MANUAL MATERIAL TRANSMITTED					
MANUAL: INCOME MAINTENANCE			CHANGE NUMBER: 169		
DELETE			INSERT OR CHANGE		
PAGES	CHAPTER	DATED	PAGES	CHAPTER	DATED
ENTIRE CHAPTER	1		i - xv	1	5/2000
i - xv	1				
1 - 124 - 124a	1		1 - 114	1	5/2000
125 - 140	1		115-130	1	5/2000
53 - 54	11	12/97	53 - 54	11	5/2000
FORM OFS-5		11/98		FORM OFS-5	5/2000
FORM ES-PW-2		7/94		FORM OFS-PW-2	5/2000
FORM IM-MS-1					
FORM CAO-40					
FORM ES-FS-3a					
FORM ES-PW-4		7/94		FORM OFS-PW-4	5/2000
			NEW	FORM OFS-CI-1	5/2000
DATE: MAY, 2000		TO: ALL INCOME MAINTENANCE MANUAL HOLDERS			

This change revises Chapter 1 to delete outdated references to the C-219 and M-219 systems, incorporate new RAPIDS terminology and procedures where appropriate, and update references to forms that have been revised. The entire Chapter has been re-paginated to eliminate gaps in the text.

In addition, the following specific policy changes have been made.

Sections 1.2,B and C: References to the CAF and ES-2 have been changed to OFS-2. Since the CAF is actually an OFS-2 that has been printed by RAPIDS, the term CAF is being replaced by OFS-2 on the system generated form. The OFS-RR-1 is now a separate section. A statement has been added to require signature of the OFS-RR-1 in the presence of the Worker.

Section 1.2,D: A statement has been added concerning the requirement to attach form OFS-CI-1 to any case information that is released to another agency or organization.

Section 1.2,F: A clarification was made to the NOTE concerning prorated months when an ABAWD moves to West Virginia from another state.

Section 1.10: Form ES-PW-4 and ES-PW-2 have been revised and are now the OFS-PW-4 and OFS-PW-2. Spaces referring to old M-219 data blocks were removed. All copies of the old forms must be destroyed.

Section 1.15: A statement on the limitation of QI-2 applications was added.

Section 1.21,5,2: Spenddown information is entered on Screen AGTM, so the IM-MS-1 is obsolete.

Section 1.24,F: A statement has been added concerning the retention of the original redetermination period when a change is made in coverage groups.

Section 1.25,M: Clarification was added to state that the beginning date of eligibility begins on the first day the AG meets all eligibility requirements.

Section 1.25,S,2: A note was added about AG's approved for DCA being categorically eligible. In item a clarification was added concerning the determination of the DCA amount. The maximum amount for the AG size is used, with no deductions or incentives applied.

Section 11.5,A,4: Terminology has been changed to reflect expanded categorical eligibility.

Form OFS-5 has been revised to include spaces for case name and number. The old forms may be used until a new supply is printed.

Policy questions should be directed to the OFS Policy Unit. Questions about RAPIDS coding should be directed to the RAPIDS Help Desk.

Work-Around 00-03 - FS Categorical Eligibility (IM Manual Section 1.4,R,3)
RAPIDS will: Only those FS AG's which consist of entirely of WV WORKS and/or SSI recipients will be considered Categorically Eligible for FS in RAPIDS.

Work-Around: For all FS applications, determine offline if the AG is Categorically Eligible. Run eligibility. If the FS AG fails inappropriately, use AGOE to override the fail to pass. Remove the failure reason codes on AGOE and enter the appropriate reason code for categorical eligibility from the table below. Validate the results on AGEC and confirm. System-generated notices will be correct.

Federal reporting requires us to specify receipt of which benefit(s) causes Food Stamp Categorical Eligibility. Therefore, when receipt of a benefit causes the Food Stamp AG to be Categorically Eligible, a reason code specific to that benefit must be set for reporting purposes. When multiple reasons for Food Stamp Categorical Eligibility exist, all applicable codes should be set. This includes those situations where Categorical Eligibility is determined by RAPIDS. During the Work-Around phase, the worker must enter all applicable reason codes on AGOE.

Code	Reason	Comments
620	Cat. Eligible for FS - All AG Members Receive SSI	Entered by the worker when all AG Members Rec SSI. Currently determined by RAPIDS but no code is entered.
621	Cat Eligible for FS - All AG Mbrs Rec WV WORKS	Entered by the worker when all AG Members Rec WV WORKS. Currently determined by RAPIDS but no code is entered.
622	Cat Eligible for FS - All AG Mbrs Rec SSI and/or WV WORKS	Entered by the worker when all AG Members Rec SSI and/or WV WORKS. Currently determined by RAPIDS but no code is entered.
623	Cat. Eligible for FS - Due to receipt of WV WORKS	Entered by the worker when at least one but not all members of the AG receives WV WORKS.
624	Cat. Eligible for FS - Due to receipt of DCA	Entered by the worker when at least one member of the AG receives DCA.
625	Cat. Eligible for FS - Due to receipt of Support Service Pymt	Entered by the worker when at least one member of the AG receives Support Service Payments.
626	Cat. Eligible for FS - Due to receipt of SCA	Entered by the worker when at least one member of the AG receives SCA.

1.1 INTRODUCTION

This Chapter describes the application and redetermination processes for the Food Stamp Program, WV WORKS and all Medicaid coverage groups, except those related to long-term care. See Chapter 17. Also included is specific information about each benefit.

General requirements that are not specific to any Program or coverage group are included together. The general section is followed by a section describing all of the Department's application forms. Policies and procedures specific to each Program or coverage group are also included.

Data entry intructions for all programs are in the RAPIDS User Guide.

The application may be held, pending receipt of necessary information or verification, but there are processing time limits which must be met. All applications must have a final disposition and the client must be notified of the decision.

2. Redetermination Process

Periodic reviews of total eligibility for recipients are mandated by law. These are redeterminations and take place at specific intervals, depending on the Program or coverage group. Failure by the client to keep an appointment for a redetermination usually results in ineligibility. If the client keeps his appointment and continues to be eligible, benefits must be uninterrupted and received at approximately the same time.

The redetermination process involves basically the same activities described in item 1 above. Data system changes and client notification of any changes resulting from the redetermination conclude the process.

3. Case Reviews and Case Maintenance

While a redetermination is a required periodic review of total eligibility, a review may be conducted at anytime on a single, or combination of questionable eligibility factor(s).

The case maintenance process may involve a review or activities that update the Department's information about the recipient's circumstances between the application and first redetermination and between redeterminations. Changes in eligibility or the benefit amount may occur. If so, data system action and client notification of any changes are required.

Some special situations may require a more formal review process. This may be a special procedure to target an error problem.

NOTE: See Chapter 2 for detailed information regarding the case maintenance process.

- Inform the client of the benefits the Department offers.

- Accept an application from any person or his representative who wishes to apply.

- Ensure the client is given the opportunity to apply for all of the Department's Programs on the date that he expresses an interest.

- Obtain all pertinent, necessary information through verification, when appropriate.

- Inform the client of his responsibilities, the process involved in establishing his eligibility, including the Department's processing time limits, and how the beginning date of eligibility is determined.

- Adhere to the Department's policies and procedures to establish eligibility, including those regarding timely action and/or decision.

- Assist the client in obtaining information required to establish his eligibility.

- Maintain the confidentiality of all information received from or about the client.

  EXCEPTION: Written requests for information about Food Stamp recipients from federal, state or local law enforcement officers is provided when the officer provides verification that:

  - The individual is fleeing to avoid prosecution, custody or confinement for a felony; or

  - The individual is violating parole or probation; or

  - The individual has information necessary for the officer to conduct an official duty related to either of the two statements immediately above.

  The Worker provides only the individual's last known address and SSN and, if available, a photograph of any member of the individual's household. It is the responsibility of the CSM to review and approve the release of all such information.

separate file regarding domestic violence may be presented as evidence at a Fair Hearing, so long as the client agrees to use of the information for such purpose.

- Ensure that proper case recordings are made to document the Worker's actions and the reason for such actions.

  NOTE: Information about a domestic violence situation or the whereabouts of an individual or family who has left a domestic violence situation for a safer residence must never be recorded in the case record in order to insure the safety of the individual or family. If it is necessary to make contacts with a domestic violence agency or Social Services in conjuction with a temporary exemption from work requirements for WV WORKS, the information must be maintained in a separate file which is secured and available only to Supervisors. Information maintained in a separate file regarding domestic violence may be presented as evidence at a Fair Hearing, so long as the client agrees to use of the information for such purpose.

- Ensure that information about available community resources addressing domestic violence is available to all persons who request it, or who, in the Worker's judgement, may benefit from it. In addition, the Worker must make an immediate referral to the appropriate domestic violence or community agency when the client requests such assistance. When possible, the referral must be made the same day. If the agency cannot make arrangements to see the client the same day, a referral to Social Services must be made the same day, if possible.

E. CLIENT RESPONSIBILITY

The client's responsibility is to provide information about his circumstances so the Worker is able to make a correct decision about his eligibility. When the client is not able to provide required verification, the Worker must assist him. The client must be instructed that his failure to fulfill his obligation may result in one or more of the following actions:

- Denial of the application

- Closure of the active AG

- For WV WORKS cases: the Worker must determine how many months the client received TANF payments in the other state.

  NOTE: States have until July, 1997 to convert from AFDC/U to a TANF-funded program. Therefore, for benefits received prior to 7/97, the Worker must also determine how many months of the cash assistance payments were funded under TANF. Appendix C contains information about when other states converted to TANF funding.

- For Food Stamp cases with ABAWDs only: The Worker must contact the other state to determine and record when the individual's 36-month period began, how many months of his 3-month limit without meeting the work requirement he has used, and if any of the benefits he received were prorated.

  NOTE: Counting months for which benefits were prorated toward the 3-month limit, is an option for each state. If the client's previous state of residence include a month of prorated benefits the Worker asks only for the number of whole months of receipt. Therefore, regardless of the option chosen by the other state, the Worker must not count a prorated month.

  If he is residing in an ILC, eligibility must be determined according to Section 9.1,A,2,j. If he is residing in an NILC, the time limit does not apply, but he retains the 36-month period which began in the other state.

- Whether or not the client owes a repayment to any Program

Each Program has specific requirements related to receipt of benefits from other states. Refer to Date of Application under each Program section below.

