RIGHTS AND RESPONSIBILITIES

West Virginia Department of Health and Human Resources (WV DHHR)
Bureau for Children & Families
Division of Family Assistance

FOOD STAMP AND MEDICAID PROGRAMS

In accordance with Federal law and U.S. Department of Agriculture **(USDA)** policy and U.S. Department of Health and Human Services **(HHS)** policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs.

To file a complaint of discrimination, write **USDA**, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, DC 20250-9410 or call 202-720-5964 (voice and TDD) or write **HHS**, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, DC 20201 or call 202-619-0403 (voice) or 202-619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

Read each statement carefully and answer yes or no to <u>each</u> statement.

FOOD STAMP PROGRAM

Yes ☐ No ☐ **1)** **I understand that** Food Stamp benefits are to be used by my family and me to purchase food or seeds. I cannot sell my Food Stamp benefits or use someone else's benefits for myself. The Food Stamp benefits will not be used for any other purpose. **I understand** that I may not use my EBT Food Stamp benefits to purchase food on credit. This means I cannot pay for food already purchased or food to be received in the future.

Yes ☐ No ☐ **2)** **I understand** that my Food Stamp benefits will be deposited in an EBT account and cannot be replaced under any circumstances. If I choose an authorized cardholder who has access to my EBT account, benefits used by the authorized cardholder also cannot be replaced.

I also understand that if I do not use Food Stamp benefits deposited in an EBT account for a period of 180 days that the benefits will be unavailable to me unless I contact the DHHR office, and after proper notice the benefits may be used to repay outstanding claims. **I also understand** that if I do not use benefits in an EBT account for a period of 270 days that the benefits will be removed from the account. I may voluntarily request that benefits in my account be used to repay claims established against my Food Stamp benefits at any time.

FOOD STAMP PROGRAM (Continued)

Yes ☐ No ☐ **3)** **I understand** if I or any member of my household:

A) is found guilty in a federal, state or local court of trading Food Stamp benefits for firearms, ammunition, explosives or controlled substances; **is a convicted felon for possession, use, or distribution of a controlled substance(s); or is found guilty of trafficking $500 or more in Food Stamp benefits, the guilty party will be permanently disqualified from participating in the Food Stamp Program.**

B) makes a false statement or misrepresentation of identity and/or residence to receive duplicate benefits at the same time, the responsible party will be **disqualified from the Food Stamp Program for 10 years.**

Yes ☐ No ☐ **4)** **I understand** if I am found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation, I will not receive Food Stamp benefits as follows: **First Offense** - one year; **Second Offense** - two years; **Third Offense** - permanently. In addition, I will have to repay any benefits received for which I was not eligible.

Yes ☐ No ☐ **5)** **I understand** I will have to repay any Food Stamp benefits issued to me for which I was not eligible when the reason I received the incorrect benefits was because of an unintentional error made by me or by DHHR.

Yes ☐ No ☐ **6)** **I understand** that if I fail to report or verify any household expense(s) that may entitle my household to an income deduction, I will not receive that deduction. This means I may not receive the full amount of Food Stamp benefits for which my household may be eligible. **I understand** that once I report and verify the expense(s), as required, I have the right to receive any calculated deduction beginning the following month.

Yes ☐ No ☐ **7)** **I understand** that as an able-bodied adult between the ages of 18 - 50 who does not live with a child under 18 **(ABAWD)**, I may receive Food Stamp benefits for not more than 3 months out of each 36 month period, if otherwise eligible, **if** I do not work at least 20 hours a week (averaged monthly), or do not participate in a work program for at least 20 hours per week. If **I** lose eligibility because of this time limit, I can become eligible again after I work or participate in a work program for at least 80 hours in a 30-day period. **I understand** this time-limited policy does not apply in all counties in West Virginia.

