1.2 GENERAL INFORMATION

This Section contains general information, applicable to all Programs and coverage groups.

A. APPLICANT AND POTENTIAL APPLICANT'S RIGHTS

In addition to addressing all questions and concerns the client may have, the Worker must explain the benefits of each Program and inform the client of his right to apply for any or all of them.

1. Right To Apply

No person is denied the right to apply for any Program administered by the Division of Family Assistance (DFA). Every person must be afforded the opportunity to apply for all Programs on the date he expresses his interest.

Certain programs, such as CDCS, I/DD, AD and TBI Waiver, require a medical and/or other determination by a community agency or government division other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

NOTE: When an application has been made for WV WORKS and/or Medicaid and the application is denied, withdrawn, approved for a DCA payment, or held pending additional information, the AG must not be required to make a separate application for SNAP benefits as long as the application taken is appropriate for the additional program and includes questions and answers to determine that program's eligibility.

When it is not feasible for the applicant to be interviewed, if an interview is required or requested, on the date he expresses his interest, he must be allowed to complete the process at a later date. An appointment may be scheduled for his return, or the client may return at his convenience, depending upon the procedure established by the CSM. The same procedure must be used for all applicants within the county. If a follow-up appointment is scheduled and the applicant appears for the interview, he must be seen on that day and not required to return again to complete the application process.

NOTE: SNAP applicants must be given a scheduled interview when it is not feasible to conduct an interview on the date the application is made. Any special needs such as, but not limited to, the applicant's work schedule, must be accommodated.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents printing the DFA-2, form DFA-5 must be signed by the applicant and filed in the record with the DFA-2 after it is printed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed.

2. Right To General Information

All those who have applied for benefits, or who inquire about the requirements for receiving benefits, must have the requested information provided to the county office Worker. This includes a basic explanation of the eligibility requirements and answers to general questions. If the Worker does not know the answer to the general question, he must consult with his Supervisor. If the answer is unknown to the Supervisor, they may submit the question to the DFA Economic Services or Family Support Policy Unit. Applicants, potential applicants or their representative must not be referred to the DFA Policy Unit for a direct response.

NOTE: The Worker must not act as a financial planner or make suggestions about the client's current or future financial situation.

3. Right To Consideration For All Programs

a. Applying for Programs with the Department

It is the Worker's responsibility to explain and make available all of the Department's programs for which the applicant could qualify. Certain programs, such as CDCS, I/DD, AD, and TBI Waiver, require a medical and/or other determination by a community agency or government division other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs. Unless the applicant specifically states he is not interested in being considered for WV WORKS, including DCA; SNAP benefits; Medicaid; or SCA, during the appropriate time period, the Worker must evaluate potential eligibility for each of these. The evaluation of eligibility is accomplished in eRAPIDS.

All applications for any program must be evaluated for all other programs based on the available information.

When an Evaluated AG passed and is confirmed, a client notice is issued from eRAPIDS to inform the applicant that he may be eligible for a benefit for which he did not apply and that he must contact his local office for information or to apply.

b. Applying at the Federally-Facilitated Marketplace (FFM)

Individuals may apply at the Marketplace for insurance affordability programs and MAGI Medicaid including Parents/Caretaker Relatives, Adult, Pregnant Women and the Children Under Age 19 Group and WV CHIP. When the individual's income is at or below the income limits for Medicaid, the Marketplace will determine the applicant's eligibility for Medicaid or WV CHIP and forward the data file to eRAPIDS. The system will determine the specific Medicaid or WV CHIP coverage group through which Medicaid will be issued without delay.

The Marketplace's responsibility of determining eligibility for Medicaid is limited to Medicaid coverage implemented through the Affordable Care Act in WV effective October 1, 2013 and includes MAGI groups only. The Marketplace is not responsible to assess or determine eligibility for other Medicaid or other Department Programs, benefits or services. When the Worker identifies the individual's potential eligibility, the Worker notifies the individual of the application process for any other programs or services.

NOTE: The Adult MAGI Medicaid group begins January 1, 2014.