G. CONTINUATION OF THE CASE NUMBER AND TRANSFER OF A CLOSED CASE

Prior to data system entry for disposition of any application, the Worker must determine if there is an existing case number for the client.

When an existing case number is found in a any other county, the Worker must request immediate data system transfer to the client's new county of residence. The case record must be mailed to the new county of residence

- Screening the client for all OFS benefits and explaining that he may be eligible for more than one benefit. The client must be given the opportunity to apply for any Programs in which he expresses an interest, even if the Worker is able to pre-determine his ineligibility.

- Reviewing the OFS-2 to make certain that the client understood each question and answered to the best of his ability. If the client is unable to complete the form himself, and there is no one else to help him, the Worker must complete the form based on information provided by the client.

- Explaining the applicant's responsibility to provide complete and accurate information and the penalties for failure to do so.

- Discussing all statements On the OFS-RR-1 with the client to be sure he understands each one and marks each appropriately.

- Explaining fully the benefits of the Program(s) for which the client applies. This includes: when benefits are received, how received, description of the benefit, how to use the benefit, as well as any other pertinent information related to receipt and use of the benefit.

- Explaining how eligibility for the Program(s) is determined and, if applicable, how the amount of the benefit is computed.

- Explaining the applicant's responsibility to report changes in his circumstances.

- Providing the applicant with a list of verifications needed to determine eligibility, using form ES-6 or the RAPIDS verification checklist. He must also be told the penalty for failure to provide the verifications and what he must do if he finds he cannot obtain it by the deadline.

- Explaining other resources within the agency from which the client may benefit.

- Finding resources to meet the client's emergency needs by referral to a community resource or by an application for Emergency Assistance.

submitted by mail. Most Programs and coverage groups still require a face-to-face interview. This may be accomplished by the client's visiting the office, by his appointment of an authorized representative to apply on his behalf or by the Worker's making a home visit. Whether or not a face-to-face interview is required is found in Program-specific sections of this Chapter, along with any information which is specific to a particular Program or coverage group. The following is a general description of the mail-in application process.

NOTE: The same basic process applies when the client or his representative picks up and/or drops off an application for the client, without a contact with the Worker, and when the client requests in writing that an application form be mailed to him. The following description does not indicate which form is mailed, because the form depends upon the benefit for which the client wants to apply. The appropriate forms are shown with each Program and coverage group found in the Program-specific sections which follow.

- If an individual telephones a DHHR county office to request an application be mailed to him, the Worker will inform him of the following:

  - If he wishes, a Worker will complete the application for him in a face-to-face interview, either in the office or in his home; and

  - The mail-in application procedure will result in a delay in processing his application due to a delay in receipt of the form through the mail, and a possible face-to-face interview.

- If the individual still prefers to make an application by mail, an application form is mailed to him on the date of his telephone call. If the client requested the application by letter, an application form is mailed to him on the day the letter is received in the county office.

  When the application form is returned and contains at least the applicant's name, address and signature, an application has usually been made and the policy and procedures concerning the formal disposition of the application are applicable.

  EXCEPTION: Poverty-Level pregnant women must also have all verification included with the application form. See the Program-specific section for these cases.

- To withdraw the application at the client's verbal or written request or when he refuses to sign the application form; or

- To deny the application when at least one eligibility requirement is not met or the client has failed to establish eligibility.

- The client is notified of the action taken.

- The client receives his initial benefit, if eligible.

N. COMMUNICATION WITH SSA

Each CSM is responsible for appointing a contact person to communicate with a contact person in the local SSA Office. This contact person does not interpret policy, but works out communication problems and any problems dealing with the completion and forwarding of forms, including those involved in the joint application process for Food Stamps. The Department's contact works directly with the contact from SSA.

Any matters that cannot be worked out between the county office and the SSA contact person are referred to the OFS Policy Unit and to the SSA District Office by the appropriate staff.

O. DOMESTIC VIOLENCE ASSISTANCE

Information about community resources that address the issue of domestic violence must be readily available in each waiting room of each county office. The information must be written and must be available for the client to take with him discreetly, without having to ask for it. In addition, the Worker must provide such information when it is requested and must offer it to any person who, in the Worker's judgement, could benefit from it. When possible, this must be accomplished during the office interview. In order to insure the safety of the individual to whom information about dometic violence is given, it is suggested that the domestic violence information be part of a packet which contains a variety of information. If, during the interview, the Worker observes language or other behavior which is threatening and discussion of such matters could pose a possible threat to the person who is judged to be in need of information the Worker must avoid direct discussion with the client. In those instances, a referral to the local domestic violence program, other available community resource or to Social Services is in order so that a

1.3 APPLICATION FORMS

The forms listed below are used to make an application for the Food Stamp, WV WORKS and Medicaid Programs. Within the Medicaid Program, some coverage groups use special forms. No Program-specific instructions for completion or usage are described here. Refer to application procedures under each Program and coverage group.

A. OFS-2

The OFS-2 serves these purposes:

- It is used for gathering client information. This data is used to determine eligibility and the need for other services offered by the Department.

- It is a fact sheet containing relevant information about the AG and other members of the household who are not included in the benefit.

- It serves as a legal document and may be used in any court case.

1. OFS-2 Generated by RAPIDS

The OFS-2 is generated by RAPIDS after completion of the interactive interview and is the primary application form. Since this form is used for all 3 major Programs, denial of an application for one Program may lead to approval for another.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents printing the OFS-2, Form OFS-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed OFS-2. The OFS-RR-1 must also be completed and signed. He must not be required to return to the office to sign the OFS-2 when an OFS-5 has been signed.

NOTE: Even though Poverty-Level pregnant women and children, CHIP, QC's, QMB's, SLIMB's, QI-1's and QI-2's have separate application forms, these special forms need not be completed if a CAF is completed for another Program or coverage group. However, when the client is only interested in applying for one of these programs, that special application is used as found below.

E. CHIP-1

The CHIP-1 is used to apply for CHIP I and CHIP II. If an eligible Poverty-Level Pregnant Women, Poverty-Level Child or QC are listed on CHIP-1, an OFS-PW-4 is not required. No OFS-RR-1 is required.

F. REAPPLICATIONS NOT REQUIRING A NEW FORM

NOTE: When an application has been made for WV WORKS and/or Medicaid and the application is denied, withdrawn or approved for DCA, the AG must not be required to make an additional application for Food Stamps. Food Stamp eligibility must be determined based on the information provided for the other programs.

NOTE: AG's reopened without completion of an application form must remain in the same redetermination cycle in effect when the case was last closed. The only exception is for Medicaid AG's for which the last case action was a denial due solely to failure to meet spenddown within the application processing time limit. In this case, the POC and/or POE is backdated, if appropriate, based on the date the client requests reconsideration of his application.

Reapplications do not require completion of a new application form when all of the following conditions are met:

- The reapplication occurs no later than the end of the second month following the month of the most recent case closure.

  EXAMPLE: A Food Stamp application is denied on February 25 for failure to provide requested verification. The client reapplies April 28. Since this is within the second month following the month of closure, no new application form is required.

- The case was closed for reasons other than failure to complete a redetermination, and a redetermination was not due the effective month of closure.

- The AG, Needs Group and Income Group composition, income and other eligibility factors have not changed appreciably.

- The deprivation factor (AFDC or AFDC Related Medicaid) or category of relatedness (Medicaid) has not changed.

EXAMPLE: A WV WORKS recipient does not receive Food Stamps at the time of approval in November. In January, she decides to apply for Food Stamps. In checking the case record, the Worker finds that the OFS-2 mentions that there are two of her adult nephews in the home, but that information about their income and assets was not collected, since it was not needed for the WV WORKS application. Since the food is purchased and prepared for everybody together, the nephews are required to be included in the same Food Stamp AG. Since the latest OFS-2 does not reflect any information about the nephews, a new OFS-2 is required for the Food Stamp application.

EXAMPLE: Same situation as in the Example above except that the nephews have no income or assets. A new OFS-2 is still required to reflect the circumstances of the nephews.

EXAMPLE: An AFDC-Related Medicaid client applies for Food Stamps after receiving Medicaid only for several months. The OFS-2 used to approve the Medicaid shows that the OFS-RR-1 section dealing exclusively with the Food Stamp Program was not previously completed. The OFS-2 cannot be altered once it is signed by the client. Therefore, a new OFS-2 and OFS-RR-1 are required.

NOTE: At redetermination for one Program or coverage group, the client may want to apply for an additional benefit. If so, the same OFS-2 is used as an application for the new benefit and a redetermination for the active case, regardless of the Program or coverage group.

- Categorically Eligible AG's, as defined in item R,3, do not require a new form when all of the following conditions are met:

  - There is a WV WORKS application pending; and
  - Food Stamp benefits were denied; and
  - Subsequent to the denial, they are determined eligible to receive WV WORKS; and
  - The AG is otherwise Categorically Eligible.

  The Worker provides benefits using the original application and any other pertinent information provided subsequent to that application. Benefits are paid from the date for which WV WORKS eligibility is established or the date of the original Food Stamp application, whichever is later. Changes must be recorded in CMCC.

- When an individual's Food Stamp work requirement penalty expires, or he becomes exempt, he is added to the AG without having to complete an application, unless he is the sole AG member.

- When an ineligible ABAWD begins a new 36 month clock, becomes exempt, or the county he resides in becomes on NILC, unless he is the sole AG member.

- When the case is closed for failure to return the ES-FS-2 as a 12-month review (See Section 2.2,B), an OFS-2 is not required when the completed ES-FS-2 is returned by the last day of the 13th month.

B. COMPLETE APPLICATION

When the applicant signs an OFS-2 or OFS-5 which contains, at a minimum, his name and address, his application is complete, and must be acted upon.

An application is considered incomplete when the applicant chooses not to sign the OFS-2. When this occurs, it is a withdrawal and appropriate data system action and client notification must be completed. The recording in Case Comments must specify that the client did not want to sign the application and the reason for his decision. The client should always be encouraged to sign the application to avoid a misunderstanding that he was denied the right to apply.

The Worker must send written notification to the affected AG and the authorized representative 30 days prior to the date of the disqualification. The letter must include: the fact that disqualification of the authorized representative is proposed, the reason for the action, the AG's right to a Fair Hearing, the telephone number of the office and the name of the person to contact for additional information.

