\_\_\_\_ to \_\_\_\_\_

**Below are the sources of income used to calculate your family's income and the calculation used to determine your family share.**

**Please check the information below. If there is a mistake contact your caseworker listed on page one of this notice.**

Your family's <b>monthly gross income</b> was determined from the following sources:		
<input type="checkbox"/>	Wages or salary (18 NYCRR § 404.5(b)(5)(i)) before taxes in the amount of:	\$ _____ per month.
<input type="checkbox"/>	Social Security (18 NYCRR §404.5(b)(5)(iv)) in the amount of:	\$ _____ per month.
<input type="checkbox"/>	Child Support (18 NYCRR §404.5(b)(5)(xi)) in the amount of:	\$ _____ per month.
<input type="checkbox"/>	*Other income not listed above as defined in New York State regulation 18 NYCRR §404.5(b)(5) in the amount of:	\$ _____ per month.
	<b>Your family's total monthly gross income:</b>	\$ _____ per month.

The following information is an explanation of how your weekly family share was determined.		
Family's total monthly gross income	\$ _____	X 12 months = \$ _____ Annual Income
Family's annual gross income	\$ _____	
Minus 100% state income standard for a family size of _____	\$ _____	
Remaining income	\$ _____	
Remaining income	\$ _____	X family share % _____ % = \$ _____
\$ _____	/ 52 weeks =	\$ _____ weekly family share.

Family Size	100% Annual State Income Standard
1	
2	
3	
4	
5	
6	
7	
8	

For families with more than 8 persons, add \$3,960 for each additional person.

\*Other income not listed above and defined in New York State regulation 18 NYCRR 404.5(b)(5) are defined as but not limited to the following: net income for non-farm self-employment, i.e. gross receipts minus expenses from one's own business, professional enterprise or partnership; or net income from farm self-employment, i.e. gross receipts minus operation expenses from the operation of a firm by a person on his own account, as owner, renter or sharecropper; or dividends, interest (on savings or bonds) income from estates or trusts, net rental income or royalties; public assistance (PA) or welfare payments include PA payments such as PA, SSI and home relief; or pensions and annuities include pensions or retirement benefits paid to a retired person or his survivors; or unemployment compensation, workers' compensation; or alimony; or veterans' pensions.