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4. Right To Voter Registration Services

The National Voter Registration Act of 1993 (NVRA), also known as the Motor Voter Act, is a federal civil rights law that requires public assistance agencies to provide voter registration services. A voter registration application and declination form must be provided at any point a client engages in an application, recertification, or reports a change of address in conjunction with benefits. When an application, recertification or change of address is submitted via any method other than a face-to-face contact with a Worker, a voter registration application and a declination form must be mailed to the client.

West Virginia election laws require that the Department of Health and Human Resource offices provide voter registration services in conjunction with the following benefits:

- WV WORKS
- SNAP
- Low-Income Energy Assistance Program
- Medicaid

NOTE: When an individual who applied for Medicaid through the Marketplace expresses to the Department an interest in voter registration, the Worker must provide a voter registration application and a declination form if the inquirer decides not to register.

Workers must provide the same level of assistance with voter registration applications as they would with any other agency form or service. This includes reviewing the voter registration application to ensure all required fields are completed and answering any questions the client may have. Workers must submit all completed declination forms, including those marked “yes”, “no”, or those left blank by the client, and voter registration applications to their county NVRA Coordinator.

See Appendices F & G for Worker and County Coordinator responsibilities.

The Bureau for Children and Families (BCF) State Coordinator shall oversee reporting and compliance of voter registration services. A list of responsibilities assumed by the BCF State Coordinator may be found in Appendix H.

The BCF State Coordinator may be contacted at (304) 356-4619.

5. Right to Fair and Equitable Treatment of Applicants and Recipients

a. Introduction

West Virginia has established procedures for ensuring fair and equitable treatment of applicants and recipients of public assistance. The West Virginia Department of Health and Human Resource prohibits discrimination against its customers on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

- The West Virginia Human Rights Act, West Virginia Code §5-11-1
- The Age Discrimination Act of 1975, 42 U.S.C. §6101 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794
- The Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq.
- Title VI of the Civil Rights Act of 1964, 42 U.S.C. §20000d et seq.
- Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 et seq.
- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996
- The Civil Rights Restoration Act of 1987
- The Food and Nutrition Act of 2008
- USDA Departmental regulation 4330-2
- USDA Regulation, 7CFR Part 16.

Federal law protects individuals with a disability and defines that as a person who has;

- a physical or mental impairment that substantially limits one or more of the major life activities of that individual; or
- a person who has a record of such an impairment; or
- a person who is being regarded as having such an impairment.

There are two key issues regarding discrimination against people with disabilities:

- Individualized treatment: Individualized treatment requires that individuals with disabilities be treated on a case-by-case basis, based upon facts and objectivity. Such individuals

may not be treated differently on the basis of generalizations or stereotypes.

- Effective Opportunity and Access: Effective opportunity and access means that individuals must be given the same access and opportunities to programs of assistance as individuals who do not have disabilities.

Federal law also protects individuals with Limited English Proficiency (LEP) and defines that as;

- Individuals who do not speak English as their primary language; and

- have a limited ability to read, speak, write, or understand English.

It is the responsibility of the Worker to consider whether a person may have a special need, and how that may affect his ability to comply with rules, fill out forms, attend scheduled appointments, etc. If the Worker determines that a person has a disability or LEP and that affects his ability to comply, the Worker has the authority to make reasonable modifications or accommodations to ensure that the person receives equal access to all programs and services. Any evidence must be documented in the case record and in Case Comments.

A flag must be entered to alert the Worker that an accommodation may be needed and also to track cases for Federal reporting requirements.

NOTE: WV WORKS participants who have a documented disability must be placed in the AD component in Work Programs in addition to other component codes.

b. Methods and Examples of Accommodations

At this time West Virginia does offer the following methods of accommodations to all applicants and recipients:

- Sign Language Interpretation

  1. Attempt to locate free certified sign language interpreters in the community in advance.
  2. Contact the Commission for the Deaf and Hard of Hearing in advance to locate names and numbers of local interpreters (if any).

3. Contact the current contract holder for language translation and interpreter services.

- Visual Impairment Services

  All general public information should be made available in accessible formats such as large print, audio, and Braille. Public entities are responsible for providing these upon request, unless doing so causes an undue burden. Public entities are prohibited from charging a fee for auxiliary aids and services.

