# RIGHTS AND RESPONSIBILITIES

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

### SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

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Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State Information/Hotline Number at (800) 642-8589.

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

## SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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

**I understand** that I cannot do, or attempt to do the following either in public, in private, or online: buy, sell, trade, steal or otherwise use SNAP benefits for monetary gain or other considerations; purchase food in containers with deposits and discard the product to receive cash refund deposits; and purchase or sell food originally purchased with SNAP benefits for monetary gain or other considerations. *Any of these actions is considered SNAP trafficking.*

Yes ☐ No ☐ 2) **I understand** if any member of my assistance group is found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation including trafficking, the individual will not receive SNAP benefits as follows: **<u>First Offense</u>** - one year; **<u>Second Offense</u>** - two years; **<u>Third Offense</u>** - permanently. In addition, I understand my assistance group will have to repay any benefits received for which it was not eligible.

## SNAP PROGRAM (Continued)

Yes ☐ No ☐ 3) **I understand** if I or any individual:

A) is found guilty in a federal, state or local court of trading SNAP 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 SNAP benefits, the guilty party will be **permanently disqualified from participating in the SNAP 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 SNAP Program for 10 years.**

C) is found guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, the guilty party will not be eligible for benefits for two (2) years for the first offense and permanently for the second offense.

Yes ☐ No ☐ 4) **I understand** that my SNAP 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 understand** that if I do not use SNAP benefits deposited in an EBT account for a period of 365 days then that benefit only will be removed from my account. I also understand there may be remaining benefit amounts in the account that will not be available to me until my account status has been reset to active. I may voluntarily request that benefits in my account be used to repay claims established against my SNAP account at any time.

Yes ☐ No ☐ 5) **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 SNAP 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 ☐ 6) **I understand** that if I receive SNAP benefits I have to report when my total household income exceeds the SNAP 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 understand** that none of the other SNAP reporting requirements listed on this form apply to my household.

Yes ☐ No ☐ 7) **I understand** that unless I am exempt, I must comply with work requirements by registering with WorkForce West Virginia, and providing information about employment status and job availability.

Yes ☐ No ☐ 8) **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.

Yes ☐ No ☐ 9) **I understand** that I am authorized to receive information and referral services about TANF-funded programs as well as other programs offered by the WV Department of Health and Human Resources and other organizations in West Virginia. **I understand** that this information will be included in every SNAP notification letter sent to me.

## HEALTH COVERAGE PROGRAMS

Federal law prohibits discrimination on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. A complaint of discrimination may be filed by visiting www.hhs.gov/ocr/office/file or by writing 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). HHS is an equal opportunity provider and employer.

Yes ☐ No ☐ 10) **I understand** that as a recipient of Medicaid, I may volunteer for the Bureau for Child Support Enforcement (BCSE) services, including obtaining medical support. These services are provided by BCSE at no charge to me.

Yes ☐ No ☐ 11) **I understand** I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Yes ☐ No ☐ 12) **I understand** that if my income is above the Medicaid limits, I may 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 ☐ 13) **I understand** that a period of ineligibility for Medicaid long term care may result if resources were transferred within the sixty (60) month period prior to the date of application by the applicant or applicant's spouse. This includes transfers into certain trusts.

Yes ☐ No ☐ 14) **I understand** that I am required to disclose to the State any interest my spouse or I have in an annuity. **I understand** the State must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse or a minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided. Failure to comply with these requirements may be considered a transfer of resources for less than fair market value and result in ineligibility for Medicaid long term care services.

Yes ☐ No ☐ 15) **I understand** that federal and West Virginia law mandates the recovery of Medicaid payments made after June 9, 1995 for nursing care or home and community-based waiver services and related hospital and prescription drug services on behalf of individuals age 55 or older at the time the payment is made. 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 impose a lien or will defer recovery from the estate when:

- The individual qualifies for Medicaid under the adult expansion provisions of the Affordable Care Act; or
- The individual has a surviving spouse living in the home; or
- The individual has a surviving child who is under age 21 living in the home; or
- The individual has a child living in the home who meets the Social Security Act's definition of blindness or permanent and total disability; or,
- The individual's sibling has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to a medical institution.

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