

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**NOTICE OF FRAUD DETERMINATION,  
DISQUALIFICATION FOR CHILD CARE BENEFITS  
AND REPAYMENT PLAN**

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 Hearings Information and Assistance		<b>1-800-342-3334</b>
		Record Access		
		Legal Assistance Information		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

**YOU HAVE THE RIGHT TO AN AGENCY CONFERENCE AND TO A FAIR HEARING TO APPEAL THIS DECISION. BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO REQUEST AN AGENCY CONFERENCE AND/OR A FAIR HEARING.**

**SECTION I – THIS NOTICE IS TO INFORM YOU:**

1. The Department of Social Services has determined that you have fraudulently received child care benefits and you are disqualified from receiving child care benefits, AND
  2. You have received an overpayment and you must repay the overpayment.
- The regulation which allows us to do this is: 18 NYCRR 415.4(i).**

**SECTION II – FRAUD DETERMINATION**

The Department's finding of fraudulent receipt of child care benefits was based on:

- Your conviction by a court of law on \_\_\_\_\_ of fraudulently receiving child care benefits.
- Your signing a voluntarily admission dated \_\_\_\_\_.

The fraudulent activity resulted in an overpayment of \$ \_\_\_\_\_, occurring from \_\_\_\_\_ to \_\_\_\_\_.

**SECTION III – LENGTH OF DISQUALIFICATION PERIOD**

As a result of the fraudulent receipt of benefits, you are disqualified from receiving child care benefits. New York State regulation, 18 NYCRR 415.4(i)(13), establishes time periods for suspension or termination of benefits depending on the number of offenses and the amount of fraudulent benefits received.

- Six months, because this is your first offense.
- 12 months, because this is your second offense or the amount of fraudulent benefits you received was between \$1,000 and \$3,900.
- 18 months because this is your third offense, or the amount of fraudulent benefits you received was in excess of \$3,900.
- Five years, because you have committed four or more previous offenses.
- Other (State length of period and reason): \_\_\_\_\_

**SECTION IV – EFFECTIVE DATE OF DISQUALIFICATION**

- Your disqualification will begin on \_\_\_\_\_ and end on \_\_\_\_\_.
- You will be subject to the above disqualification penalty if you apply for and are found eligible for child care benefits at a future date.
- Your disqualification period will begin or resume once you are no longer participating in an activity required by TA.

**SECTION V: REPAYMENT PLAN AGREEMENT**

**If you are requesting a Fair Hearing regarding this decision, you are not required to complete and sign the repayment plan at this time. However, you must complete and sign the Fair Hearing request on the reverse side of this form and return it to the address indicated.**

You are required to make full repayment by \_\_\_\_\_. If you are unable to repay the overpayment as shown below or you want to set up another agreement plan, or if you have any questions, please call \_\_\_\_\_ at \_\_\_\_\_, right away. Otherwise, sign this agreement, make a copy of it for yourself, and return the agreement to the address at the bottom of this page.

**Your repayment plan is shown below.**

- Recovery will be made from your child care benefits. To repay this debt, you must pay \$ \_\_\_\_\_ each week to your child care provider. This is in addition to your current family share of \$ \_\_\_\_\_ per week. Effective \_\_\_\_\_, your **total family share** will be \$ \_\_\_\_\_ per week and the amount we pay to your provider will be reduced to \$ \_\_\_\_\_.
- To repay this debt, you must pay the Department of Social Services \$ \_\_\_\_\_ per week. Your first payment is due on \_\_\_\_\_. The final payment is due on \_\_\_\_\_.

**Send payments to:**

- You must continue to follow the repayment plan and/or court order that is already in effect, and is attached to this notice.

**I agree to repay by this method. I understand that failure to pay the amount stated above on time will result in a discontinuation of my child care benefits and/or legal action may be taken in the court to recover this overpayment.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Return this repayment plan agreement to:**

**RIGHT TO A CONFERENCE:** You may have an agency conference to review these actions. A conference is when you meet with someone from the agency, other than the person who made the decision, to discuss your case. You may request an agency conference by calling the number on the front of this notice, in the upper right hand corner. 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. Requesting an agency conference is not the same as requesting a fair hearing. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you disagree with the decision made by our agency, you may request a fair hearing. At the hearing you will have the opportunity to present written and oral evidence to demonstrate why you think the agency's decision is wrong and the action should not be taken. You have the right to be represented by legal counsel, a relative, friend or other person, or you may represent yourself. You have the right to bring witnesses and to question witnesses at the fair hearing. You have the right to present written and oral evidence at the hearing, and should bring any documents that may be helpful in presenting your case, such as this notice, pay stubs, receipts, child care bills, medical verification, letters, etc. There is additional information below on how to obtain access to your file and copies of documents in your file.

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING:**

When 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.

**TO REQUEST A FAIR HEARING:**

**Telephoning:** 1 800-342-3334 (Please have this notice with you when you call).

**Online:** Complete an online request form at: <http://www.otda.state.ny.us/oah/forms.asp>.

**Walk In Locations:** 14 Boerum Place, Brooklyn, NY OR 330 West 34<sup>th</sup> Street, Third Floor, Manhattan, NY.

**Writing:** Complete the following information, sign and mail a copy of this entire notice to the New York State Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. **Please keep a copy for yourself.**

**Faxing:** Complete the following information, sign and fax this entire notice to the New York State Office of Administrative Hearings at: 518-473-6735.

<input type="checkbox"/>	<b>I want a fair hearing. The Agency's action is wrong because:</b> _____  _____
<input type="checkbox"/>	<b>I understand I may be eligible for aid continuing (current recipients only). My benefits have been stopped and I wish to have my benefits restored (aid continuing) until the hearing decision is issued.</b> If you request a fair hearing and aid continuing, within ten (10) days of the date of the postmark of the mailing of this notice, your child care 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 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 you receive that you were not entitled to, which may be collected by reduction of future child care benefits, through 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.
<input type="checkbox"/>	<b>I do not want my benefits continued until the hearing decision is issued.</b>

<b>Signature of Client:</b>	<b>Date:</b>
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**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:** You have a right to look at your case file, and to receive free copies of the documents that the agency will put into evidence and other documents necessary for you to prepare for the fair hearing. To review your file or receive copies of any documents in your file, you can 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 the documents mailed to you, you must specifically ask that they be mailed. You should ask for documents ahead of time. They will be provided to you within a reasonable time before the date of the hearing.

**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 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 page 1 of this notice.