- Interpreter Services With Phone Companies

  Verizon offers interpreter services free of charge. An Interpretation Unit is accessible through Verizon's main phone number.

- Interpreter Services With Community Resources

  If an individual requires an interpreter, the Worker must contact local resources to locate one. Examples of community resources include, but are not limited to, the Board of Education, local colleges and the Division of Rehabilitation Services. If a local community resource cannot be located, the Supervisor of the Worker must contact the DFA Policy Unit for assistance.

- Interpreter Services For Participants In The Refugee Assistance Program

  Interpreter services are available for individuals who are participating in the Refugee Assistance Program. See Section 18.10, request for services can be made by contacting the following agency:

  Office of Migration and Refugee Services
  1116 Kanawha Boulevard, East
  Charleston, West Virginia 25301
  (304) 343-1036

EXAMPLE: An individual applies for WV WORKS. He has a learning disability and is unable to read, comprehend or complete the application. A reasonable accommodation is for the Worker to read the application to the individual and to explain the information fully.

EXAMPLE: A client is physically unable to come to the local office

for appointments made to keep her benefits. A reasonable accommodation is for the Worker to arrange to do a phone interview and/or a home visit, if necessary.

EXAMPLE: A client who has limited mobility comes into the office for a redetermination of benefits. An accommodation for this person is to ensure that an interview room equipped for disabled individuals is available for this client at the time of his appointment. If no such room is available, the Worker may assist the client to an appropriate work station to conduct the interview.

c. Complaint Procedures

Any person, who believes that he has been the subject of discrimination on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information in employment or in any program or activity conducted or funded by the Department, has a right to file a complaint. (Not all prohibited bases will apply to all programs and/or employment activities.) This complaint can be filed by the individual or his representative.

Procedures to file a complaint are:

The individual may make the complaint using the Civil Rights Discrimination Complaint form (IG-CR-3) by phone or in person to the Civil Rights Compliance Officer, within 180 days of the incident to the following address or phone number.

Employee Management
DHHR Equal Employment Opportunity (EEO) Officer
One Davis Square, Suite 400
Charleston, West Virginia 25301

For SNAP benefits only, a copy of the IG-CR-3 must be sent to the following address, or the individual may file a direct complaint to:

United States Department of Agriculture
Director, Office of Adjudication
1400 Independence Ave SW
Washington, DC 20250-9410
(800) 632-9992

The individual may also file a Civil Rights program complaint of discrimination with USDA by completing the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or by calling (866) 632-9992 to request the form.

The individual may write a letter containing all of the information requested in the form. Send the completed complaint form or letter by mail to: U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov

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 Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

The individual may also report concerns for federal review within 180 days of the date of the incident to the following address.

Health and Human Services
Office for Civil Rights
U.S. Department of Health & Human Services
Room 515-F
200 Independence Avenue, S.W.
Washington, D.C. 20201
Or call (202) 619-0403 (voice) or
(800) 537-7697 (TTY)

A written complaint should include the following information:

- The name of the person(s) felt to have been treated unfairly
- The date and description of the alleged discriminatory action
- The name(s) of other persons, if any, who were present when this action occurred
- The date the complaint is made
- The signature of the person or representative making the complaint

Each complaint received must be investigated and corrective action taken, if appropriate. The investigations and corrective actions are handled in conjunction with DHHR's EEO Officer.

Each office must post the ADA/Section 504 Notice in a prominent area to provide information regarding rights under the ADA and Section 504.

For SNAP benefits only, the following USDA nondiscrimination statement must be included, in full, on all materials produced for public information, education or distribution regarding the program:

The U.S. Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If an individual wishes to file a Civil Rights program complaint of discrimination with USDA, they can complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or by calling (866) 632-9992 to request the form. The individual may write a letter containing all of the information requested in the form. Send the completed complaint form or letter by mail to: U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

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 Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

USDA is an equal opportunity provider and employers.

