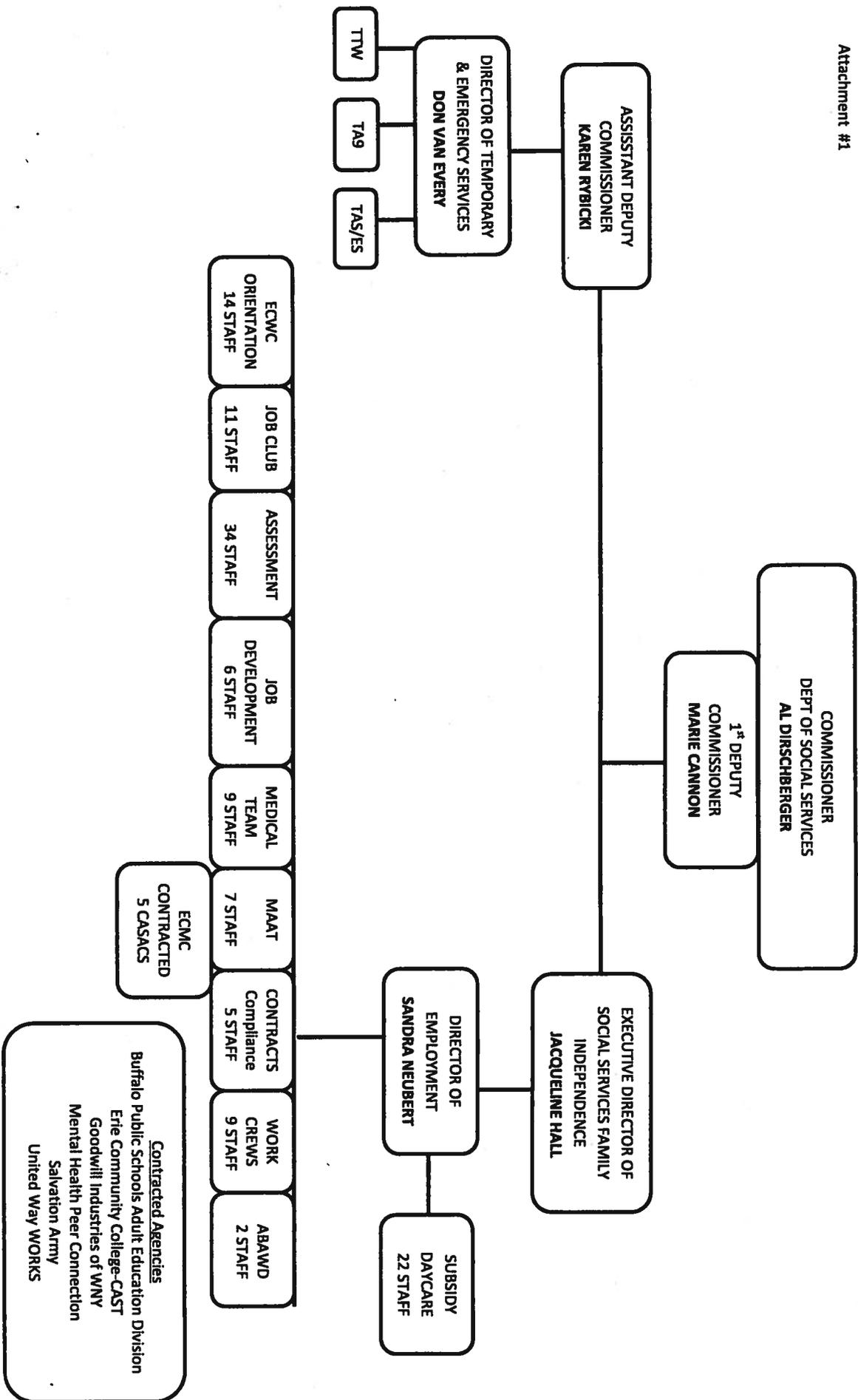


**Temporary Assistance and Supplemental Nutrition Assistance Program
Employment Plan 1/1/16 – 12/31/17 – Attachment Pages**

- Attachment 1. Organizational Chart of Erie County Department of Comprehensive Employment**
- Attachment 2. Self Sufficiency Agreement Form (B4319)**
- Attachment 3. Employment Registration Agreement Form (B2341)**
- Attachment 4. Work Support Check List (B-5664)
(8 pages – 4a,4b,4c,4d,4e,4f,4g,4h)**
- Attachment 5. Employment Orientation (2 pages 5-front & 5 reverse)**
- Attachment 6. Job Search Referral Form (B2342-A-2)**
- Attachment 7. Training Program Approval Letters
(3 pages B3854 Front & Reverse & B3854-A).**
- Attachment 8. Monthly Evaluation Calendar**
- Attachment 9. Job Search Log**
- Attachment 10. Medical Form LDSS-4526 For Employability Assessment,
Disability Screening and Alcoholism/Drug Addiction
Determination (2 pages – front/back)**



SELF-SUFFICIENCY AGREEMENT



The Erie County Department of Social Services will assist you to develop a plan leading to **self-sufficiency**.

