




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Transitional Assistance
600 Washington Street • Boston, MA 02111

JANE SWIFT
Governor

ROBERT P. GITTENS
Secretary

JOHN A. WAGNER
Commissioner

Field Operations Memo 2002-15
July 11, 2002

To: Transitional Assistance Office Staff
From:  Cescia Derderian, Assistant Commissioner for Field Operations
Re: Restoration of SSFSP Benefits

Background

The Department did not have full funding for SSFSP benefits for FY 2002 and implemented a funding reduction in the month of May effectively reducing SSFSP benefits to zero. Some funding has been made available and the Department will provide SSFSP benefits for the month of July **only**.

**SSFSP
Recipients
Active as of
July 11, 2002**

AUs with an active SSFSP member(s) with a State Funding Reduction amount on file as of the close of business Thursday, July 11, 2002 will be selected and issued the State Funding Reduction amount on file as of the July benefit cycle. AU Managers do not need to take any action regarding these payments.

AUs authorized as of the close of business July 11, 2002 will be sent a BEACON-generated notice on July 15, 2002, informing them of the SSFSP payment and that their benefits can be accessed immediately. The notice will include the amount of SSFSP benefits the AU will receive. The notice also informs recipients that the Department will contact them if further funding becomes available. See Attachment A for a copy of the notice being sent to active recipients.

**SSFSP
Applicants
Pending as of
July 11, 2002**

SSFSP applicants authorized after July 11, 2002 who are eligible for all or a prorated July cyclical benefit must be issued a supplemental payment once the AU is approved. AU Managers must issue a SSFSP Supplement/Immediate Needs Issuance payment for the SSFSP benefits owed as follows:

- On the Financial Tab of the Results Tab on the Eligibility Explorer window, click on the Benefit caret; and
- Use the State Funding Reduction amount as the cyclical SSFSP amount if the AU is entitled to the full July cyclical benefit amount; or
- Use the State Funding Reduction amount to calculate the prorated SSFSP benefits if the AU is **not** entitled to a full July cyclical benefit amount. Calculate the prorated SSFSP benefit as follows:
 - ♦ Multiply the State Funding Reduction amount by 12 (months) to get a yearly total;
 - ♦ Divide the amount by 365 (days) to get a daily total;
 - ♦ Multiply that amount by the number of days in the July cycle for which the AU is eligible.
- Enter the July cyclical benefit amount or the prorated amount on the Related Benefits window and authorize the payment on the Interview Wrap-up window.

SSFSP applicants authorized after the close of business July 11, 2002, will **not** receive a BEACON-generated notice informing them of the supplemental SSFSP payment. AU Managers **must** complete and send to the AU's current mailing address either the *SSFSP-Restore* or *SSFSP-Restore (S)* form (see Attachments B and C) with the proper appeal language on the reverse. A multi-lingual notice must also be included.

AU Managers are responsible for copying the necessary amount of forms. These forms will **not** be available for ordering.

**Further
Information**

You will receive further information as it becomes available.

Questions

If you have any questions, please have your Hotline designee call the Policy Hotline at 617-348-8478.

Client Name
Client Address

SSN:
TAO

Date

AN IMPORTANT NOTICE ABOUT YOUR SSFSP BENEFITS

Dear *Client Name*:

The Department has money for the State Supplemental Food Stamp Program (SSFSP) for the month of July. You will **not** get any more SSFSP benefits unless further money is made available. If you are going to get more SSFSP benefits we will tell you.

Your SSFSP benefits for July in the amount of _____ is now in your EBT Account.

If you get Federal food stamps the amount will stay the same unless there are other changes in your case.

If you disagree with the amount of your SSFSP benefits, you have the right to a fair hearing. The back side of this notice has important information about your hearing rights. To ask for a hearing, complete the back side of this notice.

Manual Citation 106 CMR: 360.030, 362.200, 362.220, 364.600, 365.520, 366.130.

Please call your worker (*Worker Name*) at (*Worker Phone Number*) if you have any questions about your case.





Commonwealth of Massachusetts
Department of Transitional Assistance

TAO Name & Address

AN IMPORTANT NOTICE ABOUT YOUR SSFSP BENEFITS

Date _____

Name _____ SSN _____

Address _____

Dear _____,

The Department has money for the State Supplemental Food Stamp Program (SSFSP) for the month of July. You will **not** get any more SSFSP benefits unless further money is made available. If you are going to get more SSFSP benefits we will tell you.