This disqualification provision does not apply to drug and alcoholic treatment centers and GLF's which act as authorized representatives for their residents.

F. WHO MUST SIGN

More than one signature is never required for a Food Stamp application.

If an applicant for, or recipient of WV WORKS is applying for Food Stamps, Food Stamp benefits cannot be denied solely because of the absence of the two signatures required for WV WORKS. The rules governing who must sign are the same as below.

The individual who is interviewed signs the application. If more than one individual is interviewed, both may, but are not required, to sign.

G. CONTENT OF THE INTERVIEW

All Food Stamp applicants must be screened for Expedited Service on the day the application is made, whether the client is applying for Food Stamps only or Food Stamps in combination with any other Program.

NOTE: The applicant may bring any person he chooses to the interview.

All individuals who apply for Food Stamps are interviewed in a face-to-face contact, unless the application is taken by SSA, or unless the Food Stamp applicant requests the office interview be waived due to the following:

- He is unable to appoint an authorized representative; and

- There is no AG member able to come to the office because of transportation difficulties or similar hardships. Hardship conditions include, but are not limited to, illness, care of a benefit group member, hardships due to residence in a rural area, prolonged severe weather, work or training hours which prevent participation in an office interview.

checklist to the applicant and note that the application is pending. When the information is received, benefits are retroactive to the date of application.

When the client fails to appear for a scheduled intake interview, the Worker must reschedule the initial interview within 30 days following the date of application.

If the agency failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the agency acted in a timely manner.

EXAMPLE: Application was made November 2. The pending information was received November 17, but the Worker overlooked the application until December 17. It was processed on December 17 when the Worker discovered the error. The client was found eligible. The client is issued benefits retroactive to November 2.

K. PAYEE

The term payee identifies the individual whose name is entered as the primary person in RAPIDS.

L. REPAYMENT AND PENALTIES

1. Repayment

When the Worker discovers a Food Stamp overpayment has occurred or there is an outstanding claim, a referral is made to IFM upon approval. See Chapter 20.

2. Penalties

Individuals who have committed an Intentional Program Violation (IPV) are ineligible for a specified time, determined by the number of previous IPV disqualifications. See Chapter 20.

The Worker must determine if any member(s) of the applicant AG has been disqualified and the length of the disqualification period. See AIIP in RAPIDS.

M. BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the date of application. Benefits for the initial month are prorated from the date of application, over the number of days remaining in the month.

Cases receiving a child support deduction that have not established a 3-month record of child support payments are certified for up to 3 months until a 3-month payment record is established.

An individual living in an ILC who meets the ABAWD definition and who is not working or not exempt as found in Section 9.1,A, must have an initial certification period of no longer than 3 months. After the initial 3 months, the certification period is based on individual circumstances.

- 3 Months: All FS AGs with earned income and no WV WORKS recipient included in the AG must be certified for 3 months.

  NOTE: AGs eligible for a certification period of three months or less have their certification periods increased by one month if they are approved after the 15th day of the month of application. This does not apply to Expedited Service cases which have verification postponed, but does apply to ABAWDs.

- Up to 6 Months: AGs in which there is little likelihood of change in unearned income and AG status.

- Up to 12 Months: AG's consisting entirely of unemployed persons, or person age 60 or over, with stable unearned income and those for whom a child support payment record has been established.

- 12 Months: WV WORKS cases.

- Up to 24 Months: AG's consisting entirely of elderly or disabled adults with no earned income. However, a contact must be made every 12 months. Form ES-FS-2 will be automatically mailed to the client to accomplish the contact. Workers will be notified when the report is due. See Section 2.2,B.

O. EXPEDITED PROCESSING

NOTE: It is possible for a client to qualify for Expedited Service at any time during the application process.

Expedited Service is the term used for special procedures in processing applications meeting specific requirements. The requirements and procedures follow.

1. Eligibility Requirements

   The following groups of cases are eligible for

from the date the Worker discovers the entitlement, not from the date of application.

AG's requesting, but not entitled to Expedited Service, have their applications processed according to normal standards.

The OFS-2 or CMCC must show that the application was screened for Expedited Service and the justification for the Worker's decision at application. Any changes in the original decision are recorded on CMCC.

3. Variations In Usual Procedures

AG's which qualify for Expedited Service are entitled to receive faster service. To ensure faster service, some exceptions to standard procedures apply.

a. Verification Requirements

Verification of eligibility requirements is temporarily waived, unless it can occur within the Expedited Service time frame. Only verification of identity is required. This does not mean that eligibility requirements are waived prior to approval, only that the routine verification of them is postponed. This also applies to the verification of and the application for an SSN. All reasonable efforts must be made to meet all routine verification requirements prior to confirmation. See Chapter 4.

Postponed verification must be received prior to the second issuance.

EXCEPTION: Combined Issuance requires verification be received prior to the third issuance.

If the applicant is able to verify identity, before or at the same time the additional information for which the case was pending is received, procedures for Expedited Service will apply. The client also qualifies for Expedited Service if the verification of identity is received at the same time the pending information is received. In addition, if the pending information is received, but not acted on, and then the verification of identity is received, Expedited Service procedures are appropriate. This must be explained to the client.

- Application is made on or after the 16th of the month.

- The client is eligible for the initial month and the next subsequent month.

- The client is eligible for Expedited Service.

To reduce the time period between the receipt of the Combined Issuance and the third month's issuance, the approval must be confirmed on the first working day of the third month if the client continues to be eligible.

The policy regarding Combined Issuance applies when the applicant is also a WV WORKS applicant. The procedures used to accomplish the Combined Issuance must not delay the processing of WV WORKS cases.

The client must be told during the intake interview that his Combined Issuance must last until his next issuance is received and the date his next issuance will be mailed. He must also be told that no additional Food Stamps are available should he use them all prior to receipt of the next issuance.

RAPIDS notifies each client who receives a Combined Issuance.

P. CLIENT NOTIFICATION

See Chapter 6. In addition, for Expedited Service the ES-FS-15, Notification of Denial of Expedited Service must be used for each Food Stamp applicant who requests Expedited Service, but does not qualify for it. The ES-FS-15 is a Worker-requested notice in RAPIDS. When possible, the ES-FS-15 must be given to the client at the intake interview. The case record must indicate that an ES-FS-15 was given.

A recording in CMCC is sufficient for those cases approved for Expedited Service and those cases not requesting Expedited Service.

Q. DATA SYSTEM ACTION

Each application requires data system action to approve, deny or withdraw.

- A redetermination is indicated by Recertification written in red at the top of the SSA/DHS-1.

- All procedures and time limits which apply to applications accepted by SSA, apply to redeterminations accepted by SSA.

b. Worker Responsibilities

- Screen and, if eligible, process the application for Expedited Service.

  NOTE: The date of application for the Expedited Service time limits is the date the application is received in the county office.

- Screen the SSA/DHS-1 to determine if further information is necessary.

  If the form is incomplete, any needed information must be supplied by the client. The form is not returned to SSA, and, under no circumstances, is the client required to visit the county office for completion of the form. The client can be requested to visit the office, but the application cannot be denied solely because he does not. Needed information may be obtained by telephone, mail or home visit.

  If verification not provided by SSA is needed, the Worker must notify the client of the required information within 3 working days of the date the application is received from SSA.

- Process according to normal procedures if the AG does not qualify for Expedited Service.

- Process any SSA/DHS-1's completed as redeterminations the same way applications are handled.

c. QA Errors

If an error is a result of information supplied by SSA, it is not included in the county's error rate. However, if SSA supplied the correct information and the Worker failed to take the appropriate action, the county is charged with the QA error.

The TANF programs and the time period for which an AG is categorically eligible is listed below.

- WV WORKS: Any month for which benefits are received
- DCA: 3 months beginning with the month of approval
- Supportive Payments: As long as actively enrolled in Work Programs (WP)
- SCA and WVSCA: Until the voucher expiration date

(2) Pure AG's

When the AG contains only recipients of SSI, or SSI and one of the TANF-funded benefits above, the AG is categorically eligible. This also includes the following:

- Persons determined eligible for SSI even though benefits have not been paid yet.
- Persons determined eligible, but who receive zero benefits, such as:
  - SSI recipients whose benefits are withheld for repayment
  - Persons whose SSI payments are suspended.
- The presence of any of the following people does not prevent the remaining AG members from being Categorically Eligible.
  - Ineligible alien
  - Ineligible student
  - Any individual disqualified due to enumeration

b. Who Is Not Categorically Eligible

An AG is not Categorically Eligible in the following situations:

- A person who is normally required to be a member of the AG is disqualified due to an IPV.

- The Worker must not deny an AG that could be Categorically Eligible until the 30th day to determine if the AG is eligible to receive a TANF funded benefits.

- Workers must be certain that the denied application of a potentially Categorically Eligible AG is easily retrievable.

  This applies to AG that:

  - Have an application for TANF funded benefits pending; and
  - Are denied Food Stamps; and
  - Are later determined eligible for TANF funded benefits; and
  - Are otherwise Categorically Eligible.

The Worker must provide benefits using the original application and any information supplied later. Benefits are issued from the date for which TANF funded benefit eligibility is established or the date of the original Food Stamp application, whichever is later. The client cannot be required to complete a new OFS-2 or another interview. The Worker may contact the client to update the OFS-2 information by mail or by telephone.

(2) SSI Applicants

Persons who apply for SSI and Food Stamps at the same time have Food Stamp eligibility determined as any other benefit group until Categorical Eligibility is met.

SSI applicants who are denied Food Stamps, must be informed in the denial notice of the possibility of potential Categorical Eligibility should they become SSI recipients.

S. REDETERMINATION VARIATIONS

Redetermination procedures are the same as application procedures except in the following situations.

completed by the Worker. The benefit group is notified of this service by form ES-FS-3. See item R.

- Failure to keep a redetermination appointment, or to reapply, results in case closure.

4. Completion

A Food Stamp redetermination is a reapplication for benefits. Under no circumstances are benefits continued past the month of redetermination, unless a redetermination is completed and the client is found eligible.

If the recipient is no longer eligible, the case is closed.

Clients who reapply in a timely manner, complete the interview and provide requested verification within the Worker's deadline must receive uninterrupted benefits or have lost benefits restored if the Department's delays cause benefits to be interrupted. The client does not lose the right to uninterrupted benefits if the Worker establishes a deadline for verification which extends into the new certification period. Uninterrupted benefits means benefits are received within 30 days of the last issuance. For longer certifications, uninterrupted benefits means benefits are received at the usual time in the issuance cycle.