I agree to:

- participate in developing a self-sufficiency plan;
- look for a job and accept one if offered;
- keep scheduled appointments;
- call to reschedule if unable to keep an appointment;
- attend treatment or rehabilitation program, if required;
- participate in an approved work activity, including work experience, if required; and
- report employment and provide verification.

The Agency agrees to:

- Develop a plan to assist you with achieving self-sufficiency;
- offer services to help you obtain employment;
- provide child care information;
- provide supportive services while you participate in approved work activities
- answer any questions regarding eligibility; and
- provide an opportunity to discuss any problems

I understand that if I do not participate in mandated assigned work activities, my application may be denied or my benefits may be reduced or discontinued.

The Erie County Department of Social Services will assist you in the agreed plan of activities which will lead you to self-sufficiency.

Signed _____ Date _____

Temporary Assistance is subject to the following time limits:

- 5 years (60 months) for families with children
- 2 years (24 months) for single individuals and childless couples

When these time limits have been reached and you are applying for Temporary Assistance, you will be assessed or reassessed for eligibility for the Safety Net Non-Cash program.

EMPLOYMENT REGISTRATION AGREEMENT FORM

DUTIES OF A NON-EXEMPT PERSON

As a non-exempt person, you are expected to meet one or more of the requirements listed below as assigned by this Agency. The purpose of these requirements is to assist you in finding and keeping a job so that you will no longer be in need of temporary assistance.

If you are receiving Family Assistance, the law and regulations that allow us to do this are Title 9-B of the Social Services Law and 18NYCRR385.

If you are receiving Safety Net, the law and regulations that allow us to do this are Title 9-B of the Social Service Law and 18NYCRR385.

If you are only receiving SNAP Benefits, the law and regulations that allow us to do this are 18NYCRR385.

You must actively seek employment at all times and provide evidence of such activity if requested by the Social Services District.

You must report any and all employment obtained while receiving temporary assistance to your Social Welfare Examiner for proper budgeting.

You must participate in an initial assessment and in the preparation of an employability plan.

You must accept job referrals and/or any legal and suitable offer of employment.

You must provide medical verification and/or undergo a medical examination or other diagnostic assessment necessary for the purpose of determining any limitations to your employment activity.

You must participate in any work activity as assigned by the Social Service District.

ACKNOWLEDGMENT

I have read the above requirements, I understand them, and I agree to comply.

Signature of Applicant

Date

Signature of Employment Counselor

Date

WORK SUPPORTS

FOOD/NUTRITION

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
<p style="text-align: center;">SNAP (Supplemental Nutrition Assistance Program) Formerly the Food Stamp Program</p>	Low income households	Proof of: Identity, DOB, SSN, address, income (4 weeks), expenses (shelter, utility, childcare & medical)	<p><u>Online</u> www.mybenefits.ny.gov By phone (716) 858-7239 Fax completed applications to (716) 858-6834 or Mail to: ECDSS, PO Box 120 Buffalo NY 14201 Attn: SNAP Division In person: 158 Pearl Street 1st Floor, Buffalo NY 14202 Monday through Friday, 8:00 a.m. – 4:00 p.m.</p>	SNAP benefit value depends on household size, income and expenses. Maximum benefits: 3 people-up to \$511 4 people-up to \$649
<p style="text-align: center;">WIC (Women, Infants & Children) A Federal Nutrition Program administered by Catholic Charities</p>	Income eligible pregnant women, breastfeeding women & children under age 5	Proof of: Income (includes public assistance) and vaccination records for the child	<p>Call the Growing Up Healthy Hotline 1-800-522-5006 to locate the WIC local agency nearest to you. Online: http://www.ccwny.org/wic</p>	Provides food vouchers, nutrition education and referrals

HEALTH

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
Medicaid	Adults & Children with limited incomes & resources	Proof of: Income, resources, expenses, identification, citizenship/immigration, residency and SSN	<p><u>Online: www.nystateofhealth.ny.gov</u> In person: 158 Pearl Street 4th Fl. Buffalo, NY 14202 Monday through Friday, 8:00 a.m. – 4:00 p.m. (716) 858-6244 By phone: 1-855-355-5777</p>	Health insurance
<p>Child Health Plus (under 19 years old)</p> <p>Family Health Plus (19-64 years old)</p>	People with limited incomes that do not qualify for Medicaid	Proof of: Identity, SSN, citizenship or immigration status, residence, income, employer based health insurance availability and child care	<p>Apply through New York State of Health Marketplace: www.nystateofhealth.ny.gov (855) 355-5777 For more information: 1-800-698-4543 Child Health Plus 1-877-934-7587 Family Health Plus</p>	Health insurance
Wal-Mart & Sam's Club Prescriptions Savings Program	All are eligible	Prescription from Doctor	<p>No application- plan provides for commonly prescribed dosages of generic prescriptions. See www.Walmart.com for list of medications.</p>	Low cost prescriptions \$4 fee for 30 day supply. \$10 fee for 90 day supply.
Community Health Center of Buffalo Federally Qualified Health Center	People with no health insurance or high deductible and/ or copay	Per program requirements	<p>Walk-ins are welcome 34 Benwood Avenue Buffalo, NY 14214 (716) 986-9199 www.chcb.net</p>	Low-cost Medical, Dental, Family Planning, and Pharmacy services for a fee based on income & household size.