B. OVERVIEW OF THE ELIGIBILITY DETERMINATION PROCESS

The components of the eligibility determination process and a brief description of each follow:

1. Application Process

This process determines initial eligibility for one or a combination of programs. Depending on the program or coverage group for which an individual applies, the application may be submitted by mail, phone, electronically, Marketplace, inROADS, in person, or receipt of an application through the SSA's data exchange. See K below for inROADS applications.

NOTE: Insurance Affordability programs may apply by a Single-Streamlined Application (SLA).

Certain programs, such as CDCS, I/DD, AD, and TBI Waiver, require a medical and/or other determination by a community agency or government division other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

The application may be held, pending receipt of necessary information or verification, but there are processing time limits which must be met. All applications must have a final disposition and the client must be notified of the decision.

2. Redetermination Process

Periodic reviews of total eligibility for recipients are mandated by law. These are redeterminations and take place at specific intervals, depending on the Program or coverage group. Failure by the client to complete a redetermination usually results in ineligibility. If the client completes the redetermination process by the specified program deadlines and remains eligible, benefits must be uninterrupted and received at approximately the same time.

The redetermination process involves basically the same activities described in Application Process above. Data system changes and client notification of any changes resulting from the redetermination conclude the process.

3. Case Reviews And Case Maintenance

While a redetermination is a required periodic review of total eligibility, a review may be conducted at any time on a single, or combination of questionable eligibility factor(s).

NOTE: SNAP recipients may be requested, but not required, to complete a face-to-face interview between redeterminations. See Section 2.2 for an explanation of the procedure used when the Worker or Agency needs to clarify information received about the SNAP AG.

The case maintenance process may involve a review or activities that update the Department's information about the recipient's circumstances between the application and first redetermination and between redeterminations. Changes in eligibility or the benefit amount may occur. If so, data system action and client notification of any changes are required.

Some special situations may require a more formal review process. This may be a special procedure to target an error problem.

NOTE: Home visits for SNAP AG's may only be made on case-by-case basis and not because an AG fits an error prone or other profile.

4. Resource Development

Medicaid recipients are responsible for applying for and accepting alternative means of support. This is an eligibility requirement for this Program. See Chapter 5.

WV WORKS recipients are responsible for taking necessary steps to apply for alternate available resources. This resource development is part of the Personal Responsibility Contract. See Section 5.2 for details and exceptions.

SNAP recipients must be encouraged to take advantage of any potential resources that may be available, but failure to apply for or accept such benefits does not affect SNAP eligibility.

C. APPLICATION REGISTER AND OTHER COUNTY CONTROLS

1. Application Register

Each local office must maintain a register of applications received by the Department on Form DFA-15, Application Log, or a similar method, containing at a minimum, the same information on the DFA-15. The office

may choose to have the application register maintained for the entire office or unit. If retained by each unit, copies of the registers must be compiled at the end of each month and stored together in one location.

2. Home Visit Register

The local office must devise a method to control and monitor inquiries and requests for applications which require a home visit. In addition, any home visit made must be shown on the log.

If any other registers or controls related to the application process are required, they are program or coverage-group specific and listed with the program or group.

The Worker, Supervisor, CSM or RD may establish any other registers necessary for the day-to-day operation of the local office.

D. WORKER RESPONSIBILITIES

The Worker has the following general responsibilities in the application process. Responsibilities that are Program- or coverage group-specific are found in the Program sections of this Chapter.

- When the Worker has access to the applicant, he must inform him of Department benefits, and providing SSN's for non-applicants is not required but will be used to facilitate enrollment in insurance affordability programs for verification of financial information.

- Accept an application from any person or his representative who wishes to apply.

  NOTE: Certain programs, such as CDCS, I/DD, TBI and ADW require a medical and/or other determination by a community agency or government division other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

- Ensure the client is given the opportunity to apply for all of the Department's Programs on the date that he expresses an interest.

- Obtain all pertinent, necessary information through verification, when appropriate.

- Inform the client of his responsibilities, the process involved in establishing his eligibility, including the Department's processing time limits, and how the beginning date of eligibility is determined.

- Adhere to the Department's policies and procedures to establish eligibility, including those regarding timely action and/or decision.

- Assist the client in obtaining information required to establish his eligibility. When the Worker must make a collateral contact, such as an employer, the Worker must not disclose the client's status as an applicant/recipient of a Department program.