Yes ☐ No ☐ **8)** **I understand** that if I receive Food Stamp benefits **as a Simplified Reporting household certified for 6 months,** I have to report when my total household income **exceeds the Food Stamp gross income limit.** **I also understand** that I will be notified what this amount is and that I must report this to DHHR by the 10th of the month after the increase happens. **I also understand** that **if my household lives in a time-limited county and contains an ABAWD, I must report when that person's work hours are reduced to less than 20 hours a week, averaged monthly. I understand that none of the other Food Stamp reporting requirements listed on this form apply to my household.**

Yes ☐ No ☐ **9)** **I understand** that unless I am exempt, I must comply with work requirements including cooperating with Food Stamp Employment & Training (FSE&T), registering with the Bureau of Employment Programs (BEP), and providing information about employment status and job availability.

Yes ☐ No ☐ **10)** **I understand** that if I refuse or quit employment **or reduce my work hours to below 30 hours per week** without good cause I may be penalized.

FOOD STAMP PROGRAM (Continued)

Yes ☐ No ☐ **11)** **I understand that if I receive Food Stamp benefits as a Change Reporting household, consisting entirely of adults at least age 60 or age 18** and disabled, **with no earned income and certified for 24 months, I must** notify DHHR within 10 days of the following changes**, in addition to those listed in number 31.**

A) When my household's **assets** reach or exceed $3,000;

B) My household's **unearned income** changes by more than $50;

C) There is a change in the amount of court-ordered **child support** I pay or any member of my household pays to someone outside the household. I understand that the child support payment I report will be checked by computer match with the Bureau for Child Support Enforcement (BCSE) and that I have the right to contest any information that BCSE provides.

MEDICAID PROGRAM

Yes ☐ No ☐ **12)** **I understand** by accepting Medicaid under any category, **I agree** to give back to the State any and all money that is received by anyone listed on this application from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has or will make payment. In addition, **I agree** that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. **I further agree** to notify the **DHHR** office if I or anyone listed on this application is involved in any accident. **I understand** that this assignment of funds continues as long as I or anyone listed on this application receives Medicaid.

Yes ☐ No ☐ **13)** **I understand** it is an eligibility requirement that I must cooperate with **DHHR** and with any provider of medical services in pursuing any resource available to meet the medical expenses of any Medicaid recipient. **I agree** to assign to **DHHR** benefits available to any Medicaid recipient from any third-party source as a result of injury, accident, or illness. **I understand** that the amount payable to **DHHR** will never exceed the amount of the Medicaid liability. **I authorize** payment of any such third-party resources directly to **DHHR**. If the liable third-party makes payment directly to me, **I agree** to refund **to DHHR** an amount up to**,** but not exceeding**,** the amount of Medicaid liability. **I understand** that this repayment must be made even if my eligibility for Medicaid has stopped prior to my receiving such monies. **I further authorize** the release of any medical information or any information regarding medical insurance to **DHHR** and also authorize the release of any medical insurance information to medical provider(s) for billing purposes. **Authorization** is also given to **DHHR** to release medical payment information to attorneys and/or insurance companies for the resolution of third-party claims.

Yes ☐ No ☐ **14)** **I understand** that as a recipient of Medicaid, I may be required to cooperate with the Bureau for Child Support Enforcement (BCSE) in child support activities, including obtaining medical support.

Yes ☐ No ☐ **15)** **I understand** I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).

MEDICAID PROGRAM (Continued)

Yes ☐ No ☐ **16)** **I understand** that if my income is above the Medicaid limits, I might still be eligible to receive a medical card if I have excess medical bills. **I further understand** that my Worker will advise me of the amount of medical bills I have to show and that I have 30 days from the date I apply to provide the bills. The bills can be paid or unpaid and can be bills for me, my husband/wife, or dependent minor children who live with me. My Worker will explain which bills cannot be used and why.