HEALTH CONTINUED

Good Neighbors Health Care	People with limited incomes	Per program requirements	175 Jefferson Ave., Buffalo, NY (716) 856-2400 No appointments 1 st come, 1 st served basis. Limited space. Call for hours. www.harvesthouse.ws/goodneighbors	Services include medical, vision, dental, and chiropractor care.
Medicaid Cancer Treatment Program (MCTP)	Certain uninsured individuals who have been diagnosed with or are being treated for certain cancers and are not eligible for other Medicaid Programs	Proof of identity, citizenship or immigration status, residence, income, and certain expenses such as child care	Cancer Services Program 1-866-442-2262 Medicaid Help Line 1-800-541-2831	Free treatment for breast, cervical, colorectal and prostate cancer.

CHILD CARE

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
Transitional Child Care	People who are transitioning from Temporary Assistance to employment, with incomes below 200% poverty level	Proof of: ID for all household members, income (including child support), household composition, & provider information	Temporary Assistance (TA) Recipients should contact their TA Worker regarding transitional child care	Transitional child care assistance is available up to 12 months
Subsidized Child Care (Low Income Child Care Assistance)	People with incomes 200% or less of the poverty level. Cost of care is based on a sliding income scale	Proof of: ID for all household members, income (including child support), household composition & provider information	ECDSS Day Care Unit Erie County Dept. of Social Services Rath Building 95 Franklin St 4 th floor Buffalo, NY 14202 858-8953 (TYKE) www2.erie.gov/socialservices	Assistance with child care costs
Child Care Resource Network	Anyone in need of child care assistance		1000 Hertel Ave Buffalo, NY 14216 (716) 877-6666 or www.wnychildren.org	<ul style="list-style-type: none"> ▪ Locating child care ▪ Parenting education ▪ Provider training ▪ Info for businesses
YMCA School Age Child Care (SACC)	Anyone with children ages 5-12		Register at your Local YMCA or Online www.ymcabuffalonia.org/Programs.html	<ul style="list-style-type: none"> • Child Care • Financial Assistance available to those who qualify

HOUSING

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
Belmont, Section 8 & Housing Authority	Low income families, elderly and disabled individuals	Proof of Income	Belmont (716) 884-7791 www.belmonthousingwny.org BMHA (716) 855-6774 www.ci.buffalo.ny.us HUD (716) 551-5755 www.racbny.org	Government subsidies to reduce rents of those eligible
Security Agreement An agreement with the landlord that replaces a security deposit	Low income individuals and Temporary Assistance (TA) Recipients	ID, Landlord form, Inspection form, Proof of income	Erie County Dept. of Social Services Housing Unit 478 Main St. 1 st floor Buffalo, NY 14202	Security agreement

CHILD SUPPORT

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
ECDSS Office of Child Support Enforcement	Child support services are provided upon application, to all individuals	<ul style="list-style-type: none"> ▪ The name of the absent parent ▪ His/her Social Security Number ▪ Name and location of their most recently known employer ▪ Last known address of absent parent ▪ Most recent court order 	<p>If you are currently receiving Temporary Assistance or Medicaid, filing with the local Child Support Unit is automatically done for you.</p> <p>If you are not receiving benefits from TA or Medicaid you will apply in person: Office of Child Support Enforcement Rath Bldg. 95 Franklin St, 7th Floor Buffalo, NY 14202</p> <p><u>Application for Child Support Services.</u> 1-888-208-4485</p> <p>www.childsupport.ny.gov</p>	<ul style="list-style-type: none"> ▪ Assists you in locating an absent parent for your child ▪ Helps in the establishment of paternity for your child ▪ Assists in the obtainment of a child support order for your child ▪ Enforces the child support payment as well as delinquent payments ▪ Assists in the actual collection phase of child support collection ▪ Assists in the process to gain additional support for your child