EXCEPTION: Cases which have met all redetermination requirements are entitled to uninterrupted benefits. When this cannot be done due to the time frame for submitting missing verification, the Worker must take action to reinstate benefits so that the client receives benefits within five working days after supplying the missing verification, if eligible.

Clients who fail to reapply timely, fail to appear for an interview or fail to submit missing verification by the established deadline lose the right to uninterrupted benefits. Some failure to provide verification may only result in loss of a deduction, not ineligibility.

5. Overdue Redetermination

Food Stamp AG's which are due for redetermination are automatically closed by the data system on the adverse action deadline of the month when a redetermination is due.

prorated amount for the current month. If the current month's benefit is not confirmed until after deadline, RAPIDS issues the prorated amount for initial month and the full amount for the on-going month.

2. Ongoing Benefits

a. Amount

Once eligibility is established, the AG is eligible to receive Food Stamps for a full month. See Chapter 10.

b. Method of Issuance

Food Stamps are mailed alphabetically on a staggered schedule, according to the client's last name. The State Office mails them during the first 9 working days of each month. For security reasons, the schedule is not released to the public and is, therefore, not included in this Manual.

U. PERSONAL RESPONSIBILITY CONTRACT (PRC)

The PRC is not used for Food Stamp purposes.

V. ORIENTATION

Attending WV WORKS orientation is not an eligibility requirement for Food Stamps.

1.6 AFDC MEDICAID

A. APPLICATION FORMS

The OFS-2 is used. See Section 1.3,F for reapplications when a new form is not required.

B. COMPLETE APPLICATION

When the applicant signs an OFS-2 or OFS-5 which contains, at a minimum, his name and address, his application is complete.

An application is considered incomplete when the client chooses not to sign the OFS-2, or OFS-5. When this occurs, it is a withdrawal, and appropriate data system action and client notification must be completed. The recording in case comments must specify that the client did not want to sign the application and the reason for his decision. The client should always be encouraged to sign the application so there is no misunderstanding that he was denied the right to apply.

C. DATE OF APPLICATION

The date of the application is the date the applicant signs an OFS-2 or OFS-5 which contains, at a minimum, his name and address.

If the client, who became ineligible due to a lump sum payment requests recomputation, the date of application is the date of his request.

D. INTERVIEW REQUIRED

An interview is required when an OFS-2 is required. See item A above and Section 1.3,F for situations when an OFS-2 is not required.

E. WHO MUST BE INTERVIEWED

The specified relative with whom the child lives must be interviewed.

If the child is living with both parents, both must be interviewed unless:

- One parent is hospitalized; or

H. DUE DATE OF ADDITIONAL INFORMATION

The client and the Worker agree on the date by which additional verification must be obtained.

I. AGENCY TIME LIMITS

Data system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.

EXCEPTION: When the delay is a result of factors outside the control of the Department and the applicant; e.g., inability to obtain medical reports.

J. AGENCY DELAYS

If an application has not been acted on within the required time limit due to agency error, corrective action must be taken immediately. The procedures in Section 19.9,J must be followed.

K. PAYEE

The payee is the individual in whose name the medical card is written. The following rules apply.

- Deprivation Factor Is Not Unemployment: The specified relative with whom the child resides is the payee.

- Deprivation Factor Is Unemployment: The unemployed parent is the payee, unless it is in the best interest of the family for the other parent to be the payee.

L. REPAYMENT AND PENALTIES

See Section 20.4,B.

M. BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. However, eligibility may be backdated up to 3 months prior to the month of the application, when the client met all eligibility requirements in the prior month(s). When the client is eligible for backdated coverage, the system must be coded with the month, year on which the backdated period begins.

R. REDETERMINATION VARIATIONS

1. Completion Of The Redetermination

If the client continues to be eligible, the Worker must make necessary data system changes to indicate changes in the client's circumstances. If the client is no longer eligible, the case is closed after proper notification.

2. Overdue Redeterminations

A case is overdue if changes are not transmitted by the last day of the month in which the redetermination was due, regardless of the effective date.

S. THE BENEFIT

1. Retroactive Benefits

The first medical card generated by the data system shows eligibility through the end of the current month. In situations where retroactive eligibility is established, a separate card is used for each retroactive month.

2. Ongoing Benefits

The initial medical card shows the eligibility dates for the current month. After the initial month's medical card, a new card is issued monthly which shows the month's eligibility dates.

3. Ending Date Of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

T. PERSONAL RESPONSIBILITY CONTRACT (PRC)

The PRC is not used for Medicaid purposes.

U. ORIENTATION

Attending WV WORKS orientation is not an eligibility requirement for Medicaid.

1.8 TRANSITIONAL MEDICAID (TM)

NOTE: Eligibility is based on income, assets and deprivation of parental support of the AFDC Medicaid Coverage Group. See Section 16.5,C for the eligibility requirements that must be met.

There is no application procedure for this coverage group, instead the Worker is expected to evaluate all AG's which become ineligible for AFDC Medicaid due to hours of employment, amount of employment income or loss of the $30 + 1/3 disregard.

Although there is no formal redetermination process for TM cases, recipients must comply with the requirements for Phase I recipients found in Chapter 16, to qualify for Phase II coverage.

A new medical card is received on approximately the first of each month.

Phase I coverage ends on the last day of the sixth month of the Phase I period, or on the last day of the effective month of closure, whichever occurs first.

Phase II coverage ends on the last day of the sixth month of the Phase II period, or on the last day of the effective month of closure, whichever occurs first.

When TM coverage terminates for any reason, all AG members must be evaluated for coverage under all other Medicaid coverage groups.

may also choose to pick up a form, complete it at a later date and return it in person for processing. Again, no meeting with a Worker or registration with the receptionist may be required. However, at any point, the client may choose to meet with a Worker to discuss the status of his application. Also at the client's request, form CHIP-1 may be mailed to him by the county office; it must be mailed on the same day it is requested.

B. COMPLETE APPLICATION

The application is complete when the client signs a CHIP-1, OFS-5, OFS-2 or OFS-PW-4, as appropriate, which contains, at a minimum, his name and address.

C. DATE OF APPLICATION

The date of application is the date the client signs a completed CHIP-1, OFS-5, OFS-2 or OFS-PW-4 as defined in item B.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents printing the OFS-2, form OFS-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed OFS-2. The OFS-RR-1 must also be completed and signed. He must not be required to return to the office to sign the OFS-2 when an OFS-5 has been signed.

When the application is returned by mail or left at the office without an interview, the date of application is the date that a signed application which contains, at a minimum, the client's name and address, is received in the county office.

D. INTERVIEW REQUIRED

No interview is required when the CHIP-1 or OFS-PW-4 is used.

E. WHO MUST BE INTERVIEWED

No interview is routinely required, but when an interview is conducted the following persons must be interviewed:

- At least one parent with whom the child lives; or
- The adult, other than a parent(s), with whom the child lives; or
- The child, if he does not live with a parent(s) or other adult.

When an application is not processed within agency time limits, the application must be processed immediately upon discovery and coverage must be backdated for any prior eligibility period. This may be more than 3 months if due to an agency error. To determine if the client is eligible to receive direct reimbursement for out-of-pocket medical expenses, see Chapter 2.

K. PAYEE

Depending on the child's living situation, the payee is a parent, other adult household member, or the child.

L. REPAYMENT AND PENALTIES

This does not apply to QC, Poverty-Level or CHIP-1 cases.

M. BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month of application, if eligible. Eligibility may be backdated up to 3 months prior to the month of application, provided all eligibility requirements were met. However, in no case can the beginning date for CHIP-1 Medicaid be earlier than 7/1/98.

N. REDETERMINATION SCHEDULE

The first redetermination is scheduled in the 12th month of eligibility and completed annually after that.

O. EXPEDITED PROCESSING

Action must be taken to approve, deny or withdraw the application within 13 calendar days of the date a complete application is received in the county office. A complete application is defined in item B, above. If additional information or verification is required after the complete application is received, the Worker must request it immediately to allow the client 10 days to provide it, as required in item H, and to complete the application process within 13 days.

When application is made at the same time for another Medicaid coverage group(s) for another family member(s), or for other Programs, the application process for the QC, Poverty-Level or CHIP-1 child(ren) must be completed within 13 days, even though the application process for other individuals or for other Programs may still be pending.

P. CLIENT NOTIFICATION

See Chapter 6.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply. See Chapter 2.

S. THE BENEFIT

The first medical card generated by the data system shows retroactive eligibility and eligibility through the end of the current month.

The ongoing medical card shows the eligibility dates for the current month. A new card is issued monthly and shows that month's eligibility dates.

The ending date of eligibility is the last day of the month of the effective date of closure.

1. Poverty-Level Pregnant Woman, Age 18 And Over

   The pregnant woman only is required to sign the OFS-PW-4 or the OFS-2.

2. Poverty-Level Pregnant Woman Under Age 18 And Living At Home With A Parent(s)

   At least one parent of the minor pregnant woman and the minor pregnant woman must sign the OFS-PW-4 or the OFS-2.

3. Poverty-Level Pregnant Woman Under Age 18 And Not Living At Home With A Parent(s)

   The pregnant woman only is required to sign the OFS-PW-4 or the OFS-2.

E. BEGINNING DATE OF ELIGIBILITY

1. Application While Pregnant

   A pregnant woman may have her eligibility determined back to the date her pregnancy was originally diagnosed, provided she met all eligibility requirements at the time.

2. Application After Pregnancy Ends

   When the client applies within 3 months of the termination of the pregnancy, eligibility may be backdated up to three months, prior to the month of application, in which she met all eligibility requirements.

F. EXPEDITED PROCESSING

Data system action must be taken to approve, deny or withdraw the application within 13 days of the date a completed OFS-PW-4 or OFS-2 is received in the county office.

When an OFS-2 is used, the application for Medicaid coverage as a Poverty-Level pregnant woman must be processed within 13 days of the date a complete application is received, even though the application for the other Program may not require faster processing.

G. SPECIAL PROCEDURE

When the Poverty-Level pregnant woman's application is denied for any reason, a list of denied applications is generated by RAPIDS and made available to the Office for Maternal and Child Health.