Yes ☐ No ☐ **17)** **I understand** that federal and West Virginia law mandates the recovery of Medicaid paid after June 9, 1995 on behalf of individuals age 55 or older who receive Medicaid payment for nursing care or home and community based waiver services and related hospital and prescription drug services. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for the mentally retarded or other medical institutions when an individual is determined permanently institutionalized.

The state will not recover or will defer recovery from the estate when:

- The individual has a surviving spouse
- The individual has a surviving child who is under age 21 or who is blind or disabled.

The amount of the recovery is the amount Medicaid pays for these services for the individual.

After a proof of claim is filed against the estate, heirs affected by Estate Recovery may file a hardship waiver.

Estate Recovery is not an eligibility requirement to receive Medicaid or payment for the services.

WV WORKS

Yes ☐ No ☐ **18)** **I understand** that **if I am included in the WV WORKS payment** I have a lifetime limit of 60 months to get cash assistance, whether I live in West Virginia or any other state/territories in the United States. **I further understand** that I may obtain from my Worker the number of months remaining in my lifetime limit. **I also understand** that **if I am included in the WV WORKS payment,** I am required to participate in a work activity **beginning with the first month of benefits I receive**.

Yes ☐ No ☐ **19)** **I understand** that **all adults included in the WV WORKS payment** must sign the Personal Responsibility Contract (PRC) as a condition of eligibility. Failure to sign the PRC will result in not receiving cash assistance.

Yes ☐ No ☐ **20)** **I understand** that if I have a learning disability, or a physical or mental condition, I may have legal rights under the Americans with Disabilities Act (ADA). If the ADA applies to me and I **am unable to perform the action requested by DHHR,** (1) DHHR can help me do it, or DHHR can change what I have to do, (2) DHHR can call or visit if I am not able to come to the DHHR office, (3) DHHR can tell me what DHHR forms and letters mean.

Yes ☐ No ☐ **21)** **I understand** that if a child is moving out of my home for at least 30 days, I must report this change within 5 days of my knowing that the child will no longer be living with me or I am ineligible for benefits for 6 months.

WV WORKS (Continued)

Yes ☐ No ☐ **22)** **I understand** that parents who receive WV WORKS and who work or attend school are usually eligible for child care with no fee. A parent who loses WV WORKS due to earnings may also be eligible for 12 months of additional child care by paying a fee for the services. For more information on how to complete the required application, I may **be referred to a child care agency.**

Yes ☐ No ☐ **23)** **I understand** that unless I choose direct deposit into a bank account, my WV WORKS benefit will be deposited into an EBT account and cannot be replaced under any circumstances. If I choose an authorized cardholder who has access to my EBT account, benefits used by the authorized cardholder also cannot be replaced.

I also understand that if I do not use cash benefits deposited in an EBT account for a period of 180 days that the benefits will be unavailable to me unless I contact DHHR, and after proper notice the benefits may be used to repay outstanding claims. **I also understan**d that if I do not use benefits in an EBT account for a period of 270 days that the benefits will be removed from the account. I may voluntarily request that benefits in my account be used to repay claims established against my cash assistance at any time.

EMERGENCY ASSISTANCE (EA)

Yes ☐ No ☐ **24)** **I understand** that**, if approved for Emergency Assistance benefits,** I will not be eligible to receive Emergency Assistance within 12 months after the beginning date of my 30 day period of eligibility unless I qualify for Emergency Assistance created by natural or man-made disasters.

Yes ☐ No ☐ **25)** **I agree** to cooperate fully with instructions received from **my Worker** regarding my request for or receipt of Emergency Assistance benefits and I am fully aware that my failure to cooperate with or failure to otherwise carry out the instructions may cause the denial of or loss of Emergency Assistance benefits. **I further agree** to cooperate by accepting a referral to community resources in order to eliminate or prevent an emergency.