UTILITIES

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
<p>Lifeline</p>	<p>Eligible low-income subscribers. Families receiving Medicaid, HEAP, SSI, TA, SNAP, VA benefits, Housing Assistance, Lunch Program Assistance or families w/ low incomes. Only one life line per household.</p>	<p>Proof of earned and unearned income. The subscriber must present the same type of documentation covering 3 consecutive months within the previous 12 months, if the documentation does not cover a full year of income.</p>	<p>Contact your telephone company.</p> <p>Verizon Wireless: 800-417-3849 Cricket Communications: 800-975-37083 T-Mobile: 800-892-2253 Safelink Wireless: 800-SAFELINK</p> <p>Time Warner Cable: 800-892-2253 Verizon: 800-837-4966</p>	<p>Provides discounts on monthly telephone (wire line or wireless) service</p> <p>Eligible household can receive up to \$9.25 per month in discounts.</p>
<p>Safelink Wireless Wireless telephone service offering Lifeline services to qualified customers.</p>	<p>Families with low income and no other lifeline services in the household. Individuals are eligible if already participating in other State or Federal assistance programs such as Federal Public Housing Assistance, TANF, SNAP, SSI, HEAP, and/or Medicaid.</p>	<p>Proof of income. Documents that are accepted include: Medicaid statement, supplemental security income statement, document that contains your program ID, 4 months of consecutive pay stubs, letter from your employer, last year's income tax return, employer W-2 form</p>	<p>1-800-SAFELINK (1-800-723-3546)</p> <p>www.safelinkwireless.com</p>	<p>FREE cellular phone with plan that provides up to 250 minutes and 1000 texts <i>every month</i></p>
<p>HEAP (Home Energy Assistance Program) Federally funded assistance with home heating costs and energy conservation for eligible households.</p>	<p>Families with limited income and resources</p>	<p>Proof of: Residency, income, resources, expenses, birth certificates & SSN for all household members and a recent fuel bill.</p>	<p>Apply in person or mail application to: Erie County HEAP Program 478 Main St—1st floor Buffalo NY 14202 For Additional information: Social Services HEAP: 716- 858-7644 Senior Services HEAP 716-858-7870</p> <p>https://otda.ny.gov/programs/</p>	<p>Components include electricity, weatherization referral, and cooling assistance (in summer months- based on medical necessity).</p>

UTILITIES CONTINUED

<p>Weatherization Assistance Program (WAP)</p> <p>Assists families & individuals by reducing their heating/cooling costs & improving the safety of their homes.</p>	<p>Available to both homeowners and renters with low income or receive government assistance through the following programs: SSI, TANF, SNAP, or HEAP.</p>	<p>Proof of income or categorical eligibility.</p>	<p>For residents outside city of Buffalo: Supportive Services Corp www.supportiveservices.org (716) 685-6252</p> <p>For East Side of Buffalo Residents: Lt. Col. Matt Urban Human Services Center of W.N.Y. www.urbanctr.org (716) 893-7222</p> <p>For South Buffalo Residents: NHS of South Buffalo www.nhssouthbuffalo.org (716) 823-3630</p>	<p>Services may include, but are not limited to insulation of attics and walls; heating system repairs or replacement; hot water tank and pipe insulation; installation of energy-efficient lighting and refrigerators; window and outside door repair or replacement, correction of ventilation problems that can lead to mold growth, and identification of lead paint hazards.</p>
<p>Neighbor For Neighbor Heat Fund</p> <p>The fund provides grants to assist individuals to:</p> <ul style="list-style-type: none"> Prevent disconnection of their utility service Pay current or past due energy bills. Purchase home heating fuel of any kind. 	<p>You may qualify if you are 55+ years old OR a member of the household must be handicapped or have a disability that reduces the household's income OR have a certified medical emergency OR be receiving unemployment benefits. Also, you must reside in National Fuel's service territory. However, you do not need to be a National Fuel customer</p>	<p>Proof of: identification, monthly income, and monthly expenses. Also, applicants must show proof that they have made an effort to make their utility payment (proof of at least four monthly payments over the past 12 months other than those provided by HEAP or other assistance programs)</p>	<p>Contact:</p> <p>The Salvation Army at (716) 883-9800 extension 230 or Catholic Charities at (716) 856-4494 or (716) 218-1400 (ask for Parish Outreach)</p> <p>NHS of South Buffalo www.nhssouthbuffalo.org</p> <p>Supportive Services Corp www.supportiveservices.org</p>	<p>Each Neighbor for Neighbor grant is determined by individual need, with a maximum amount of \$300. All grants go directly to the home heating supplier. A household can only receive one grant during a program year.</p>

TAX

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
<p>Earned Income Tax Credit (Fed/State)</p> <p>The Earned Income Tax Credit (EITC) is a benefit for working people with low to moderate income.</p>	<p>Individuals who have earned income and adjusted gross income within certain limits and meet certain rules.</p>	<p>Photo ID, Proof of SSN's for all, foreign status, if applying for an ITIN, birth dates for all, wage statements (Form W-2, W-2G, 1099-R, 1099-Misc) from all employers, interest income, copy of last year's federal and state returns, bank account number and routing number, total paid to daycare provider and the daycare provider's tax identifying number</p>	<p>You must file a tax return to claim EITC. Income Tax returns may be filed at a VITA site FREE of charge</p> <p>IRS information 1-800-829-1040 www.IRS.gov</p>	<p>Taxpayer Credit. EITC reduces the amount of tax you owe and may give you a refund</p>

