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 $170 per week. Ms. B claims no business expenses. Ms. B received $731 pay for August. Her hours of participation are: $731 divided by $8.00 = 91.38 (rounded to 91 hours.) In this example Ms. B has a work requirement of 128 hours month week; therefore, she must participate in another core or non-core work activity for no less than 37 hours/month.

To receive support service payments, self-employed Work Eligible Individuals must complete and sign a self-reported timesheet, DFA-TS-12, to determine the days actually worked.

College attendance must be verified by provision of a timesheet, DFA-TS-12, signed by the client to determine days and hours of actual attendance.

The calculation of hours of participation for other allowable activities is based on the following process:

Step 1: Determine the client's total monthly hours of participation, as reported on his timesheet.

Step 2: Add hours for paid vacation and paid sick leave. Do not include excused absences in this figure.

The result is the monthly participation hours which are entered by the Worker and recorded in Work Program comments.

Time for excused absences as found in Section 24.3, up to 16 hours is entered separately. Time for federally designated holidays is entered separately and is not converted to a weekly average.

For informational purposes, we consider EI, FB, FU, FV, OJ, PB, PU, and PV as paid work components. All other components are considered non-paid work components. For paid work components, RAPIDS will add actual monthly participation hours to the monthly excused absence hours and monthly holiday hours and then divide the result by 4.33. Round that result to obtain the weekly average for TANF reporting purposes. For non-paid work activities, RAPIDS will divide monthly completed hours by 4.33, excused absence hours and holiday hours by 4, and then round the number for each entry. These items will not be added together but will be reported as individual items for TANF reporting purposes. This process is completed for each component separately.

EXAMPLE: Kelly participated 41 hours in JR and 88 hours in VT.
JR = 41 / 4.33 = 9.46 = 9
VT = 88 / 4.33 = 20.32 = 20
29 hours participation average / week

EXAMPLE: The participant is required to complete 128 hours in a core activity. He actually participates 103 hours in JR and will receive 8 hours for federally designated holiday. Attached to his time sheet were 2 doctor's statements for 16 hours of excused absences. Hours will be entered on as follows:

Component	Scheduled Hours	Competed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	128	103	16	8

103 ÷ 4.33 = 23.79 = 24 average hours/week attended
16 ÷ 4 = 4 average hours/week excused absence
8 ÷ 4 = 2 average hours/week for federal holidays
30 weekly average

3. Case Recordings

Appropriate case recordings are required in documenting participation hours for Work-Eligible Individuals and how support service payments are calculated (Example, transportation).

4. System Coding Of Participation Hours

Participation hours for months in which WV WORKS benefits were received must be entered in RAPIDS Work Programs as soon as possible but no later than the last day 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, "Work Component and Hour Entries Deadlines".

D. DISABILITY/INCAPACITY – DEFINITION ONLY FOR TEMPORARY GOOD CAUSE

NOTE: A two-parent family with one parent disabled or incapacitated according to this section is still considered a two-parent family for minimum participation rate requirements. The family may be temporarily granted good cause for not meeting the minimum requirements. See Section 13.10. 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 for a Work-Eligible Individual 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 in case comments.

If the disability is not obvious to the Worker, disability may be established according to other criteria below. If disability cannot be established according to this item (1), see Establishing Disability With A Physician's Statement 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 are 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 the same as 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
  - ADW Waiver
  - I/DD Waiver
  - TBI 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 Establishing Disability Without A Physician's Statement 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 apply here.

E. LIMITATIONS ON DATA SYSTEM ENTRIES

The following limits must be used when entering hours of participation for Work-Eligible Individuals in RAPIDS.

- Job Search - Limited to entries of 161 hours/month 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 240 hours/month, unless the client is able to document more hours.

- Paid In-Home Care Providers - Limited to entries of 175 hours/month, even when 24-hour care is needed.

- All other allowable activities are limited to entry at 240 hours per month as completed.