EXAMPLE: During October, Mr. Foxworthy attended vocational training 18 days at 7 hours per day for a total of 126 hours. The school observed 1 holiday in October. Mr. Foxworthy missed 3 days of excused absences. He was ill 2 full days and missed another day due to flood waters covering the road to his home. Since only 2 days of excused absences can be credited as participation hours, his total hours for October are 126 + 7 (holiday) + 14 (excused absences) = 147.

EXAMPLE: Ms. Crump participates in a CWEP assignment 128 hours per month. She works 8 hours per day the first 4 weeks of each month, Monday through Thursday. There were no observed holidays during the month. In October, Ms. Crump had medical appointments and was absent on the following dates: 10/3, 2 hours; 10/11, 4 hours; 10/17, 2 hours; and 10/23, 4 hours. Although these absences are considered excused, the total that can be credited towards her participation for October are 8 hours for 10/11 and 10/23. Her total participation hours are: 116 + 8 = 124.

EXAMPLE: Ms. Poovy has a minimum weekly work requirement of 30 hours. She is assigned to JOIN and is scheduled to work 135 hours per month. She normally works 8 hours per day Monday through Friday during the first 3 weeks each month and the remaining 15 hours on Monday and Tuesday of the fourth week. During October she had an excused absence for the entire day on Tuesday, 10/6 (8 hours). There were no holidays. Her total attendance for October was 127 hours. The conversion chart shows that without the excused absence added in, she still meets the minimum weekly average of 30 hours for October. The Worker enters 30 hours in WPSC for October. The Worker could add the excused absence which would give this client an average of 31 hours per week but chose not to in order to save counting this absence as participation hours towards the 10 days per year maximum.

Unexcused absences that cannot be made up during the month are not counted as hours of participation. Only the hours actually worked count.

Record the results of all contacts with the employer/contractor concerning this issue on RAPIDS screen CMIC. At the end of the month the time sheet must correctly identify any absence. Any inconsistency or irregularity on the time sheet must be worked out with the employer/contractor. Absences that are made up during the month are not reported as excused or unexcused.

3. Holidays

Established holidays at the client's work **or** training site are counted as days worked by the client when he would normally have been scheduled to work or attend training on that day.

4. Paid Vacation/Sick Leave

When the client is on paid vacation, paid sick leave, or paid annual leave from work, the time he would normally have spent at work during that time is counted as hours worked.

C. PARTICIPANT DOCUMENTATION

1. Methods Of Documenting Participation Hours

All hours of participation in activities must be verified. The Participant Time Sheet, OFS-TS-12, is the standard time sheet used to document participation. When used, it is given to providers to report attendance and satisfactory progress in the activity. These time sheets may also be given to the client to have providers complete. Some employers/sponsors have their own time sheets. These are acceptable means of verification as long as these time sheets provide the necessary information and are signed by the sponsor or his representative. Documentation is required and must be available from the activity site at least every two weeks for all activities except for Job Readiness and Job Search Assistance in which documentation is required and must be available daily. Monthly time sheets must be filed in participants' **case** records.

For clients who are employed, other documents and methods may be used to verify work hours. Although time sheets, verbal, and written confirmation from the employer may be used, the following alternative methods may also be used to document these hours:

- Pay stubs
- Time cards
- Sign-in/sign out sheets
- Rosters

For employment, based on valid documentation, hours may be projected for 6 months unless there is a change in the number of work hours. When this happens, then actual hours must be documented and prospectively reported for 6 months. At the end of 6 months, current hours must be re-verified. The preferred method of verification of hours is 30 days of pay stubs to be used to project the client's participation for up to a six month period.

To receive support service payments, employed participants who continue to receive cash assistance must submit a time sheet signed by the employer listing the days worked. Pay stubs cannot be used for this purpose. Employed participants who no longer receive cash assistance must submit the application for continued support service payments, DF-SS-2. In addition, a time sheet signed by the client listing the days worked must be submitted.