Your SSFSP benefits for July in the amount of _____ is now in your EBT Account.

If you get Federal food stamps the amount will stay the same unless there are other changes in your case.

If you disagree with the amount of your SSFSP benefits, you have the right to a fair hearing. The back side of this notice has important information about your hearing rights. To ask for a hearing, complete the back side of this notice.

Manual Citation 106 CMR: 360.030, 362.200, 362.220, 364.600, 365.520, 366.130.

If you have any questions about your case, please call your worker at the number listed below.

Worker Name _____

Worker Telephone Number _____



Notice of Request for a Fair Hearing

Massachusetts Department of Transitional Assistance

Division of Hearings

P.O. Box 167, Boston, Massachusetts 02112-0167

YOUR RIGHT TO APPEAL: If you disagree with any action or inaction taken by the Department of Transitional Assistance (DTA), you have the right to appeal and receive a fair hearing before an independent referee. DTA must receive your request for a fair hearing no later than 90 days from the date on this notice. Exceptions to the 90-day time limit are: (1) you have 10 days to request a hearing on Emergency Assistance (EA) shelter benefits, (2) you have 30 days from the date of mailing of the notice by the Department of Revenue to request a hearing regarding the intercept of your state tax refund, (3) you may appeal the amount of your Food Stamp (FS) benefits at any time during your FS certification period, if you think you are not receiving the correct amount, (4) you have up to 120 days if DTA fails to act on your request for services, and (5) you have up to 120 days to appeal alleged coercive action or otherwise improper conduct or up to one year under certain specified circumstances.

HOW TO APPEAL: If you wish to request a fair hearing, send this page with the bottom section completed to: DTA, Division of Hearings (DOH), P.O. Box 167, Boston, Massachusetts 02112 or fax to (617) 348-5311. Please keep the copy for your own records.

IF YOU ARE CURRENTLY RECEIVING ASSISTANCE, READ THIS BLOCK: Your benefits will be continued until a decision is made on your appeal if DOH receives your appeal request within 10 days from the date on this notice. If you are appealing a FS issue, and your FS certification period ends before your appeal is decided, you will continue to receive the same FS benefits only until the end of your certification period. If you receive assistance during your appeal, but lose your appeal, DTA can recover from you the assistance to which you were not entitled. If you receive TAFDC time-limited benefits during an appeal, which you then lose, the months for which you have received assistance will count toward your time-limited benefits. If you do not wish to continue to receive assistance during your appeal, check Box A below. If you do not receive benefits during your appeal, and you win your appeal, DTA will promptly correct any underpayment.

WHEN THE HEARING WILL BE HELD: You will be given at least 10 days notice prior to the fair hearing of the date, time and place of the hearing to permit you time to prepare your case. Fair hearings on EA shelter benefits are expedited; you will be given at least two days notice prior to the fair hearing of its date, time and place. If you wish to have a fair hearing scheduled sooner, check Box B below. If you have good cause for not being able to attend the fair hearing, please contact DOH at (617) 348-5321 or 1-800-882-2017 (TTY (617) 348-5337 or 1-800-532-6238) for the hearing impaired, before the hearing date, so that your hearing can be rescheduled. Failure to appear at the fair hearing without good cause may result in the dismissal of your appeal, except for the first scheduled hearing involving any aspect of the FS Program where good cause for rescheduling need not be demonstrated.

YOUR RIGHT TO BE ASSISTED AT THE HEARING: If you cannot speak English or understand it well or if you are hearing impaired and wish to have DOH provide an interpreter, please write that on this appeal request or call DOH at (617) 348-5321 or 1-800-882-2017, at least a week before the hearing. At the hearing, you may be accompanied by an interpreter, attorney, or other representative at your expense. You may wish to contact a local legal services office or community agency for assistance. Information about local legal services offices and other services provided by community agencies in your area can be obtained by contacting your local office. These agencies may provide advice or representation at no cost.

You or your representative may subpoena witnesses, present evidence and cross-examine witnesses. The referee must make a decision on all evidence presented at the fair hearing. You or your representative will be permitted to see your case file before the hearing. If you want to review your case file, schedule an appointment with your worker before the hearing.

