ATTACHMENT A

ACTION TAKEN ON YOUR APPLICATION FOR CHILD CARE BENEFITS

NOTICE DATE		NAME AND ADDRESS OF AGENCY/CENTER OR D
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	TE

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

[] **ACCEPTED** to receive _____ Child Care for the period _____ to _____.

Payment will be provided on behalf of the following child(ren):
_____

Your child care provider(s) is: _____

Benefits will be paid at the rate of $_____ per _____, less your parent fee.

[] Directly to you after receipt of provider's monthly bill.

[] Directly to your provider after receipt of provider's monthly bill.

You are responsible for a fee which must be paid to _____ in the amount of $_____ per week.

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

In order to continue to receive benefits you must:

- Notify your caseworker immediately of any change in family income, household composition (i.e., birth of a child, etc.), living arrangements, employment, child care arrangements or other changes which may affect your continued eligibility.
- Complete and return to your caseworker a questionnaire that will be used to determine your continued eligibility.
- Pay any fee required by your local department of social services.
- If you are receive Transitional Child Care, you must cooperate in

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 calling _____. (Please have this notice in front of you when you call.) You also may request a fair hearing by mail 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

Address:_____

Phone #:_____ Case Number:_____

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 verification, child care bills, 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

ATTACHMENT B

NOTICE OF INTENT TO CHANGE CHILD CARE BENEFITS

NOTICE DATE: _____	NAME AND ADDRESS OF AGENCY/CENTER OR D
EFFECTIVE DATE: _____	
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	TE

This notice is to tell you that this agency intends to change your _____ Child Care benefits. The changes are explained below next to the boxes that have been checked. [X]

We will:

[] REDUCE your benefits effective _____ from $_____ to $_____.

[] INCREASE your benefits effective _____ from $_____ to $_____.

[] CHANGE your benefits effective _____.

Payment will be provided on behalf of the following child(ren):

_____

Your child care provider(s) is:_____

Benefits will be paid at the rate of $_____ per _____, less your parent fee.

[] Directly to you after receipt of provider's monthly bill.

[] Directly to your provider after receipt of provider's monthly bill.

You are responsible for a fee which must be paid to _____ in

the amount of $_____ per week.

The reason for this action 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 calling _____. (Please have this notice in front of you when you call.) You also may request a fair hearing by mail 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

Address:_____

Phone #:_____ Case Number:_____

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 verification, child care bills, 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, you will owe any child care money or benefits you should not have received. If you want to avoid this possibility, check the box below to indicate you do not want your aid continued, and send this page along with your fair hearing request. If you do not check the box, the action(s) described above will be taken on the effective date listed on the top of the first page of this notice.

[ ] I do not want the child care 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.

ATTACHMENT C

NOTICE OF INTENT TO DISCONTINUE CHILD CARE BENEFITS

NOTICE DATE: _____	NAME AND ADDRESS OF AGENCY/CENTER OR D
EFFECTIVE DATE: _____	
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	TE

This notice is to tell you that this agency intends to discontinue your _____ Child Care benefits. The reason for this action is:

_____

_____

_____

_____

The Law(s) and/or Regulation(s) which allow us to do this is:

_____

_____

_____

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE REST 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

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

_____

_____

_____ _____

Signature of Client Date

Address: _____

Phone #:_____ Case Number:_____

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 verification, child care bills, 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, you will owe any child care money or benefits you should not have received. If you want to avoid this possibility, check the box below to indicate you do not want your aid continued, and send this page along with your fair hearing request. If you do not check the box, the action(s) described above will be taken on the effective date listed on the top of the first page of this notice.

[ ] I do not want the child care 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