NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

APPROVAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS

NOTICE DATE: / /	EFFECTIVE ELIGIBILITY 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: **1-800-342-3334** Record Access: Legal Assistance Information:

OFFICE NO.:	UNIT NO.:	WORKER'S NO.:	UNIT OR WORKER'S NAME:	WORKER'S TELEPHONE NO.: ( ) -

Your application dated ____/____/____ for child care benefits has been approved. You are eligible to receive child care benefits for child care provided on (date) ____/____/____ through (date) ____/____/____ while you are ____.

Comments:

YOU HAVE THE RIGHT TO A CONFERENCE AND/OR A HEARING TO APPEAL THIS DECISION.
READ THE BACK OF THIS NOTICE ON HOW TO REQUEST A CONFERENCE AND/OR HEARING TO APPEAL THIS DECISION.

BENEFITS. Payment will be provided on behalf of the following:

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

Actual payments may vary as permitted by regulation.

Benefits will be paid: ☐ Directly to you ☐ Directly to your provider

Your child care provider must submit a bill and attendance sheet to your local department of social services.

FAMILY PAYMENTS. 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 Payment** must be paid to ____
in the amount of $____ per week, to recoup an overpayment.

☐ Effective ____/____/____, a **Court-Ordered Payment** 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 % 1% = $____
$____ / 52 weeks = $____ weekly family share

All family share amounts are rounded to the nearest $0.50. There is a minimum family share requirement of $1 per week. This fee is waived for those receiving Temporary Assistance, experiencing homelessness, or when such assistance is provided to a child where the child care services unit is comprised of the eligible child(ren) only. This fee is also waived for those receiving child care as a protective service, a preventive service, or for a foster child.

In order to continue to receive benefits these are your responsibilities:

- Notify your caseworker immediately of any increase in family income that exceeds 85% of the state median income or any change related to who lives in your house, employment, child care arrangements, or other changes that may affect your continued eligibility or the amount of your benefit.
- Promptly pay any family share required.

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

CLIENT/FAIR HEARINGS COPY

RIGHT TO ACCEPT OR DECLINE SERVICES: Approval of your benefits does not obligate you to accept the services. You may choose to decline the services by contacting your local department of social services.

If you disagree with your local department of social services' decision, you may request a conference and/or a fair hearing.

1. **CONFERENCE:** You have a right to a conference with your local department of social services to review the determination. If you want a conference, you should request one AS SOON AS POSSIBLE, because the outcome of the conference may impact your decision to request a fair hearing. At the conference, you may present information to demonstrate why you believe the agency action is not correct.

   You may request a conference by:

   (1) Calling: ( ) - (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Writing: Check the box below and mail to _____

   Please keep a copy for yourself.

   ☐ I want a conference. I do not agree with the agency's action. You may explain on a separate paper why you disagree, but you do not have to include a written explanation.

2. **FAIR HEARING:** You have a right to a fair hearing to appeal the determination of the local department of social services. If you want a fair hearing, you have 60 DAYS from the NOTICE DATE, located on the front page, to make the request. You can request a fair hearing without requesting a conference.

   You may request a fair hearing by:

   (1) Calling: 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

   (2) Online: To send your fair hearing request online, go to https://otda.ny.gov/hearings/, click on the links to request a fair hearing using the online form, and follow the instructions to complete and submit the form online.

   (3) Writing: Check the box, complete the information below 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.

   (4) Faxing: Check the box, complete the information below and fax both sides of this form to (518) 473-6735.

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

   Name: _____ District: _____

   Address: _____ Case Number: _____

   _____ Phone Number: ( ) -

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, child care 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 searching online, using key words such as your county of residence and "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 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 conference or 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.