OCFS-LDSS-7009 (Rev. 11/2021) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NOTICE OF CHILD CARE ASSISTANCE OVERPAYMENT AND REPAYMENT REQUIREMENTS

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 — **1-800-342-3334**
		Record Access
		Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

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.

SECTION I – NOTICE OF CHILD CARE ASSISTANCE OVERPAYMENT

You received more child care benefits than you should have (an overpayment) from ____________________ to ____________________. The amount of the overpayment is $ ____________.

The reason the overpayment occurred is:

- ☐ You or someone in your household failed to inform us of changes that affect your eligibility or benefit level.
- ☐ We incorrectly gave you more benefits than you should have gotten due to: ____________________
- ☐ Other: ____________________

Explanation and Calculation of Overpayment: ____________________

The regulations that allow us to do this are 18 NYCRR 415.4(i) and (j).

SECTION II – REPAYMENT PLAN AGREEMENT: DO NOT COMPLETE IF REQUESTING A CONFERENCE OR FAIR HEARING

If you agree that you received an overpayment, as shown in Section I, you are required to make full repayment by / / .

Please select a repayment option below, sign, make a copy for yourself, and return to the address at the bottom of this page.

If you are unable to repay the overpayment, want to set up another repayment agreement, or have questions, please call ( ) - .

Please select one of the following repayment plan options:

☐ **Revised Family Payment** – Recovery will be made from my child care benefits. This option is only available if you are still receiving child care benefits. I will pay $ __________ per week, in addition to my current family share of $ __________ per week. **My total family payment is now** $ __________ **per week.** I will make this payment each week to my child care provider. My first payment is due on / / . The local department of social services will pay the child care provider $ __________ per week.

☐ **Installment Payment** - I will make weekly payments of $ __________ to the local department of social services. I will send payment to the address below. My first payment is due on / / . The local department of social services will pay the child care provider $ __________ per week.

☐ **Lump Sum Payment** - I will make one payment of $ __________ to the local department of social services. I will send payment to the address below. My payment is due on / / .

I agree to repay by this method. I understand that failure to pay the amount stated 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
X	/ /

Return this repayment plan agreement to: **Return Payment to:**

CLIENT/FAIR HEARING 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://www.otda.ny.gov/oah, 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