



This is to notify local districts that the mandatory client notice LDSS-2425: "Repayment of Interim Assistance Notice" has been revised.

The following are the 7/99 revisions that have been made to this form:

- I. General- The revision date was **changed** to **7/99** on both the Front and Reverse of the form

II. Front

- A. In the "Dear Sir/Madam" section all references to "Public Assistance" have been changed to "Safety Net Assistance and other payments furnished to you with State and local funds for your basic needs".
- B. The Header on the Calculation Chart was changed to read:
- Safety Net Assistance and Other Payments for basic needs calculation
- C. All references to "1900" have been changed to "2000"
- D. The regulatory reference was changed to:
- Section 1631(g) of the Social Security Act (42 U.S. Code 1383[g])
- E. The second header, in the chart at the bottom of the page, was changed to read:
- Less: Amount of Safety Net Assistance Benefits and Other Payments For Basic Needs
- F. The footer at the bottom of the page about the requirement to notify the Department of any changes was removed because this notice is sent to former recipients who are now on SSI.

III. Reverse:

- A. The address to write for a fair hearing was changed from the "Fair Hearing Section, New York State Department of Social Services" to the "Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance".
- B. The chart outlining the time limits to request a fair hearing was deleted and replaced with the following wording:
- You have 60 days from the date of this notice to request a fair hearing.
- C. The "Access to Records/Information" section was updated and split into two sections entitled, "Access to Your File and Copies of Documents" and "Information".

Date January 10, 2000

Trans. No. 00 INF-1

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Delivery of the revised LDSS-2425 to the Albany Warehouse is expected at the end of March 2000. Your district will **not** automatically receive copies.

As explained in 89 LCM-155, clear photocopied masters of the revised **Spanish** version will be available to each district needing Spanish notices. Districts will then reproduce the forms locally.

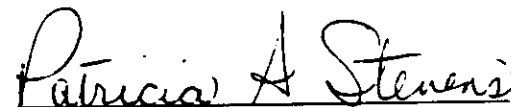
The restrictions on local equivalent notices contained on pages 10-11 of 89 ADM-21 continue to apply. Any request for approval of local equivalent notices with format changes must be submitted in accordance with the procedures described in 89 INF-53 and pages 12-1 through 12-5 of the Local District Manager's Guide.

In order to ensure that usage of the revised forms begins within a reasonable amount of time, you may continue to use the existing (8/94) forms until your stock is depleted, or until December 1999, whichever occurs first.

Requests for the LDSS-2425 (Rev. 7/99) should be submitted on OTDA-876 (Rev. 6/98): "Request For Forms or Publications" form, and should be sent to:

Office of Temporary and Disability Assistance  
Document Services  
P.O. Box 1990  
Albany, New York 12201  
Attention: Document Supply Control & Distribution

Questions concerning ordering forms should be directed to Document Services at 1-800-343-8859, extension 6-6223.



Patricia A. Stevens  
Deputy Commissioner  
Division of Temporary Assistance

## FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 ADM-21	94 INF-44	350.5, 351.22	SSL 22	FSSB	GIS 89
89 ADM-8		351.23	SSL 366-a	Section	MA007
89 ADM-6		352.31(d)		VI-A, B	
88 ADM-4		355, 358-3.3,		VII-all	
87 ADM-4		359, 360-2.4,		XV-C	89 LCM-155
86 ADM-10		2.5, 2.6, 6.4			89 LCM-22
86 ADM-7		7.5		PASB	
85 ADM-45		369.6		Section	
85 ADM-17		387.19		VI-all	
82 ADM-55		387.20		IX-I-7	
81 ADM-55		505.14(b) (5)			
80 ADM-90		(v), (viii),			
94 INF-44		(x)			
93 INF-45		385.3		Local	
92 INF-46		385.14		District	
92 INF-34				Manager's	
90 INF-57				Guide	
89 INF-53				pp. 12-1	
88 INF-83				through	
88 INF-28				12-5	

## REPAYMENT OF INTERIM ASSISTANCE NOTICE

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					
<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto;"></div>				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

Dear Sir/Madam:

In accordance with your authorization, the Secretary of Health and Human Services has sent your retroactive Supplemental Security Income (SSI) payment to this Department. This payment includes benefits for a period during which you received Safety Net Assistance and other payments furnished to you with State and local funds for your basic needs. We have deducted the amount of Safety Net Assistance and other payments furnished to you with State and local funds for your basic needs beginning with the date you became eligible for SSI benefits (or were reinstated after a period of suspension or termination) and ending in the month we received your initial SSI payment of the following month if your Safety Net Assistance and other payments furnished to you with State and local funds for your basic needs payments could not be stopped soon enough.

The REGULATION that allows us to do this is 18 NYCRR Part 353.

The amount of public assistance received during this period is shown below.

Our Calculations show that:

☐ There is no balance due you      ☐ There is a balance due of \$ \_\_\_\_\_

Safety Net Assistance and Other Payments furnished for basic needs calculation

MONTH	20	20	20	20	20
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					
<b>GRAND TOTAL</b>					\$
<b>TOTAL</b>	\$	\$	\$	\$	\$

REMARKS

I certify that the above is a true statement of receipts and disbursements under our agreement with the Secretary of Health and Human Services for the purpose of furnishing interim assistance to individuals as established in Section 1631(g) of the Social Security Act ( 42 U.S. Code 1383[g] )

Worker's Signature _____		Title _____	
Amount of SSI Check	\$	Date of SSI Check	
Less: Amount of Safety Net Assistance benefits and other payments for basic needs	\$	Date SSI Check Received By Department of Social Services	
Refund Due	\$	Date Reimbursement Check Sent To You	
<b>TOTAL AMOUNT OF AGENCY REIMBURSEMENT</b>	<b>\$</b>		

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**  
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

CLIENT/FAIR HEARINGS COPY

**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 is wrong, you may request a State fair hearing by:

(1) **Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 852-4868

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County:**  
(716) 266-4868

If you live in: **Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County:** (315) 422-4868

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

If you live in: **Nassau or Suffolk County:** (516) 739-4868

OR

(2) **Writing:** By sending a copy of this notice completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, 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:

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Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

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 bills, heating 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 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. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your 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 1 of this notice or write us at the address printed at the top of page 1 of this notice.

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 1 of this notice or write to us at the address printed at the top of the front of this notice.