TAX CONTINUED

<p>Voluntary Income Tax Assistance (VITA)</p> <p>IRS certified volunteers provide free basic income tax return preparation with electronic filing to qualified individuals.</p>	<p>For individuals who generally make \$53,000 or less, persons with disabilities, the elderly, and limited English speaking taxpayers who need assistance in preparing their own tax returns</p>	<p>Photo ID, Proof of SSN's for all, foreign status, if applying for an ITIN, birth dates for all, wage statements from all employers, interest income, copy of last year's federal and state returns, bank account number and routing number, total paid to daycare provider and the daycare provider's tax identifying number</p>	<p>VITA sites are generally located at community and neighborhood centers, libraries, schools, shopping malls and other convenient locations across the country. To locate the nearest VITA site near you, use the VITA Locator tool at www.irs.gov or call 800-906-9887.</p>	<p>Free basic income tax return preparation with electronic filing to qualified individuals.</p>
<p>Child Tax Credit</p>	<p>Must have a child under 17 years old that has lived with you more than half the year and does not provide more than half of support for themselves. Child must also be a U.S. citizen, U.S. national, or U.S. resident alien. Child must be claimed as a dependent on your federal tax return</p>	<p>Proof of: Income-W2 Child's citizenship or resident alien status. Tax Form 8332</p>	<p>Tax Form 1040 or 1040A must be completed.</p> <p>IRS 1-800-829-1040 or NYS taxes 1-800-225-5829</p> <p>www.irs.gov</p>	<p>Tax credit that may be worth as much as \$1,000 per qualifying child depending upon your income</p>
<p>Child & Dependent Care Credit</p>	<ul style="list-style-type: none"> Your child is under 13 years old and requires day care services A qualifying individual that is physically or mentally incapable of self-care has been living with you 	<p>To claim credit, you must meet criteria:</p> <ul style="list-style-type: none"> Have earned income and cannot pay another dependent for care. Child or dependent must have lived w/ you for more than ½ year. 	<p>Tax Form 2441 and 1040 or 1040A must be completed. More information can be obtained at: 1-800-829-3676</p> <p>www.irs.gov</p>	<p>The credit amount is a percentage of the amount of work-related expenses you paid to a care provider for the care of a qualifying individual. The percentage depends on your adjusted gross income</p>
<p>Education Credit</p> <p>Helps with the cost of higher education by reducing the amount of tax owed on your tax return. There are two different types of education credit:</p> <ul style="list-style-type: none"> <u>American Opportunity Tax Credit (AOT)</u> <u>Lifetime Learning Credit (LL)</u> 	<p>You, your dependent or a third party pays qualified education expenses for higher education. An eligible student must be enrolled at an eligible educational institution and must be you, your spouse, or a dependent you list on your tax return</p>	<p>Proof of Income-W2 form</p>	<p>Income Tax Form</p> <p>More information can be obtained at: www.tax.state.ny.us</p> <p>www.irs.gov</p>	<p>The American Opportunity Tax Credit can help parents and students pay part of the cost of the first four years of college. Maximum annual credit is \$2500 per student.</p> <p>The Lifetime Learning Credit can help pay for undergraduate, graduate and professional degree courses--including courses to acquire or improve job skills. The credit is worth up to \$2000 credit per tax return.</p>

TAX CONTINUED

NYS Household Credit	You cannot be claimed as a dependent on someone else's federal income tax. Filing status: Single <\$28,000 Families <\$32,000	Proof of income- W2 form	For Forms: 1-800-462-8100 Tax dept. info: 1-800-225-5829 IT-214 NYS Tax Rebate	Single-up to \$75 Joint-\$20-\$90 plus \$5-\$15 more per additional exemption claimed.
Real Property tax credit Tax credit or check to homeowners/ renters who pay a high % of income on rent/property tax.	Homeowners & renters who meet financial eligibility criteria; based on income, property taxes or amount of rent paid	Maximum yearly household gross <u>income</u> : <\$18,000 Adjusted average rent must not exceed \$450.	www.tax.state.ny.us	Households with at least one person over 65 can receive up to \$375. Households with members under 65 can receive up to \$75.

MISC.

PROGRAM	WHO GETS IT?	DOCUMENTS REQUIRED	HOW TO APPLY?	BENEFITS
Harvest House of South Buffalo Baby & Children's Ministry	Low income families	Clients must bring a Baby & Children's Ministry Referral Slip with them at their first visit, and a new referral slip is needed for each additional child not on the original form. Referral slips must be renewed every 3 years. ID is required each visit	175 Jefferson, Buffalo, NY (716) 824-7818 Baby & Children's Ministry www.harvesthouse.ws/	Provides FREE clothing, safe cribs, car seats, strollers, toys, books, etc.

HELPFUL WEBSITES:

www2.erie.gov/socialservices For information on all Social Services programs

www.mybenefits.ny.gov This website is a prescreening tool which provides a quick and easy way for people who live in New York State to find out if they might be able to receive:

- ✓ Help with buying food
- ✓ Temporary Assistance (TA)
- ✓ Special tax credits
- ✓ Home Energy Assistance
- ✓ Weatherization Assistance Program (WAP)
- ✓ Various Health Insurance programs for individuals, families, children, and sole proprietors
- ✓ WIC - Women, Infants and Children
- ✓ HIV Uninsured Care Program
- ✓ A wide variety of services for older New Yorkers, including:
 - Health insurance information, counseling and assistance (HIICAP)
 - NY Connects-Information on long term care and assistance in linking to services
 - Legal assistance
 - Nutritional services
 - Help with the purchase of prescription drugs

This website will take you about 10 minutes to use. When you're finished, it will tell you if you might be able to receive help through programs such as Supplemental Nutrition Assistance Program.

