**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**EXTENSION OF 60-MONTH LIMIT FOR CASH ASSISTANCE**

☐ **Initial Consideration** ☐ **Reconsideration**

## BASIS FOR CONSIDERATION

This consideration is based on :

☐ Domestic Violence
☐ Late Onset Incapacity
☐ Educational Activity
☐ Caregiver for Relative
☐ Disability
☐ Pregnancy or age of child

## IDENTIFYING INFORMATION

1. Case Name _____ 2. RAPIDS Case Number _____ 3. SSN _____

4. Address _____

Street/PO Box City County State Zip

5. ☐ Single Parent Household ☐ 2-Parent Household

6. Is either parent excluded from the AG? ☐ Yes ☐ No

## RECIPIENT STATUS

7. Months of TANF in C-219 _____ 8. Months of WV WORKS _____ 9. Months of TANF in Other State _____

10. Date 60th Month will be received _____ 11. 55th Month Notice sent? ☐ Yes ☐ No

**NOTE:** Any of the above which do not apply must be marked "Not applicable" (N/A). This form is designed to be printed before being completed in ink. If you prefer completing it in WORD or WordPerfect, please use bold to highlight entries.

**DFA-EX-1 (11/05)**

## BATTERED OR SUBJECTED TO EXTREME CRUELTY

12. Has the client reported domestic violence? ☐ Yes ☐ No
13. Are they continuing to follow a plan under the direction of a domestic violence agency? ☐ Yes ☐ No
14. Is the household requesting the case be reopened after receiving 60 months? ☐ Yes ☐ No

## PROVIDING CARE FOR A RELATIVE

15. Would the caregiver be subject to a work requirement if not needed at home to provide this care? _____
16. Relative in the home who requires care? ☐ Child ☐ Spouse ☐ Parent ☐ Grandparent
17. Has the need for institutionalization or equivalent level of care been verified? _____
18. Copy of verification attached? _____
18a. If no, why _____
19. How long will care need to continue? _____ 20. Other arrangements being made? _____
21. If yes, describe other arrangements. _____

## TEMPORARILY INCAPACITATED – SUDDEN OR LATE ONSET

22. During or after the 55th month of benefits, has the client recently experienced an illness or injury that will temporarily render him incapacitated? ☐ Yes ☐ No
23. Date of onset _____ 24. If yes, has a determination been made by MRT? _____ 24a. When _____
25. Is client cooperating with medical treatment and/or rehabilitation, as appropriate? _____
26. Length of expected incapacity _____ _____
26a. After treatment, will client be able to engage in gainful employment? ☐ Yes ☐ No

## DISABLED

27. Was disability established prior to the 55th month? _____ 27a. How? (circle one) SSA RRB MRT

28. If not established prior to the 55th month, was a referral for SSI made and accepted? _____ 28a. When? _____

29. If not established prior to the 55th month, has information been sent to MRT? _____ 29a. When? _____

30. Results and/or status of referral and nature of disability claimed: _____

31. Results/status of SSI application (If denied, why? Is the denial in appeal?) _____

32. Please attach most recent MRT decision _____

## PREGNANT OR HAS CHILD UNDER SIX MONTHS

33. If pregnancy is claimed, has it been verified? _____ 33a. Due date _____

34. Date at which youngest child reaches six months of age. _____

35. Other information from local office, if any. _____

## IN A VOCATIONAL TRAINING OR EDUCATIONAL ACTIVITY

36. Name of training or educational course _____

37. Type of School _____ 38. Is attendee making satisfactory progress? ☐ Yes ☐ No

39. Expected outcome (certificate or diploma) _____

40. Was attendee enrollment in his 55th month? ☐ Yes ☐ No

41. Expected date of completion or course ending date _____

42. Other information from local office, if any _____

## DECLARATIONS

I, (please print) _____ completed this form on _____

with true and correct information to the best of my knowledge on the date of completion.

_____ _____

Signature of county office staff member who completed this form Date

Telephone number of contact person if additional information is needed: _____

I, (please print) _____ reviewed this form on _____

and concur that it is an accurate description of the case and the activities involved in case management. Based on the facts of the case and the client's and/or the case manager's reason for the request, I recommend that the Committee vote to

☐ **APPROVE** ☐ **DENY** the request for an extension.

_____ _____

Signature of Supervisor reviewing this form Date

Provide any additional information that may aid in making the extension decision.

_____

_____

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