1.11 RESERVED FOR FUTURE USE

When the redetermination is completed and the individual(s) remains eligible under another coverage group, the new eligibility period must begin the month immediately following the month of the redetermination.

C. THE BENEFIT

1. Initial Benefit

The first medical card generated by the data system shows eligibility through the end of the current month.

2. Ongoing Benefit

A new medical card for the CEN is received on approximately the first day of each month.

3. Ending Date Of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

D. ESTABLISHING THE DATE OF APPLICATION

The date of application is the first day of the month which shows on data exchange as the Medicaid effective date, or the date given on the SSA referral or by the BMS Buy-In Unit.

E. WHO MUST BE INTERVIEWED

No interview is required.

F. WHO MUST SIGN

No signature is required.

G. DUE DATE OF ADDITIONAL INFORMATION

All information is on data exchange, or is provided by SSA or the Buy-In Unit.

H. AGENCY TIME LIMITS

The Worker must enter the SDX information for approval within 45 days of the date on which the client first appears on data exchange, or the referral from SSA or the BMS Buy-In Unit.

I. AGENCY DELAYS

Data system entry must be made immediately upon discovery of the overdue entry.

J. PAYEE

The SSI recipient is the payee, unless the use of a substitute payee is justified.

K. REPAYMENT AND PENALTIES

This does not apply to SSI Medicaid cases.

L. BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the Medicaid effective date on data exchange. When the SSI recipient is eligible for retroactive coverage, the date on data exchange already reflects this.

Q. REDETERMINATION VARIATIONS

There is no redetermination of SSI Medicaid.

R. THE BENEFIT

The SSI recipient is the only individual who appears on the medical card. See Chapter 16.

1. Retroactive Benefits

The first medical card generated by the data system shows the coverage begin date entered in ANBR, and eligibility through the end of the current month.

2. Ongoing Benefits

The ongoing medical card shows the eligibility dates for the current month. A new card is issued monthly which shows that month's eligibility dates.

3. Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.15 QUALIFIED MEDICARE BENEFICIARIES (QMB) SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) AND QUALIFIED INDIVIDUALS (QI -1 AND QI-2)

A. APPLICATION FORMS

The OFS-MCAT-2 is used when application is made only for QMB, SLIMB, QI-1 or QI-2. The OFS-2 is used when application is also made for another Program.

The OFS-MCAT-2 may be mailed to the county office.

When the QMB, SLIMB, QI-1 or QI-2 client requests an application by mail, the Worker must explain:

- The date of application for QMB, SLIMB, QI-1 or QI-2 coverage is the day the signed application form which contains a name and address is received in the DHHR office.

- The processing time frame is 30 days, beginning with the date of application.

- In addition to QMB, SLIMB, QI-1 or QI-2 the client may qualify for other coverage groups, but a face-to-face interview is required.

A reapplication is treated as any other application, except in some situations when a new form is not required. See Section 1.3,F.

B. COMPLETE APPLICATION

The application is complete when the client signs an OFS-MCAT-2, or OFS-2 which contains, at a minimum, his name and address.

C. DATE OF APPLICATION

The date of application is the date a completed OFS-MCAT-2, or OFS-2 containing, at a minimum, the client's name and address is received in the county office.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the OFS-2, Form OFS-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed OFS-2. The OFS-RR-1 must also be completed and signed. He must not be required to return to the office to sign the OFS-2 when an OFS-5 has been completed.

- QI-2 clients will receive a lump sum check in December of each year.

H. DUE DATE OF ADDITIONAL INFORMATION

When the client visits the office and an interview is conducted, the Worker and client decide on a reasonable time for the client to return the information. When the client mails the OFS-MCAT-2, the Worker then uses the RAPIDS verification checklist or form ES-6 to inform the client of additional information needed. The client must be given at least 10 days after the date the verification checklist or ES-6 is mailed to return the information.

I. AGENCY TIME LIMITS

Data system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

J. AGENCY DELAYS

When the Department fails to request necessary verification, the Worker must immediately send the RAPIDS verification checklist or form ES-6 to request it. He must inform the client that the application is being held pending. When the verification is received and the client is eligible, medical coverage is retroactive to the date eligibility would have been established for QMB, SLIMB, QI-1 or QI-2.

When the QMB, SLIMB, QI-1 or QI-2 application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay. QMB, SLIMB, QI-1 and QI-2 cases must have the eligibility period backdated.

The QMB client is eligible to receive direct reimbursement for out-of-pocket medical expenses if the Department has not acted on the application within a reasonable period of time. See Chapter 2.

K. PAYEE

The QMB, SLIMB, QI-1 or QI-2 recipient is the payee. When there is an eligible couple, the couple chooses the payee.

L. REPAYMENT AND PENALTIES

This does not apply to QMB, SLIMB, QI-1 or QI-2.

2. The Date Of The Redetermination

The State Office mails a redetermination packet to each case. The packet contains a cover letter, and form OFS-MCAT-2.

3. Scheduling The Redetermination

See item 2 above. The client may telephone the Worker or come into the office if he requires assistance completing the redetermination form.

When the client is in the office to complete a redetermination for another Program, the QMB, SLIMB, QI-1 or QI-2 redetermination must be completed at the same time.

4. Completion Of The Redetermination

a. QMB and SLIMB

When the redetermination is completed and the individual(s) remains eligible, the new POE begins the month immediately following the month of the redetermination.

b. QI-1 and QI-2

The new POE begins in January with the new program year.

R. THE BENEFIT

1. QMB

The QMB recipient is the only individual who appears on the medical card.

Individuals eligible for only QMB coverage receive a Medicaid card.

a. Retroactive Benefits

There are no retroactive benefits for QMB. See item J., Agency Delays, for corrective procedures.

b. Ongoing Benefits

Each month's eligibility is reflected on a new medical card.

2. SLIMB and QI-1

Medicaid coverage is limited to payment of the

1.16 QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)

A. APPLICATION FORMS

The OFS-2 is used.

B. COMPLETE APPLICATION

A complete application is made when the client or his representative signs an OFS-2 or OFS-5 which contains, at a minimum, his name and address.

C. DATE OF APPLICATION

The date the client signs the OFS-2 or OFS-5 which contains, at a minimum, his name and address is the date of application.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the OFS-2, Form OFS-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed OFS-2. The OFS-RR-1 must also be completed and signed. He must not be required to return to the office to sign the OFS-2 when the OFS-5 has been signed.

D. INTERVIEW REQUIRED

A face-to-face interview is required.

E. WHO MUST BE INTERVIEWED

The QDWI applicant or his representative must be interviewed.

F. WHO MUST SIGN

The QDWI applicant or his representative must sign the OFS-2 or OFS-5.

G. CONTENT OF THE INTERVIEW

In addition to the interview requirements in Section 1.2, the following must be discussed in the interview:

- The QDWI recipient has only his Medicare, Part A, premium paid.
- The QDWI recipient receives no medical card.

P. CLIENT NOTIFICATION

SSA notifies the client that the Department is paying his Medicare premium and the amount that SSA will refund to him. The Worker has no responsibilities in this process.

Q. DATA SYSTEM ACTION

Data system action is required.

R. REDETERMINATION VARIATIONS

The redetermination cycle is set by RAPIDS.

S. THE BENEFIT

Medicaid coverage is limited to payment of the Medicare, Part A, premium. The Buy-In Unit at BMS is responsible for this process. No medical card is sent to this coverage group.

Eligibility ends when the Buy-In Unit at BMS notifies SSA that buy-in has terminated.

H. AGENCY TIME LIMITS

Agency time limits are as follows:

- Thirty (30) days, if based on a deprivation factor other than disability.

- Ninety (90) days, if disability must be established.

I. AGENCY DELAYS

When the Department fails to request necessary verification, the Worker must immediately send a verification checklist or form ES-6 to request it. He must inform the client that the application is being held pending. When the verification is received and the client is eligible, medical coverage is retroactive to the date of the medical emergency.

J. PAYEE

The client who is the illegal alien is the payee.

K. REPAYMENT AND PENALTIES

This does not apply.

L. BEGINNING DATE OF ELIGIBILITY

Eligibility begins the date the medical emergency is diagnosed.

M. REDETERMINATION SCHEDULE

The redetermination schedule is the same as for the coverage group for which the alien is approved. However, the case is opened when treatment for the medical emergency begins and closed at the end of the medical emergency, even if it is prior to the redetermination date.

When the client has an ongoing emergency, the Worker must check periodically to determine if the emergency has ended.

N. EXPEDITED PROCESSING

There is no expedited processing requirement.

1.18 INDIVIDUALS RECEIVING HOME AND COMMUNITY BASED SERVICES UNDER TITLE XIX WAIVERS

The application process for HCB Waiver (Elderly/Disabled) and the MR/DD Waiver (Mentally Retarded/Developmentally Disabled) is found in Chapter 17.

B. COMPLETE APPLICATION

The application is complete when the parent(s) or legal guardian signs an OFS-2 or CAF or OFS-5 which contains, at a minimum, the client's name and address.

C. DATE OF APPLICATION

The date a parent(s) or legal guardian signs the application, which contains, at a minimum, the client's name and address, is the date of application.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the OFS-2, Form OFS-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed OFS-2. Form OFS-RR-1 must also be completed and signed. He must not be required to return to the office to sign the OFS-2 when the OFS-5 has been signed.

D. INTERVIEW REQUIRED

A face-to-face interview is required.

E. WHO MUST BE INTERVIEWED

The parent(s) or legal guardian of the child must be interviewed.

F. WHO MUST SIGN

The parent(s) or legal guardian of the child must sign the OFS-2.

G. CONTENT OF THE INTERVIEW

In addition to the interview requirements in Section 1.2, the Worker must inform the parent(s) or legal guardian that other forms must be provided by the Case Management Agency to determine eligibility, and that the medical eligibility decision is made by BMS.

H. DUE DATE OF ADDITIONAL INFORMATION

The Worker and the parent(s) or legal guardian decide on a reasonable time for the information to be returned.

I. AGENCY TIME LIMITS

The agency must take action to approve, deny or withdraw the application within 30 days of the date of application.

P. CLIENT NOTIFICATION

See Chapter 6.

Q. DATA SYSTEM ACTION

Each application requires data system action to approve, deny or withdraw.

R. REDETERMINATION VARIATIONS

The redetermination process is the same as the application process with the following exceptions:

1. The Redetermination List

There is no redetermination list.