200% of Federal Poverty Guidelines Chart (Income eligibility guidelines for Child Care Assistance) June 1, 2015 through May 31, 2016		
Family Size	Monthly	Annual
1	\$1,962	\$23,540
2	\$2,655	\$31,860
3	\$3,348	\$40,180
4	\$4,042	\$48,500
5	\$4,735	\$56,820
6	\$5,428	\$65,140
7	\$6,122	\$73,460
8	\$6,815	\$81,780

Employment Orientation

- Erie County has a Work First policy.
 - As an applicant for, or recipient of, Temporary Assistance you must:
 - Continually look for a job, even if you are not assigned to do so, and be prepared to provide evidence that you have been looking for employment.
 - Accept a job offer when one is available.
 - Participate in assessment of your ability to work and participate in work activity assignments.
 - Participate in work activities as assigned by the Department of Social Services, unless a determination has been made that you are exempt from work activities. You may also be required to get a medical examination or medical statement to participate in a work activity assignment to verify that you have a medical condition that prevents you from working.
 - If a determination has been made that you are exempt from participation in work activities, you may be required to accept medical care or other employment services to restore your ability to work. You may also be required to attend a meeting with the Department of Social services staff to provide evidence to determine whether or not you continue to be exempt from work requirements.
- Employment Counselors will evaluate your job skills and ability to work and will conduct a New York State drug and alcohol screening with you.
- As an applicant you will be assigned to a job search activity. This will be a three (3) week supervised job search to help you find employment.
- If you do not find an employment, and your Temporary Assistance case opens, you will be placed in a work activity.
 - You may be required by state and federal law to participate in work activities up to forty (40) hours a week to gain skills and experience.
 - Work experience provides participants with an opportunity to acquire the general skills, training, knowledge and work habits necessary to obtain and retain employment.
 - Your assignment will continue until you find a job, you are determined to be exempt, or your case closes.
 - The Employment Division Staff will assist you with supportive services such as child care and transportation during your assigned work activity.
- **If you do not comply with employment requirements, job search or the medical evaluation process your application may be denied.**
- **It is very important that you be early or on time for all appointments.** Failure to do so without good cause may result in the denial of your application. If denied, you will be required to file a new application.
- You are responsible for the repayment of student financial aid.

- If your Temporary Assistance case opens and you are approved, you may be eligible for remedial education or vocational training at no cost to you.
- You must cooperate with Department of Social Services in establishing paternity and collecting support.
- If you are under 18 and you are a parent who is not married and who is caring for a child and have no children under twelve weeks of age, you must be enrolled in an educational activity. This includes working towards a high school diploma or its equivalent (if you have not completed high school), or participating in an alternative educational program approved by your Employment Counselor. When you find employment and your Temporary Assistance case closes, you may be eligible for transitional child care.
- Temporary Assistance is subject to the follow time limits in New York State:
 - 5 years (60 months) for families with children
 - 2 years (24 months) for single individuals and childless couples.

Signature _____ **Date** _____

ERIE COUNTY COMPREHENSIVE EMPLOYMENT DIVISION

() 290 Main Street, Room _____

() 158 Pearl Street, Room _____

Buffalo, New York 14202

THIS WILL INTRODUCE: _____

APPLYING FOR POSITION OF: _____

TO SEE: _____

NAME OF COMPANY/AGENCY: _____

ADDRESS: _____

DATE: _____ TIME: _____

APPLICANT ELIGIBLE FOR:

- () **TEAP ON-THE-JOB TRAINING** (Training and employment assistance program)
- () **PIVOT** (placing individuals in vital opportunity training)
- () **InVEST** (individual vocational education and skills training)
- () **WOTC** (work opportunity tax credit)

REFERRED BY EMPLOYMENT COUNSELOR: _____

TELEPHONE NUMBER: _____ DATE: _____

* * * * *

TO BE FILLED OUT AND RETURNED BY EMPLOYER

APPLICANT'S NAME: _____

COMPANY/AGENCY: _____

() HIRED STARTING DATE: _____

() NOT HIRED REASON: _____

() DID NOT REPORT FOR INTERVIEW ON DATE:

HIRING OFFICIAL: _____ DATE: _____

() WOTC VOUCHER COMPLETED AND SENT TO NYSDOL

EMPLOYMENT COUNSELOR: _____

ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES

EMPLOYMENT COMPLEX
 290 MAIN ST. - 5th FLOOR
 BUFFALO, NEW YORK 14202

- () Date
- () Case Number
- () Category

Dear Recipient:

The training program you are enrolled in at _____

- Has been Denied - Reason _____
- Has been Approved from _____ to _____

You will be receiving a TANF Employment Related Training allowance for this period. It is to assist you in meeting your educational and/or training needs.