NONDISCRIMINATION NOTICE FOR CLIENTS: Under federal and state law the Massachusetts DTA does not discriminate on the basis of race, color, sex, sexual orientation, national origin, religion, creed, age or disability. If you have any questions or concerns, we encourage you to contact the Director of Equal Opportunity, DTA, 600 Washington Street, Room 4039, Boston MA 02111, Tel. (617) 348-8490 (TTY (617) 348-5599 for the hearing impaired).

I, _____, hereby request a fair hearing before a referee of DOH.

A. I do not wish to continue receiving the disputed amount of assistance during the appeal process.

B. I request an expedited hearing.

The reason I wish to request a fair hearing is _____

Your Name (Print) _____ SSN _____

Address _____ Telephone () _____

City/ZIP _____ Date _____

Your Signature _____

My authorized representative is: Name _____ Title _____

Address _____ City/ZIP _____

Telephone () _____



Estado de Massachusetts
Departamento de Asistencia Transicional

TAO Name & Address

UN AVISO IMPORTANTE CON RESPECTO A SUS SSFSP BENEFICIOS

Fecha _____

Nombre _____ SSN _____

Dirección _____

Estimado(a) _____

El Departamento tiene los fondos para el Programa Suplementario Estatal de Cupones de Alimentos (SSFSP) para el mes de julio. Usted **no** recibirá ningunos beneficios a menos que los fondos adicionales sean disponibles. Si usted fuera a recibir más beneficios SSFSP, le informaremos.

Sus beneficios SSFSP para julio en la cantidad de _____ están ahora en su cuenta de EBT.

Si usted recibe cupones de alimentos federales, la cantidad seguirá siendo la misma a menos que hay otros cambios en su caso.

Si usted no está de acuerdo con la cantidad de sus beneficios SSFSP, usted tiene el derecho a una audiencia justa. El reverso de este aviso contiene información importante sobre sus derechos para una audición justa. Para solicitar una audición, llene el reverso de este aviso.

Las regulaciones utilizadas para tomar estas decisiones son 106 CMR: 360.030, 362.200, 362.220, 364.600, 365.520, 366.130.

Si usted tiene alguna pregunta con respecto a su caso, sírvase llamar a su trabajador al número de teléfono que aparece abajo.

Firma del Trabajador (a)

Número de Teléfono



Aviso para solicitar una audiencia

Departamento de Asistencia Transicional de Massachusetts

División de Audiencias (Division of Hearings)

P.O. Box 167, Boston, Massachusetts 02112-0167

SU DERECHO A APELAR: Si usted no está de acuerdo con alguna acción tomada por el Departamento de Transicional Asistencia, (DTA) usted tiene el derecho a apelar y recibir una audiencia ante la presencia de un árbitro independiente. DTA debe recibir su solicitud para una audiencia administrativa dentro de 90 días de la fecha de este aviso. Las excepciones del plazo de 90 días son: (1) usted tiene 10 días para solicitar una audiencia acerca de los beneficios de albergue de Asistencia de Emergencia (EA), (2) usted tiene 30 días desde la fecha en que el Departamento de Rentas envía el aviso por correo para solicitar una audiencia relacionada con la interceptación de su reembolso del impuesto estatal, (3) si usted cree que no está recibiendo la cantidad correcta, puede apelar la cantidad de sus beneficios de Cupones de alimentos (FS) en cualquier momento durante su periodo de certificación de FS, (4) usted tiene hasta 120 días si DTA no procede en su solicitud de servicios, y (5) usted tiene hasta 120 días a apelar supuesta acción coercitiva u otra conducta inadecuada o hasta un año bajo ciertas circunstancias especificadas.

COMO APELAR: Si usted desea solicitar una audiencia, llene la sección al final de este aviso y envíela a: **DTA, División de Audiencias (DOH), P.O. Box 167, Boston, Massachusetts 02112 o envíe un facsimil (fax) al (617) 348-5311.** Por favor, retenga la segunda copia para sus archivos.

