NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS

NOTICE 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 NO.	UNIT OR WORKER NAME	WORKER TELEPHONE NO. ( ) -

Your application dated ______/______/______ for child care benefits has been **denied**, and the reason(s) your application has been denied is/are explained below.

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.

You are ineligible to receive benefits because:

☐ Your family's gross income exceeds 300% of the state income standard or 85% of the state median income, which is the maximum income allowed by New York State regulation to be eligible for child care assistance. Your family's monthly gross income of $__________ exceeds the maximum monthly income of $__________ for a family size of ______.

(Please see the attached addendum for additional information.)

☐ You have not provided us with the following documents: ______________________________

☐ You are not programmatically eligible for child care assistance because: ______________________________

☐ Due to insufficient funding the district is not opening cases at this time. ______________________________

☐ Other: ______________________________

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

CLIENT/FAIR HEARINGS COPY

Sample Only

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 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.

Sample Only

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

ADDENDUM TO DENIAL OF YOUR APPLICATION FOR CHILD CARE BENEFITS/FINANCIAL ELIGIBILITY CALCULATION

Effective Date: / /
Case Name:
Case Number:

We have determined that you are not eligible for child care benefits. Your family's monthly gross income is $.

☐ This exceeds 300% of the state income standard or 85% of the state median income, the maximum monthly gross income for initial eligibility, of $ for a family size of .

Please check the information below. If there is a mistake, contact your caseworker listed on page one of this notice. If there is a mistake, it could mean that the decision made about your benefits is not correct.

There is a child with special needs residing in your household. ☐ Yes ☐ No **If you have a child with special needs who needs child care, you may have received this notice in error. Contact your caseworker on page one of this notice to determine if you were denied child care benefits in error.**

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

Below are the monthly income standards used by the district to determine your eligibility for child care benefits. To determine eligibility for child care benefits, your family's monthly gross income for your family size was compared to 300% of the monthly state income standard and 85% of the state median income. For a family to be eligible for child care benefits, a family's income cannot exceed the monthly state income standard and monthly state median income amount listed below for its family size.

Family Size	300% Monthly State Income Standard	85% Monthly State Median Income
1		
2		
3		
4		
5		
6		
7		
8		

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

Your family's monthly gross income is $ for a family size of . This exceeds the maximum of $.

**Other income not listed above and defined in New York State regulation 18 NYCRR 404.5(b)(5) is 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 farm by a person on their 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); pensions and annuities (include pensions or retirement benefits paid to a retired person or their survivors); or unemployment compensation, workers' compensation; alimony; or veterans' pensions.*

In addition to the citations listed on this notice, refer to the district's Child and Family Services Plan at https://ocfs.ny.gov/main/childcare/plans/plans.asp for additional information.

Sample Only