You will receive a once-only allowance of \$ _____ to cover the period _____ to _____

(Please allow at least 10 days for processing)

- You will receive a recurring, semi-monthly allowance of \$ _____ to cover the period _____ to _____
- This allowance is for: Transportation Other _____

You will **not** receive an employment related training allowance because:

- Grant information incomplete on B-1383
- No schedule submitted
- Grants exceed costs of tuition fees, books and supplies
- Other _____

REMINDERS

1. Each semester or session you must provide this office with the following:
 - (A) Verification of enrollment and financial aid (B-1383).
 - (B) An official copy of your school schedule showing your hours.
 - (C) A copy of your report card or transcript.

2. Your monthly attendance must be 100% according to TANF regulations. If your attendance falls below this point for any given month you will be required to provide a valid excuse for the poor attendance **or** face possible sanction procedures. This can result in a loss of or reduction in your Public Assistance.

3. When you leave or complete the program you will need to contact your employment counselor and provide:
 - (A) Date and reason for leaving if you did not complete the program requirements.
 - (B) A copy of your certification, diploma or degree.

If you have any question regarding your allowance, or the TANF Program requirements, please call *your* Employment Counselor at 858-_____.

Sincerely,

 Employment Counselor

NAME:	ADDRESS:	CASE NUMBER:
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SNAP IMPLICATIONS: This notice applies only to your requirements to participate in temporary assistance work activities. You may or may not be required to participate in SNAP Employment and Training (FSET) activities. You were notified of the SNAP employment responsibilities and exemptions in the LDSS-4148A: *What You Should Know About Your Rights and Responsibilities, Book 1*. If you have any questions about your SNAP employment requirements, ask your worker.

CONFERENCE AND FAIR HEARING SECTION – DO YOU THINK WE ARE WRONG?

If you think our decision was wrong, you can ask for a review of our decision. If we made a mistake, we will correct it. You can do both 1 and 2:

- 1. Ask for a meeting (conference) with one of our supervisors;
- 2. Ask for a State fair hearing with a State hearing officer.

1. **CONFERENCE** (informal meeting with us) – If you think our decision was wrong, or if you do not understand our decision, please call us to set up a meeting. To do this, call the conference phone number on the front of this notice or write to us at the address on the front of the notice. Sometimes this is the fastest way to solve any problem you may have. If you ask for a conference you are still entitled to a fair hearing. If you do not want to have to comply with work requirements until a fair hearing decision is issued, you must request a fair hearing in the way described below. A request for a conference alone will not remove your requirements to participate in work activities.

2. STATE FAIR HEARING – YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

HOW TO ASK FOR A FAIR HEARING: You can ask for a fair hearing by mail, by phone, by fax or online.

Mail: Send 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, I do not agree with the agency’s action. (You may explain why you disagree below, but you do not have to include a written explanation.)

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

Fax: Fax a copy of the front and reverse of this notice to: (518) 473-6735 or

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

If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax or online, please write to ask for a fair hearing before the deadline.

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice that tells you when and where the fair hearing will be held. At the hearing, you will have a chance to explain why you think our decision is wrong. You can bring a lawyer, a relative, a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing. At the hearing, you and your lawyer or other representative will have a chance to explain why we are wrong and a chance to give the hearing officer written papers that explain why we are wrong.

To help you explain at the hearing why you think we are wrong, you should bring any witnesses who can help you. You should also bring any papers you have, such as: pay stubs, leases, receipts, bills, doctor’s statements. At the hearing, you and your lawyer or other representative can ask questions of witnesses which we bring or which you bring to help your case.

LEGAL ASSISTANCE: If you think you need a lawyer to help you with this problem, you may be able to get a lawyer at no cost to you by contacting your local Legal Aid Society or other legal advocate group. For the names of other lawyers, check your Yellow Pages under “Lawyers”.

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 that we will give to the hearing officer at the fair hearing. Also, if you call, write or fax to us, we will provide you with free copies of other documents from your file that 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 phone number on the front of this notice or write to us at the address on front 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 phone numbers on the front of this notice or write to us at the address on the front of this notice.



County of Erie

MARK C. POLONCARZ
COUNTY EXECUTIVE
DEPARTMENT OF SOCIAL SERVICES

____/____/____

COMPREHENSIVE EMPLOYMENT DIVISION

Dear _____:

You will be receiving an **Employment Related Training Allowance** in the amount of \$_____. This allowance covers the time period from: _____ through: _____. (Please allow 10 days for processing.)

This allowance is for:

- Transportation
- Special Needs/Other (specify below)

Effective _____ through _____, your Financial Assistance Worker will continue your allowance money at \$_____ per month.

Please note: It is recommended that you purchase a monthly bus pass with the transportation allowance.

If you have any questions regarding the amount of allowance you will receive or the time period for which you will receive the allowance, please call your Employment Worker at _____.

Sincerely,

Employment Worker

Job Search Log

The conciliation process includes the opportunity to avoid the SNAP sanction by demonstrating compliance with employment requirements. You may show compliance by completing at least 5 job applications and returning this completed Job Search Log to your Employment Counselor by ____/____/____. Failure to complete this document in full or provide good cause for your non-compliance may result in a SNAP benefit sanction.