2. The Date Of The Redetermination

RAPIDS sets a 12-month redetermation cycle for CDCS AG's.

3. Scheduling The Redetermination

When the AG is due for redetermination, the Worker will receive an eligibility alert. If the Worker uses client scheduling, the AG will automatically be scheduled for redetermation.

When the Worker receives notice that a redetermination is due, he must schedule it using form ES-10.

4. Completion Of The Redetermination

When the redetermination is completed and the individual remains eligible, the case is updated to reflect current circumstances.

S. THE BENEFIT

The CDCS recipient is the only individual who appears on the medical card.

1.20 AIDS PROGRAM

A. APPLICATION FORMS

An OFS-2 is completed.

B. COMPLETE APPLICATION

The application is complete when the client or his representative signs an OFS-5 or OFS-2 which contains, at a minimum, his name and address.

C. DATE OF APPLICATION

The date the client or his representative signs the OFS-2 or OFS-5, or, when the client previously applied for Medicaid and is pending spenddown, the date the client inquires about the AIDS program coverage.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the OFS-2, Form OFS-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed OFS-2. The OFS-RR-1 must also be completed and signed. He must not be required to return to the office to sign the OFS-2 when the OFS-5 has been signed.

D. INTERVIEW REQUIRED

A face-to-face interview is required.

E. WHO MUST BE INTERVIEWED

The client or his representative must be interviewed.

F. WHO MUST SIGN

The client or his representative must sign the OFS-2.

G. CONTENT OF THE INTERVIEW

In addition to the interview requirements in Section 1.2, the following must be discussed in the interview:

- The applicant must be informed that his application is forwarded to BMS for an eligibility determination.

- All notifications and services are provided by BMS.

Q. DATA SYSTEM ACTION

No data system action is required. BMS manages the provision of services.

R. REDETERMINATION VARIATIONS

No redetermination is completed.

S. THE BENEFIT

1. Special Pharmacy Program

There is no medical card issued.

2. HIV GRANT PROGRAM

There is no medical card issued.

3. Ending Date Of Eligibility

If the client becomes eligible under any other coverage group or meets his spenddown, the Worker must notify BMS immediately by memorandum and specify the beginning date of Medicaid eligibility. Some of the services provided may be paid for with the medical card.

Otherwise, BMS determines when eligibility ends.

- One parent is incarcerated; or

- One parent is employed, and his working hours preclude participation in the interview during the agency's normal working hours.

- He is physically/mentally unable to participate in the interview and this is established by a written or verbal statement of a physician, social worker, attorney or other responsible person.

When the specified relative with whom the child lives has a legal committee, the committee must be interviewed.

When the child is living with only one specified relative, and that relative is unable to participate in the interview, a representative may be interviewed. A written statement, signed by the relative, which gives the representative authority to apply on his behalf, is required.

F. WHO MUST SIGN

The individual(s) who is interviewed must sign the OFS-2.

G. CONTENT OF THE INTERVIEW

In addition to the interview requirements in Section 1.2, the following must be discussed in the interview:

- That any child under age 18 may be evaluated for SSI-Related Medicaid based on blindness or disability

- The spenddown process

- The MRT process, if applicable

- They may receive more than one medical card if a child(ren) has income or there is income deemed to a parent.

H. DUE DATE OF ADDITIONAL INFORMATION

Additional information is due 30 days from the date of application.

I. AGENCY TIME LIMITS

Data system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

2. Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on Screen AGTM, are not paid by Medicaid.

N. REDETERMINATION SCHEDULE

1. Non-Spenddown

Non-spenddown cases are redetermined in the 6th month of the POC. The 6-month period begins with the month of application, unless the POC is backdated. The date the next redetermination is due is automatically coded in the data system.

2. Spenddown

Spenddown cases are not scheduled for a redetermination and are closed at the end of the 6th month of the POC. The client must reapply for a new POC.

O. EXPEDITED PROCESSING

There is no expedited processing requirement.

P. CLIENT NOTIFICATION

See Chapter 6.

Q. DATA SYSTEM ACTION

Each application requires data system action to approve, deny or withdraw.

R. REDETERMINATION VARIATIONS

The redetermination process is the same as the application process with the following exceptions:

eligibility will end at the end of the following month and that he must reapply for Medicaid coverage.

S. THE BENEFIT

A medical card is issued for each eligible child who has income of his own. Parents and any of their children who have no income of their own appear on one medical card, unless the parent has deemed income from an ineligible spouse. When this occurs, the parent is issued his own medical card. A specified relative, other than a parent, who has income appears on his own card.

1. Non-Spenddown

a. Retroactive Benefits

The first medical card generated by the data system shows retroactive eligibility, and eligibility through the end of the current month.

b. Ongoing Eligibility

The ongoing medical card shows the eligibility dates for the current month. A new card is issued monthly which shows that month's eligibility dates.

The medical card is received on approximately the first day of each month.

c. Ending Date Of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

2. Spenddown Cases

A medical card is issued when the data system entries brings the spenddown amount to $0. All eligible individuals who are included in the case which meets spenddown appear on the medical card.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on Screen AGTM, are not paid by Medicaid.

1.22 SSI-RELATED MEDICAID, AGED, BLIND AND DISABLED

A. APPLICATION FORMS

An OFS-2 is used.

A reapplication is treated as any other application except in some situations when a new form is not required. See Section 1.3.

B. COMPLETE APPLICATION

The application is complete when the client or his representative signs an OFS-2 or OFS-5 which contains, at a minimum, the client's name and address.

C. DATE OF APPLICATION

The date that the client or his representative signs the OFS-2 or OFS-5 which contains, at a minimum, his name and address.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the OFS-2, Form OFS-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed OFS-2. The OFS-RR-1 must also be completed and signed. He must not be required to return to the office to sign the OFS-2 when the OFS-5 has been signed.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No OFS-2 is required when the requirements in Section 1.3 are met.

D. INTERVIEW REQUIRED

A face-to-face interview is required.

E. WHO MUST BE INTERVIEWED

The interview is conducted with the applicant and his spouse, if any, with whom he resides, regardless of whether or not the spouse is also an applicant.

The interview is conducted with the applicant alone, if the spouse cannot be present because:

- He is hospitalized; or
- He is incarcerated; or

H. DUE DATE OF ADDITIONAL INFORMATION

Additional information is due 30 days from the date of application.

I. AGENCY TIME LIMITS

1. Application Processing Limits

NOTE: When an applicant, age 65 or over, wishes to have his eligibility evaluated as a blind or disabled person and the process of establishing disability or blindness will result in a delay, his application is approved based on age. If at a later date his blindness of disability is established, the deprivation factor is changed.

- SSI Age-Related Medicaid: Data system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

- SSI Blind-Related Medicaid: Data system action to approve, deny or withdraw the application must be taken within 60 days of the date of application.

- SSI Disability-Related Medicaid: Data system action to approve, deny or withdraw the application must be taken within 90 days of the date of application.

2. MRT Time Limits

To ensure that the 90-day processing limit is met for MRT cases, the following time limits apply to the MRT process:

REQUIRED ACTION	TIME LIMIT
Interview client and request medical records and reports	By the 7th calendar day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request, and each 30 days thereafter
Submission to MRT	By 7 days after medical records/reports received.

reimbursement for out-of-pocket medical expenses. See Chapter 2.

K. PAYEE

The recipient is the payee. Couples may decide who is the payee.

L. REPAYMENT AND PENALTIES

This does not apply to SSI-Related Medicaid.

M. BEGINNING DATE OF ELIGIBILITY

1. Non-Spenddown

The beginning date of eligibility is the first day of the month of the POC. This date may be backdated up to 3 months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

2. Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form ES-MS-1, are not paid by Medicaid.

N. REDETERMINATION SCHEDULE

1. Non-Spenddown

Non-Spenddown cases are redetermined in the 6th month of the POC. The 6-month period begins with the month of application. The date the next redetermination is automaticaly coded in the data system.

2. Spenddown

Spenddown cases are not redetermined and are closed at the end of the 6th month of the POC. The client must reapply for a new POC. The last month of the 6-month POC is coded in in the data system.

b. The Date of the Redetermination

Cases may come into the office at any time to reapply for a new POC.

c. Scheduling the Redetermination

These cases are not scheduled for a redetermination. The client must apply for a new POC.

d. Client Notification

Spenddown cases receive a computer-generated letter at the end of the 5th month of the POC. This letter informs the client that his eligibility will end at the end of the following month and that he must reapply for Medicaid coverage.

S. THE BENEFIT

A medical card is issued for each eligible individual or couple.

1. Non-Spenddown

a. Retroactive Benefits

The first medical card generated by the data system shows retroactive eligibility, and eligibility through the end of the current month.

b. Ongoing Eligibility

The ongoing medical card shows the eligibility dates for the current month. A new card is issued monthly which shows that month's eligibility dates.

c. Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

1.23 RESERVED FOR FUTURE USE

have a spenddown, the procedures in Section 2.16,A apply.

- If the spouse is determined ineligible, the Worker sends the recipient form ES-NL-A. No data system entry is required, but the Worker must make a case recording about the denial.

B. DEATH OF THE ONLY INDIVIDUAL PRIOR TO APPLICATION OR APPROVAL

Death of an individual does not interfere with approval of a Medicaid application. However, special procedures are required when the only member of a Medicaid AG dies prior to making an application. If an application is made prior to an individual's death, the application is processed as usual and approved, if eligible. This item outlines the special procedures that the Worker must follow in the application process and at approval.

1. Who Must Be Interviewed And Sign The Application

Another individual makes the application on behalf of the deceased person. It is preferable that the person be a relative, but any other individual who is interested may make the application on behalf of the deceased person.

The Worker must obtain as much information as possible about the deceased person's income and assets, but routine verification is not required.

2. MRT Referral

It is not necessary to refer the case to MRT when the deceased person's incapacity or disability resulted in his death. However, a MRT referral may be necessary to establish incapacity, blindness or disability when there is a request for Medicaid coverage for a month(s) prior to the person's death and such incapacity, blindness or disability was not the cause of death, or the Worker is unable to determine if the incapacity, blindness or disability existed during the month(s).

All other policies and procedures related to incapacity or disability coverage groups apply.