The calculation of monthly participation hours for self-employed clients (those owning/operating their own business/service, providing child care, etc.) is determined in the following manner: Gross income minus business expenses divided by the federal minimum wage. If the number of recordable participation hours fall short of the minimum required hours, additional activity placement must be made by the Worker.

To receive support service payments, a self-employed client must complete and sign a self-reported time sheet, OFS-TS-12, to determine the days actually worked.

College attendance must be verified by provision of a time sheet, OFS-TS-12, signed by the client and an official of that institution.

Average weekly hours are determined by using the "TANF Participation Hours Conversion Chart" on the DFA Intranet site. The current calculation used on the chart in converting to weekly hours is 4.33 weeks for each month of the year. To determine the average weekly hours or participation for the first month of receipt of WV WORKS in any activity, refer to the "Participation Rate Chart – Prorated for First Month of Participation: on the DFA Intranet site.

EXAMPLE: Ms. B provides child care for her neighbor's two children, Monday through Friday from 8 a.m. to 5 p.m. The neighbor pays Ms. B $125 per week. Ms. B claims no business expenses. Ms. B received $600 pay for August 2006. Her hours of participation are: $600 divided by $5.15 = 116.5 (rounded up to 117 hours.) The conversion chart indicates this equals 28 hours per week. In this example Ms. B has a work requirement of 30 hours per week; **therefore,** she must participate in another core or non-core work activity for no less than 2 hours per week.

2. Case Recordings

Appropriate case recordings in CMIC are required in documenting participation hours and how support service payments are calculated (transportation for example).

3. System Coding Of Participation Hours

Participation hours for months in which WV WORKS benefits were received must be entered in RAPIDS Work Programs screen WPSC as soon as possible but no later than the day before BI Pulldown of the following month. The Worker must be certain to enter the hours of participation for the correct month.

For entry of participation hours after the deadline, please refer to the RAPIDS Work Programs Desk Guide, “Expansion of Component Entry and Work Hours Entry Deadlines”.

D. DISABILITY/INCAPACITY – DEFINITION ONLY FOR MINIMUM PARTICIPATION RATE

NOTE: The following definitions are used to determine the family’s minimum hours of participation, i.e., whether or not there is a disabled or incapacitated parent. See item A above. Meeting either definition does not automatically exempt the family or individual from the 60-month or 24-month time limits described in Section 15.6 and 15.7.

Disability and incapacity may be established with or without a physician’s statement as follows:

1. Establishing Disability Without A Physician’s Statement

When the disability is obvious to the Worker, no verification is required. The Worker must record his findings and the reason for his decision.

If the disability is not obvious to the Worker, disability may be established according to another criteria below in this item. If disability cannot be established according to this item (1), see item 2 below.

- The individual receives benefits from a governmental or private source, and these benefits are based on his own illness, injury or disability.

  This includes, but is not limited to: Workers' Compensation, RSDI, SSI, Veteran's Administration (VA) benefits, Black Lung benefits, Medicaid (incapacity, blindness or disability), private insurance, sickness benefits, etc. However, if any of these conditions is questionable, such as a low percentage disability for VA benefits, a physician's statement may still be required.

  For SSI and RSDI purposes, being certified for these benefits (approved, but not yet receiving payment withheld to repay, etc.) is synonymous with receiving them.

- The individual is a veteran with a service-connected or non-service connected disability, rated or paid as total, under Title 38 of the United States Code.

- The individual is a veteran who is considered by the VA to be in need of regular aid and attendance, or permanently housebound, under Title 38 of the United States Code.

- The individual is a surviving spouse of a veteran and is considered by the VA to be in need of aid and attendance, or permanently housebound, under Title 38 of the United States Code.

- The individual is a surviving child of a veteran and is considered by the VA to be permanently incapable of self-support, under Title 38 of the United States Code.