NAME:	CASE #:
--------------	----------------

1.) Employer: _____
Address: _____
Contact person: _____
Position applied for: _____ Date _____

2.) Employer: _____
Address: _____
Contact person: _____
Position applied for: _____ Date _____

3.) Employer: _____
Address: _____
Contact person: _____
Position applied for: _____ Date _____

4.) Employer: _____
Address: _____
Contact person: _____
Position applied for: _____ Date _____

5.) Employer: _____
Address: _____
Contact person: _____
Position applied for: _____ Date _____

All information reported on this document is true and accurate and I understand that this information is subject to verification for determining compliance.

Signature _____ Date _____

MEDICAL EXAMINATION FOR EMPLOYABILITY ASSESSMENT, DISABILITY SCREENING, AND ALCOHOLISM/DRUG ADDICTION DETERMINATION

I. CLIENT IDENTIFICATION

Print Client Name: _____ Veteran: Yes No

Address: _____

Case #: _____ CIN: _____ DOB: _____

Reason(s) for referral: Client states that: _____

II. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the examining health care practitioner to disclose to the Department of Social Services any information provided, any diagnoses made, conditions revealed, functional limitations and any prognoses identified, as a result of the examination given. I understand that this information will be treated as confidential.

Client Signature x _____ Date: _____

AUTORIZACIÓN DE REVELACIÓN DE DATOS MÉDICOS

Autorizo al médico examinador a revelar al Departamento de Servicios Sociales todo dato relativo a diagnósticos, afecciones médicas, limitaciones funcionales y todo pronosis detectado como resultado del examen realizado. Entiendo que estos datos son de carácter confidencial.

Firma del Cliente x _____ Fecha: _____

III. MEDICAL INFORMATION

List all medical conditions. Include psychiatric and alcohol/drug addiction diagnosis using DSM-IV format. (List all medical diagnoses and specify medical/clinical findings, including prognoses and how long each condition is expected to last.)

Medical Condition	Prognosis and Treatment Recommendations including prescribed medications	Date of original diagnosis/diagnosis type	Expected Duration From Present (Months)
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent
		Date: <input type="checkbox"/> Physical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Other	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-11 <input type="checkbox"/> 12+ <input type="checkbox"/> Permanent

IV. FUNCTIONAL LIMITATIONS (related to medical findings noted in Section III): (check column that applies)

a.) Physical Functioning	No Evidence of Limitations	Moderately Limited	Very Limited	b.) Mental Functioning	No Evidence of Limitations	Moderately Limited	Very Limited
Walking				Understands and remembers instructions			
Standing				Carries out instructions			
Sitting				Maintains attention/concentration			
Lifting, Carrying				Makes simple decisions			
Pushing, Pulling, Bending				Interacts appropriately with others			
Seeing, Hearing, Speaking				Maintains socially appropriate behavior without exhibiting behavior extremes			
Using Hands				Maintains basic standards of personal hygiene and grooming			
Stairs or other climbing				Appears able to function in a work setting at a consistent pace			
Other:				Other:			

V. TREATMENT HISTORY (list for medical, psychiatric, alcoholism and drug treatment for the past Two Years)

Name of Program/Provider	Type of Program/Provider i.e. Outpatient, Residential, Methadone (for addiction specify modality)	Length of Treatment (# of Months)
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. CURRENT TREATMENT PROGRAM IDENTIFICATION (include medical, psychiatric, alcoholism and drug treatment as applicable.)

Program Name: _____
 Address of Client's Treatment Site: _____
 Mailing Address (if different from above): _____
 Treatment Program Contact: _____ Title: _____
 Telephone #: () _____ Fax #: () _____

VII. LIMITATIONS ON WORK ACTIVITIES

- a. Taking into consideration physical, mental and addiction limitation(s), describe any working conditions, environments, or work activities which are contraindicated: _____
- b. Are these restrictions expected to last: 1-3 months 4-6 months 7-11 months 12+ months permanent
- c. Do you recommend referral to rehabilitation, including but not limited to, a mental health or alcohol/substance abuse, or a physical rehabilitation program? Yes No If yes, please specify: _____

VIII. SCREENING FOR POSSIBLE SSI REFERRAL

Based on the evidence available to you, does this individual have severe impairment(s) which has lasted, or is expected to last at least 12 months? IF YES, please check _____ Explain briefly: _____

_____ If substance abuse is also found, would such impairment be expected to continue if use of drugs and/or alcohol were to cease? Yes No

IX. HEALTH CARE PRACTITIONER'S INFORMATION

Health Care Practitioner's Name (please print): _____ Medical Position: _____
 Address: _____
 If a physician, Board eligible or Board certified specialty: _____ Tele.#: () _____ Fax #: () _____
 Is this client a patient of the examining health care practitioner? Yes No If yes, for how long? _____
 Date of Last Examination: _____
 Signature of health care practitioner: X _____ Date: _____

Please forward this completed form to Social Services Contact: _____
 Telephone #: _____ Address: _____