EXAMPLE:

Date	Recording	Worker	Data Transmission
10/10/95	Client applied. All elig. req. met except spdwn. ES-6 and 6A given for medical bills	Jones	N/A See case comments of 10/10/95
11/6/95	Medical bills received ($432). Not enough to meet spenddown.	Jones	N/A
11/8/95	More bills received ($617). Spdwn met approval notice sent	Jones	

For all Medicaid applications, the documentation on the CMCC must include, but is not limited to, the following:

- Date of application
- Date the verification checklist or ES-6 and 6A were mailed or given to the client
- Date medical bills submitted by the client were received in the local office
- Date medical expenses were added to RAPIDS, and
- The result of each 30-day review (instructions in item 2 below).
- All actions related to the MRT process, when applicable, which include, but are not limited to:
  - Date initial medical reports are requested
  - Date of follow-up activity required to obtain initial reports
  - Date medical reports are received in the

1. Approvals

The application is approved for Medicaid to cover the prior period. The medical card is mailed to the local office and is rewritten for the correct POE and mailed to the client. For a spenddown case, verified medical expenses, old unpaid bills prior to the POC, or paid and unpaid bills incurred during the POC, are used as spenddown expenses. A manually written medical card for the correct POE is mailed to the client.

2. Denials

When the Worker determines that the case does not meet spenddown in the prior period, the application is denied and the client notified using the ES-NL-A.

3. Closures

Advance notice requirements apply. When the 13-day advance notice of closure is not required, the procedure is as follows:

If a card will be generated, the address of the county office is entered in ACCH.

A closure is transmitted immediately following the approval or spenddown transaction.

When the card is received in the county office, the Worker must destroy it and manually issue a medical card to reflect the prior POE. The Supervisor initials the card and either mails it or gives it to the client. It is the client's responsibility, or that of the individual who is acting on his behalf, to take the card to medical providers.

F. CHANGING COVERAGE GROUPS AND REDETERMINATION PERIOD

When one coverage group is closed and another opened, the original redetermination period is kept.

D. INTERVIEW REQUIRED

A face-to-face interview is required.

E. WHO MUST BE INTERVIEWED

NOTE: Information in this item applies only to the intake interview. While it is possible to have only one parent participate in the intake interview, it will usually be necessary for both parents to be interviewed about the PRC and other WV WORKS requirements. A representative of the specified relative may participate in the intake interview, but the specified relative must be interviewed about the PRC and other WV WORKS requirements.

The specified relative with whom the child lives must participate in the intake interview.

If the child is living with both parents or a parent and a stepparent, both must be interviewed unless:

- One parent or stepparent is hospitalized; or
- One parent or stepparent is incarcerated; or
- One parent or stepparent is employed and his working hours preclude participation in the interview during the agency's normal working hours.

When the specified relative with whom the child lives has a legal committee, the committee must be interviewed.

If the child is living with only one specified relative who is unable to participate in the interview, a representative may participate in the intake interview. A written statement, signed by the specified relative, which gives the representative authority to apply on his behalf, is required.

F. WHO MUST SIGN

The individual(s) who is interviewed must sign the OFS-2. If the child(ren) lives with both parents or a parent and a stepparent, both must sign, even if separate interviews are conducted.

G. CONTENT OF THE INTERVIEW

In addition to the requirements outlined in Section 1.2, the following specific requirements apply.

For cases in which the caretaker relative is not a natural or adoptive parent, form OFS-WVW-10 must be explained. The form must be signed and completed prior to approval, but not necessarily during the intake interview. The Worker must explain the option of being included or excluded from the AG and answer the client's questions about the consequences of each choice. Refusal, or other failure, of the caretaker relative to sign the form results in denial of eligibility for the caretaker relative for at least 12 months. Eligibility continues to be denied beyond 12 months, for as long as the caretaker fails to choose. The original form must be filed in the case record and the client must be given a copy. See Section 9.21 for details about the limited choice for the caretaker.

- Domestic Violence: Explain that information is available throughout the office and from the Worker regarding domestic violence and that this subject is discussed with all clients. No individual is specifically targeted to receive the information. Disclosure of domestic violence may have an affect on any PRC, work requirements or time limits the client is expected to meet while a WV WORKS recipient. A referral to the appropriate community resource or domestic violence program must be made to develop a plan to assist the client in meeting any WV WORKS requirements. See Sections 13.8 for temporary exemptions to the WV WORKS work requirements and Sections 15.6 and 15.7 for WV WORKS time limits.

- Direct Deposit: The Worker must provide an enrollment brochure and explain the following about direct deposit:

  - The advantages of receiving the WV WORKS benefit by direct deposit and that enrollment is optional. The client uses a bank of his choice and once the benefit is deposited, the client is responsible for all dealings with his bank and for all fees and penalties associated with his own bank account. The WV WORKS benefit is deposited on the last State work day of the month prior to the month the benefit is due.

  - How to enroll and dis-enroll in direct deposit

  - That the effective date of the first direct deposit is dependent upon the date of submission for the enrollment form and the accuracy of the information provided and is the responsibility of the Auditor's Office. It is generally the month following the month of enrollment. The

stepparent, the parent is the payee. When the child lives with one relative other than a parent, the specified relative is the payee. When a child lives with two specified relatives other than a parent, they must choose who will be the payee.

NOTE: Payments are not issued to minor parents. Instead, the parent or other responsible adult with whom the minor parent lives, or who supervises the minor parent's living arragement, is the payee.

When a substitute payee is appropriate at application, see Chapter 2.

L. REPAYMENT AND PENALTIES

Before the case is approved, the Worker must determine if there is a WV WORKS, TANF or AFDC/U claim outstanding against any member of the AG. If so, the Worker must initiate appropriate repayment procedures prior to approval.

If the client has been making voluntary payments, he must be informed that repayment must be made, when possible, from his check, i.e., recoupment.

When the AG has been sanctioned for failure to cooperate with WV WORKS, the case is subsequently closed and a reapplication made, that AG remains sanctioned until the sanction ends.

M. BEGINNING DATE OF ELIGIBILITY

Eligibility begins on the first day, after application is made, that the benefit group meets all eligibility requirements, including signing the PRC (See item T below) and participating in orientation (See item U below). There are other circumstances which also impact on the beginning date of eligibility.

- When a parent or other caretaker relative included in the payment quits or refuses employment or training for employment, without good cause, in the 30-day period prior to the date of application, the benefit group is ineligible until 45 days after the employment or training is no longer available. See Chapter 13 for the determination of good cause.

  NOTE: This applies to full-time or part-time employment.

  EXAMPLE: A parent is placed in full-time employment with a produce shipping company. Two months later, he is laid off. The 45-day waiting period does not apply.

that the client continues in the same redetermination cycle.

Cases may be redetermined more frequently at the discretion of the Worker and Supervisor when any of the following occur:

- There are persons in the benefit or income groups who frequently change jobs or work intermittently.
- QA has found a client error in the case.
- The composition of the benefit or income groups has frequently changed and is likely to continue to change.
- A substantial change is expected.
- The AG has expenses exceeding its income.
- RAPIDS schedules a redetermination due to receipt of another benefit under the same case number.

O. EXPEDITED PROCESSING

There are no requirements for expedited processing. Cases are approved in the order in which eligibility is established.

P. CLIENT NOTIFICATION

See Chapters 6 and the RAPIDS User Guide.

Q. RESERVED FOR FUTURE USE

R. REDETERMINATION VARIATIONS

The redetermination process is the same as the application process with the following exceptions.

1. Redetermination List

RAPIDS selects cases due for redetermination on the Friday which falls between the 8th and 14th of the month prior to the month the redetermination is due. The redetermination list is displayed as an alert on the Worker's CMWA screen.

2. Scheduling Interviews

Use the ES-10 or the RAPIDS letter CSLC or CSLD to notify the client of the appointment.

b. Direct Deposit

The client may choose to have his ongoing monthly WV WORKS benefit deposited directly into his own checking or savings account. The account must be in the name of the payee for the WV WORKS benefit.

(1) Enrollment in Direct Deposit and Effective Date

The client must complete an enrollment form, attach any other appropriate information requested on the form and mail it directly to the State Auditor's Office. If he returns the form to the local office, the Worker forwards the form to the Auditor's Office. Questions about the direct deposit process or the individual's effective date, after submission of the enrollment form, must be directed to the Auditor's Office at the toll-free number, 1-800-500-4079 or at 304-558-2251. Enrollment forms must be ordered directly from the Auditor's Office by the local staff.

Direct deposit is generally effective the month following the month in which the form is submitted, when all account information is valid. Until direct deposit is effective, the client receives a check.

(2) Receipt of the Direct Deposit Benefit

The benefit is deposited into the account and available to the client on the last State work day of the month which is prior to the month for which the benefit is due. Workers will use RAPIDS Table TBIC to determine the last State work day. No check stub or deposit information is mailed to the client. Questions regarding deposit of the benefit must be directed to the individual's bank or the Auditor's Office.

Direct deposit of the WV WORKS benefit is indicated in RAPIDS on screen IQAF with a warrant number which begins with a 2. Screen IQAD shows a Y in the EFT field.

When the direct deposit transaction cannot be completed, the Auditor's Office does the following:

- Removes the client's name from the direct deposit data base; and

The monthly benefit amount is determined according to instructions in Chapter 10 and prorated. Special needs are not prorated. Instead, the full special need amount is added to the prorated amount.

The date eligibility is established must be coded in RAPIDS.

The system's response to approvals includes both the prorated benefit amount for the first month and the full benefit amount for the following month.

(2) Method of Issuance

The initial benefit is issued by RAPIDS.

d. Ongoing Benefit

The ongoing monthly benefit is determined by the data system, based on income coded in the system prior to the deadline date in the month prior to the issuance month.

2. Diversionary Cash Assistance (DCA)

NOTE: When a case is approved for DCA, the AG must not be required to file a new application for Food Stamps. Food Stamp eligibility must be determined based on the information provided on the WV WORKS application.

NOTE: There is a lifetime limit of one DCA payment for each benefit group. If an AG contains even one member who benefited from a DCA as an adult or emancipated minor, another DCA payment cannot be made to the AG.

Diversionary Cash Assistance (DCA) is a payment method available only to WV WORKS applicants. This method allows a maximum lump sum issuance of an amount equal to the maximum WV WORKS check amount, based on family size, multiplied by 3.

DCA provides an opportunity to relieve a temporary financial need as an alternative to receipt of ongoing WV WORKS payments. When the Worker and the applicant are confident that a one-time payment will meet the temporary need, DCA is explored.