LOW-INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

Yes ☐ No ☐ **26)** **I understand** that if I knowingly provide false or fraudulent information that is used in connection with the eligibility determination for LIEAP benefits I may be subject, upon conviction, to fines or imprisonment or both. **I understand** I will be required to repay benefits received to which I am not entitled and that my failure to repay such benefits may result in loss of future LIEAP benefits.

Yes ☐ No ☐ **27)** **I understand** that I will be notified, in writing, within 30 days from the date of application regarding the decision made on my application and that I may request a Hearing if I have not been notified within 30 days. If I receive a direct payment, **I understand** the payment must be used to pay for the cost of primary home heating and that a receipt which verifies my payment for the cost of primary home heating must be submitted with my application for Emergency LIEAP. **I understand** that if I am found eligible, I am entitled to only one regular LIEAP payment and one Emergency LIEAP payment during the LIEAP Program year. **I understand** intake for Regular or Emergency LIEAP will close without notice.

FOR ALL PROGRAMS

Yes ☐ No ☐ **28)** **I understand** that providing my Social Security Number (SSN) to DHHR is mandatory and is required by Federal law. The only use of the SSN is in the administration of the Medicaid, WV WORKS and/or Food Stamp Programs, with no disclosure or use of the SSN for any other purpose. I further understand that an SSN is required only for those people who **apply for and/ or** receive benefits and not for any other person.

Yes ☐ No ☐ **29)** **I understand** for all programs **that** all persons included must provide a Social Security Number (SSN). The SSN will be used to check the identity of household members, prevent duplicate participation and to make mass changes. It will also be used in computer matching and program reviews or audits to make sure my household is eligible for the benefits we are receiving. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts.

Yes ☐ No ☐ **30)** **I hereby consent** to be referred to the Social Security Administration to be issued a Social Security Number (SSN) and to have my SSN released only for the purposes described above.

Yes ☐ No ☐ **31)** **I agree** to notify **DHHR of the following changes** within **10 days** if:

For Food Stamp Benefits Only: This does not apply to Simplified Reporting households certified for 6 months.

A) We move and/or change our address, name, or telephone number;
B) Anyone obtains/loses employment;
C) There are changes in my household's amount of unearned income or gross monthly income;
D) There are changes in the source of employment and hours worked;
E) Anyone moves into/out of my household.
F) Any individual in my home starts, finishes or drops out of school or job training;
G) There are changes in my household's assets, including receiving, selling, purchasing, or losing a vehicle, **including recreational vehicles and equipment;**
H) Anyone in my household receives a lump sum payment because this may affect our eligibility for continuing benefits and I may be expected to live on this income for a specific period of time.

I understand that failure to provide this information may result in a penalty or sanction.

Yes ☐ No ☐ **32)** **I understand that DHHR** will obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Motor Vehicles, Veteran's Administration, Workers' Compensation, Bureau of Employment Programs, Bureau for Child Support Enforcement, Bureau for Public Health - Division of Vital Statistics and Office of Maternal, Child **and Family** Health, Office of Inspector General, Bureau for Medical Services, Division of Rehabilitation Services and Immigration and Naturalization Service about each member of my group. This information will be obtained by the use of the Social Security Number of each recipient.

FOR ALL PROGRAMS (Continued)

Yes ☐ No ☐ **33)** **I understand** if I am not satisfied with any action taken on my case or I feel I have been treated unfairly because of my race, age, color, national origin, sex, disability, religion, or political belief, I can ask for a Fair Hearing orally or in writing. **I understand** that anyone may attend the Fair Hearing but, if I choose to have a lawyer attend, the Department will not pay the lawyer's fee. I also may complete a civil rights complaint form, IG-CR-1, at my local **DHHR** office, or contact the **Office of the Inspector General**, Building 6, Room 817-B, State Capitol Complex, Charleston, WV 25305. (See Page 1 for the addresses for Food Stamp and Medicaid Program discrimination complaints.)

Yes ☐ No ☐ **34)** **I understand** that I may receive information and a referral to receive Family Planning Services upon request.