SI ACTUALMENTE ESTA RECIBIENDO ASISTENCIA, LEA ESTA SECCION: Sus beneficios serán continuados hasta que se tome una decisión en relación si la DOH recibe su solicitud de apelación dentro de 10 días de la fecha de este aviso. Si usted está apelando un asunto relacionado a los Cupones de Alimentos, y su periodo de certificación termina antes de que se decida su apelación, usted continuará recibiendo la misma cantidad de beneficios de Cupones de Alimentos solamente hasta la terminación del periodo de certificación. Si usted recibe asistencia durante su apelación, pero pierde la apelación, DTA puede recuperar la cantidad de asistencia a la cual usted no tenía derecho. Si usted recibe beneficios de tiempo limitado durante una apelación cual entonces pierde, los meses por cual recibió asistencia contarán en el total de su límite de tiempo. Si usted no desea seguir recibiendo asistencia durante su apelación, por favor marque la casilla A al final de la página. Si usted no recibe beneficios durante su apelación y usted gana la apelación, DTA prontamente corregirá cualquier pago necesario.

CUANDO SE LLEVARÁ A CABO LA AUDIENCIA: Usted debe ser notificado de la fecha, hora y lugar de la audiencia dentro de 10 días antes de la misma, para que tenga tiempo a preparar su caso. Las audiencias referentes a beneficios de EA serán aceleradas; usted se le informará por lo menos dos días de la fecha, hora y lugar de la audiencia. Si usted desea tener su audiencia fijada en una fecha lo antes posible, marque la casilla B al final de esta página. Si usted tiene una razón justificada para no atender la audiencia, por favor comuníquese con la DOH al teléfono (617) 348-5321 o al teléfono 1-800-882-2017 o para sordomudos, (TTY (617) 348-5337 or 1-800-532-6238) antes de la fecha de la audiencia, para que otra audiencia pueda ser programada. Si falla en aparecer a la audiencia sin una razón justificada, esto pudiera resultar en el rechazo de su apelación, excepto en audiencias iniciales que envuelven cualquier aspecto del Programa de Cupones para Alimentos en donde la razón justificada para programar una nueva cita no tiene que ser demostrada.

SU DERECHO A SER ASISTIDO DURANTE LA AUDIENCIA : Si usted no domina muy bien el inglés o si tiene problemas de audición y desea que DOH le facilite un intérprete, sírvase indicarlo en esta solicitud de apelación o llamar a DOH al (617) 348-5321 o al 1-800-882-2017, por lo menos una semana antes de la fecha de su audiencia. Durante la audiencia, usted podrá estar acompañado por un intérprete, abogado u otro representante por su propia cuenta. Su oficina local le puede suministrar información acerca de oficinas de servicios jurídicos y otros servicios ofrecidos por agencias comunitarias de su zona. Estas agencias pueden ofrecer asesoramiento jurídico o representación sin ningún costo.

Usted o su representante puede citar a testigos, presentar evidencia y contrainterrogar a los testigos. El árbitro debe dictar un fallo teniendo en cuenta toda la evidencia presentada en la audiencia. Usted o su representante podrá revisar los expedientes de su caso antes de la audiencia si así lo desea. Si desea revisar los expedientes de su caso, haga una cita con su trabajador antes de la fecha de la audiencia.

AVISO A LOS RECIPIENTES SOBRE LA POLITICA ANTI DISCRIMINATORIA: Bajo las leyes federales y estatales, el DTA de Massachusetts no puede discriminar basado en la raza, color, sexo, preferencial sexual, nacionalidad de origen, religion, credo, edad, o incapacidad. Para ayuda con cualquier asunto pertinente a esta política, le alentamos a que se comunice con el Director de Oportunidad Igual, DTA, 600 Washington Street, Room 4039, Boston, MA 02111, o llame al (617) 348-8490, o para sordomudos, TTY (617) 348-5599.

Yo, _____, solicito por la presente una audiencia ante un árbitro de DOH.

- A. No deseo seguir recibiendo la cantidad de de asistencia disputa durante el proceso de apelación
- B. Solicito una audiencialo más pronto posible.

El motivo por el cual deseo solicitar una audiencia es _____

Nombre _____ SSN _____

Dirección _____ Teléfono () _____

Ciudad/Código _____ Fecha _____

Firma _____

El nombre de mi representante autorizado es: Nombre _____ Título _____

Dirección _____ Ciudad/Código Postal _____

Teléfono () _____