WV WORKS eligibility must be established and an initial assessment conducted by the Worker before DCA is considered.

- Compare the amount of the temporary financial need to the maximum DCA amount. If the DCA is sufficient to meet the need, payment is issued for the amount of the temporary need. If the DCA is not sufficient to meet the need, the Worker and the client may determine that the amount that can be met by the DCA is sufficient and that other arrangements can be made to meet the remainder of the need. Otherwise, DCA is not appropriate, and the client is approved for an ongoing WV WORKS check. There are no circumstances under which the maximum DCA payment amount may be exceeded.

c. Determining if DCA is Appropriate

The following guidelines are used to determine if DCA is appropriate.

- The benefit group must demonstrate a need which cannot be met with current or anticipated family resources.

- A member of the benefit group must be employed or have a verified promise of employment or other verified source of income within two months of application.

- The benefit group must be eligible for a WV WORKS check based on the applicant's declaration and the best judgment of the Worker. See Chapter 4 for verification requirements.

- The applicant must agree to accept DCA by signing the Diversionary Cash Assistance Agreement, IM-WVW-3, which lists conditions and expectations.

- Child support received by the parent/caretaker or BCSE belongs to the family and is not used to reimburse the Department for the DCA.

- The applicant must agree to have the WV WORKS application withdrawn. When a DCA payment is accepted, the recipient benefit group members are ineligible for 3 months, regardless of the DCA amount or the number of months the payment represents. They remain ineligible for 3 months even if they no longer live together. The presence of one benefit group member who benefitted from a DCA, as an adult

same type to ensure that such tools would be used. Note that, in this case, it is assumed that the client has written verification of his employment. Otherwise, contact with the future employer would be necessary to verify the employment. The Worker and the client agree on the amount needed for the family for overnight lodging, rent, utility deposits and food. These items are not verifiable, since the client does not yet have a place to live in the new state and does not know where he will stay overnight on the drive. It is reasonable to assume that these costs will be incurred in moving to another state, and the amount is negotiated.

3. The Medical Card

Medicaid eligibility for WV WORKS recipients is not automatic with receipt of a payment. See Sections 1.6 - 1.22 for information, according to the appropriate Medicaid coverage group.

T. PERSONAL RESPONSIBILITY CONTRACT (PRC)

NOTE: Guidance for completion of Part 2 of the PRC, the Self-Sufficiency Plan is found in Chapter 24.

The Personal Responsibility Contract (PRC), IM-WVW-2, is an agreement between the adult members of the WV WORKS AG and the Worker as the representative of the Department. There are 2 parts to the form. Refusal or other failure, without good cause, to sign either part of the form results in ineligibility for the entire AG. Refusal or other failure, without good cause, to perform any task or to take any other action, never results in a sanction unless it was included in the PRC at the time the refusal or failure occurred. If it was, the appropriate sanction, as found in Chapter 13, is applied.

1. PRC - Part 1

Part 1 of the PRC is the same for all clients. It states the purpose of the WV WORKS Program and lists the client's rights and responsibilities. Each adult AG member must sign Part 1. In addition, the Worker must sign the form as the Department's representative. The client's signature indicates that he understands and accepts the responsibility inherent in the Program. The Worker's signature indicates that he has explained the client's rights and responsibilities and the Department's responsibilities to the client. It also indicates that the Worker has addressed all of the client's questions and concerns before requesting him to sign it.

Refusal or other failure, without good cause, to participate in the development of the self-sufficiency plan (Part 2 of the PRC) or to sign the plan once it is developed, results in ineligibility for the entire AG.

Refusal or other failure, without good cause, to adhere to the self-sufficiency plan, results in the imposition of a sanction. See Chapter 13 for information about appropriate sanctions.

During the completion of the PRC, the Worker must make every opportunity available for the individual to disclose domestic violence issues which may affect the client's particular requirements as a WV WORKS recipient. It must be stressed with the client that disclosure may be a benefit in the PRC process. If, based on observation of a couple during an interview, the Worker suspects domestic violence is a factor, he may attempt to set up a separate interview at a later date. However, any attempt to do so must be done in a manner which insures the client's safety. Under no circumstances must the individual's safety be compromised or is the client to be penalized for refusal to conduct a separate interview.

NOTE: When the client's plan involves requirements or exemptions due to domestic violence or plan monitoring with a domestic violence agency, the Worker must take special precautions when recording exemption information on the PRC or in RAPIDS. No copy of any such plan is filed in the record. The Worker may make phone contacts to monitor the plan and record only general information, i.e.; the name of the individual to whom he spoke, but not the organization; a statement that the current plan is being followed satisfactorily, etc. When monitoring the plan, the Worker must not contact the abuser, his relatives or friends, nor leave any messages regarding domestic violence on any home answering machine. The domestic violence indicator in RAPIDS serves as documentation of the reason for the requirements or exemption.

U. ORIENTATION

Each adult included in the WV WORKS benefit group must receive orientation to the Program. At the discretion of the CSM, orientation may be conducted in groups or individually.

The orientation session must explain the following items:

- The purpose of WV WORKS

of an asset without the consent of the other owner(s), and the consent is withheld, the asset is excluded as inaccessible.

EXAMPLE: Three people own a piece of property valued at $20,000. One of them applies for Food Stamps. The property cannot be sold without the consent of all three owners and each person may sell his interest only to the other two owners. The other two owners do not want to buy the applicant's interest in the property at this time. The property is excluded.

EXAMPLE: Same situation as above except that the agreement does not stipulate that only the other two owners may buy the interest in the property. One-third of the equity in the property is assigned to the client as an asset.

c. Residents of Shelters for Battered Women and Children

Assets are considered inaccessible to persons residing in shelters for battered women and children when:

- The assets are jointly owned by such persons and those with whom they lived prior to entering the shelter; and

- The shelter resident's access is dependent upon the agreement of a joint owner who still resides in the former household.

4. Special Considerations Depending on the Benefit Group Composition

a. Categorical Eligibility

Food Stamp AG's composed entirely of WV WORKS SSI recipients, or an AG that has at least one recipient of a TANF-funded benefit, are Categorically Eligible and, as such, are not required to meet an asset eligibility test. See Section 1.4,R.3.

b. Food Stamp Benefit Groups Containing at Least One SSI Recipient

Recipients of SSI, who live with at least one person who does not receive one of these benefits, are in a mixed Food Stamp AG

Case Name: _____

Case Number: _____

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

OFFICE OF FAMILY SUPPORT

Document For Protection Of Application Date

In order for you to receive the benefits for which you have applied, it is necessary for you to sign an application form. Since the information you provided during the interview was entered into a computer system, your Worker must print some of the information entered on a document for your signature.

Occasionally, there is a technical failure of the printers, such as happened on this date. Therefore, since some benefit amounts depend upon the date you applied for benefits, you are being asked to sign this statement today, instead of an application form, to protect your actual date of application. You will not be required to return to the office to sign any additional application form.

I attest to the correctness of the information that I provided during the interview. It is true and complete to the best of my knowledge.

I understand the requirements explained above and have been given the opportunity to receive answers to my questions about them.

_____ _____
Applicant Signature Date

_____
Applicant Address

_____ _____
Worker Signature Date

OFS-5 Revised 5/2000

ORIGINAL: Case Record COPY: Client

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Checklist for Medicaid Applicants

To the Medicaid Applicant:

The Worker in your local Health and Human Resources Offices will need the following listed items to make a decision about your application for Medicaid eligibility. It will help speed the eligibility determination process if you send or bring these items with your application for Medicaid. However, it is not necessary for you to have these items in order to apply. If you go in to your local Health and Human Resources Office to apply, take these items with you.

- Social Security cards for every family member who has one

- All pay stubs for the 30-day period prior to and including the date you sign the application.

    4 stubs if paid weekly
    2 stubs if paid biweekly or twice monthly
    1 stub if paid monthly

- If child care is paid by family members, a signed and date statement from the care provider regarding the amount he receives per pay period, the number of days or weeks in the pay period and names of the children kept

- Income tax return for previous year if any family member is self-employed

- Award letters, forms or other proof of current income when a family member is receiving Social Security, Veteran's benefits, SSI, retirement, etc.

- Physician's statement verifying pregnancy, if applicable.

MEDICAID APPLICATION FOR PREGNANT WOMEN AND MEDICAID CHILDREN □ WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Please answer all questions as completely and accurately as you can. If you do not understand a question. the worker will help you. If you need more space, attach another sheet of paper to application.

Name _____ (Last) _____ (First) _____ (Middle Initial)

Address _____ (Box or Route or # and Street) _____ (Apt. #)

_____ (City/Town) _____ (State) _____ (Zip)

Home Phone _____ Work Phone (If you can receive calls at work) _____

Neighbor with whom message can be left _____ Number _____

Number to call in case of an emergency _____

Social Security Number _____ Husband or person that you live with _____

Directions to Home _____

Please list everyone in your household (including yourself) and complete each space by their name:

Name Last M.I. First	Birth date M/D/Y	Social Security Number	U. S. Citizen Yes No	What other insurance do you have?	Relation to Pregnant Woman
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		
			□ □		

Total Family Members in Your Household _____

Include your unborn child as a member of your family.
For example: If you are pregnant and live alone, you should count two as your family size.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
RELEASE OF CONFIDENTIAL INFORMATION
STATEMENT

This information has been disclosed to you from records whose confidentiality is protected by federal and state law and/or regulation, in particular, 42 CFR § 431.300, et seq., 7 CFR § 272.1 (c), 45 CFR § 205.50, et seq. and West Virginia Code § 9-9-5 and § 9-9-20. Unauthorized use or disclosure of this information is punishable by criminal and/or civil penalties.

We ask that you leave this notice attached to this information to avoid accidental release. Use of the information for other than the stated purpose is prohibited. Disclosure by the recipient of this information to any other party is strictly prohibited without the express written consent of the Department. Destruction of copies after the stated need has been fulfilled is requested or if obtained for purposes of a court hearing, these records must be sealed in the court records after use.

If you need any further information regarding the confidential nature of TANF/WVWorks, Food Stamps, Medicaid, or other programs, such as LIEAP, NEMT or Emergency Assistance information, please contact the West Virginia Department of Health and Human Resources, Office of Family Support at (304) 558-8290 or contact your local West Virginia Department of Health and Human Resources Office.