Yes ☐ No ☐ **35)** **I further understand** that I may receive information and a referral for Domestic Violence services upon request.

Yes ☐ No ☐ **36)** **I understand** that appointments/meetings with my Worker may include scheduled/ unscheduled home visits, but **I also understand** that I am not required to allow the DHHR Worker to enter my home.

Yes ☐ No ☐ **37)** **I understand** that I will be required to cooperate with the Quality Assurance Reviewer in any review of my benefits as a matter of eligibility. This may require a home visit by the Reviewer and include additional verification of my situation, but I also understand that I am not required to allow the Quality Assurance Reviewer to enter my home.

Yes ☐ No ☐ **38)** **I give my permission** to DHHR to refer my family to any helping agency for needed service after my benefits end.

Yes ☐ No ☐ **39)** **I give my permission** specifically to the West Virginia State Tax and Revenue Department and the Internal Revenue Service to release to DHHR any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or DHHR policy.

Yes ☐ No ☐ **40)** **I give my permission** to the DHHR to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to Immigration and Naturalization Services, Social Security Administration, Bureau for Child Support Enforcement, Bureau for Medical Services, Bureau for Public Health, Division of Rehabilitation Services, or any other State or Federal Department/Agency/Organization primarily for the purpose of providing me with access to the services and benefits offered by these Departments/Agencies/ Organizations in an efficient manner that allows for coordination rather that duplication of service(s).

Yes ☐ No ☐ **41)** **I understand** that I may be qualified to apply for low-priced telephone services called Link-Up **America and** Tel-Assistance**/Lifeline** that the telephone company in my area offers. I give permission to DHHR to release information to the telephone company concerning my eligibility for this service. If my eligibility for DHHR programs is stopped, I understand DHHR will notify the telephone company.

FOR ALL PROGRAMS (Continued)

Yes ☐ No ☐ **42)** **I understand,** if I give incorrect or false information or if I fail to report changes that I am required to report, I may be required to repay any benefits I receive. I may also be prosecuted for fraud and **I understand** that any information given is subject to verification by an authorized representative of DHHR. Also, it is **understood** that any person who obtains or attempts to obtain welfare benefits from DHHR by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device can be charged with fraud. Punishment upon a conviction may be a fine up to $5,000 and/or a jail sentence of 5 years in jail. **For the Food Stamp Program Only** - federal penalties may include a maximum fine of $250,000 and a jail sentence of up to 20 years.

Yes ☐ No ☐ **43)** **I understand** DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services or activities. This notice is available in large print, on audio tape, **or** in Braille from any **DHHR** office. This Notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions or complaints or if I want to talk about whether I have a disability, I may contact the State ADA Coordinator at:

West Virginia State ADA Coordinator
Department of Administration, Building 6, Room 438
1900 Kanawha Blvd., East
Charleston, WV 25305-0139
(304) 558-3950
Monday through Friday 9:00 a.m. to 5:00 p.m.

Yes ☐ No ☐ **44)** **I give my permission** for any of the following entities to release any information to DHHR when this information is related to my receipt of assistance, including LIEAP. **I understand** that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. The entities that may release my information include any: financial institution; government agency or department; physician, including psychiatrists; psychologist or other counselor; drug testing facility; hospital, including psychiatric hospitals; business concern; HIV/AIDS testing services; other person with related information.

Yes ☐ No ☐ **45)** **I certify** that all statements on this form have been read by me or read to me and that I understand them. **I certify** that all the information I have given is true and correct and I accept these responsibilities.

✗ _____ _____
Applicant's or Authorized Representative's Signature **Date**

✗ _____ _____
Co-Applicant's Signature **Date**

_____ _____
Signature of Interviewing Worker Who Witnessed Signature **Date**

To Apply for Food Stamp Benefits:

X _____

Authorized Representative's Signature

_____

Telephone Number

_____

Street Address

_____

City, State, Zip Code