- The individual has one of the following conditions:

  - Permanent loss of use of both hands, both feet or one hand and one foot

  - Amputation of leg at hip

  - Amputation of leg or foot because of diabetes mellitus or peripheral vascular diseases

  - Total deafness, not correctable by surgery or hearing aid

  - Statutory blindness, unless due to cataracts or detached retina

  - IQ of 59 or less, which was established after attaining age 16

  - Spinal cord or nerve root lesions resulting in paraplegia or quadriplegia

  - Multiple sclerosis in which there is damage of the nervous system because of scattered areas of inflammation which recurs and has progressed to varied interference with the function of the nervous system, including severe muscle weaknesses, paralysis and vision and speech defects.

  - Muscular dystrophy with irreversible wasting of the muscles with a significant effect on the ability to use the arms and/or legs.

- Impaired renal function due to chronic renal disease, documented by persistent adverse objective findings, resulting in severely reduced function which may require dialysis or kidney treatment.

- Amputation of a limb, when current age is 55 or older

- Recipients of federal, state or local government disability retirement, who receive such benefits due to one of the conditions specified above. This includes, but is not limited to, payments under Civil Service Retirement (CSR) and Federal Employee Compensation Act (FECA).

- Those individuals who receive federally- or state-administered supplemental benefits under Section 1616 (a) of the Social Security Act (optional state supplementation to SSI payments) provided that eligibility to receive the benefits is based upon the disability or blindness criteria used under Title XVI of the Social Security Act or under Section 212 (a) or Public Law 93-66. West Virginia has no such program.

- Recipients of annuity payments, under Section 2,(a),(1),(iv) of the Railroad Retirement Act of 1974, who also have been determined eligible to receive Medicare under the Railroad Retirement Act.

- Recipients of an annuity payment, under Section (2),(1),(1),(v) of the Railroad Retirement Act of 1974, who have been determined to be disabled based on the criteria used under Title XVI of the Social Security Act.

- Recipients of benefits from the following Medicaid coverage groups:

  - SSI-Related Medicaid

  - HCB Waiver

  - MR/DD Waiver

2. Establishing Disability With A Physician's Statement

   The following criteria must be met to establish disability when the individual does not qualify according to item 1 above.

   a. Definition of Physician's Statement

      The term physician's statement means a medical report from a licensed medical professional, including but not limited to:

Physicians, Surgeons, Doctors of Osteopathy, Chiropractors, licensed or certified Psychologist, Nurse Practitioners, etc.

b. Content of the Physician's Statement

Generally, the statement must contain enough information to allow the Worker to determine if the client is disabled. If the physician makes a definite statement that the client is permanently and totally disabled, no further information is needed. Usually, however, the physician describes the situation, and the Worker must make the determination. In these situations, the statement must contain:

- The type of condition, including the diagnosis if known;

- Any unusual limitations the condition imposes on the client's lifestyle; and

- The length of time the condition is expected to last. This is required only to set a control for reevaluation; there is no durational requirement for which the condition must exist or be expected to exist.

c. Making the Determination

Once the necessary information is received, the Worker makes the determination based on the following guidelines:

- If the condition is one listed in Appendix D of Chapter 12 as a guideline for presumptively approving an AFDC Medicaid or AFDC-Related Medicaid case, disability is established. No durational time limits are imposed.

- Any other condition must impose limitations on the client's normal way of life. For example, a case of hypertension, requiring only a special diet and daily medication, does not substantially alter an individual's way of life, since eating is part of his daily routine, and taking medication does not significantly interrupt normal activities. However, a diagnosis of hypertension requiring daily medication, special diet, frequent rest periods and avoidance of stress substantially limits a normal lifestyle.

3. Establishing Incapacity

The definition of incapacity and the procedures for making the determination that are found in Section 12.3,C apply here.

E. LIMITATIONS ON DATA SYSTEM ENTRIES

The following limits must be used when entering hours of participation in RAPIDS.

- Job Search - Limited to entries of 40 hrs./week unless the client is able to document more hours. Job Search activities include, but are not limited to, time spent on: travel, making phone calls, interviews, completing employment applications, preparing resumes, etc.

- Truckers - Limited to entries of 60 hours/week, unless the client is able to document more hours.

- Paid In-Home Care Providers - Limited to entries of 40 hours/week, even when 24-hour care is needed.