- Maintain the confidentiality of all information received from or about the client. When the Worker must make a collateral contact, such as with a client's employer, the Worker must not disclose the client's status as an applicant/recipient of a Department program.

- When the Worker is aware an applicant is an employee of the Department or relative of a Department employee or otherwise clearly may have an interest in limiting access to his case information, the option of coding his case confidential for his protection is presented. The advantages and disadvantages of limiting access to certain staff are explained. The applicant's choice is documented in case comments.

  EXCEPTION: Staff must not initiate contact with law enforcement officials to disclose information regarding SNAP clients. However, information pertaining to a SNAP client or member of his household may be provided when written requests from federal, state or local law enforcement officers are received on official department letterhead of the issuing law enforcement agency and verifies that:

  - The individual is fleeing to avoid prosecution, custody or confinement for a felony; or

  - The individual is violating parole or probation; or

  - The individual has information necessary for the officer to conduct an official duty related to either of the two statements immediately above.

  The Worker provides only the individual's last known address and SSN and, if available, a photograph of any member of the individual's household. It is the responsibility of the CSM to review and approve the release of all such information. If a written request for information is questionable, the Supervisor or CSM must contact the DFA Economic Services Policy Unit for assistance. Additional guidance on releasing confidential information is outlined in the DHHR Common Chapters Sections 200 - 260.

NOTE: In all situations where case information is released to another organization or agency, the information must have form DFA-CI-1 attached.

Per client request, make available his case information including all electronic submissions and paper documentation during normal business hours. See DHHR Common Chapters Section 230 for additional information.

When the client discloses a domestic violence situation, extreme caution must be taken to safeguard any information about the individual's location or living situation. The Worker must not contact the individual named as the abuser or his relatives or friends for any information or verification required from the client. The eRAPIDS case must be coded with the domestic violence indicator to alert all who access the case about the client's situation. The indicator is coded in eRAPIDS with either of the following:

DA-Domestic Violence Disclosed - Referral Accepted

DR-Domestic Violence Disclosed - Referral Refused

The codes indicate disclosure of domestic violence and whether or not the client accepted a referral to a community domestic violence agency.

- Notify the client of the eligibility decision as soon as possible, but at least within the processing time frames for each Program or coverage group.

- Ensure that copies of all pertinent information are placed in the client's case record or given to appropriate staff to file.

  NOTE: Copies of any information which involve a domestic violence situation must never be placed in the case record to insure the safety of the client and to insure that the alleged abuser does not gain access to information which may compromise the safety of the client. If it is necessary to maintain records for the purpose of documentation of the situation for a WV WORKS temporary exemption from work requirements, the information must be maintained in a separate file which is secured and available only to Supervisors. Information maintained in a separate file regarding domestic violence may be presented as evidence at a Fair Hearing, so long as the client agrees to use of the information for such purpose.

- Ensure that proper case recordings are made to document the Worker's actions and the reason for such actions.

  NOTE: Information about a domestic violence situation or the whereabouts of an individual or family who has left a domestic violence

situation for a safer residence must never be recorded in the case record in order to insure the safety of the individual or family. If it is necessary to make contacts with a domestic violence agency or the Division of Children and Adult Services in conjunction with a temporary exemption from work requirements for WV WORKS, the information must be maintained in a separate file which is secured and available only to Supervisors. Information maintained in a separate file regarding domestic violence may be presented as evidence at a Fair Hearing, so long as the client agrees to use of the information for such purpose.

- Ensure that information about available community resources addressing domestic violence is available to all persons who request it, or who, in the Worker's judgment, may benefit from it. In addition, the Worker must make an immediate referral to the appropriate domestic violence or community agency when the client requests such assistance. When possible, the referral must be made the same day. If the agency cannot make arrangements to see the client the same day, a referral to the Division of Children and Adult Services must be made the same day, if possible.

- Inform the client that he is authorized to receive information and referral services about TANF and other programs offered by the WV DHHR.

- A voter registration application and declination form must be provided at any point a client engages in an application, recertification, or reports a change of address. See Section 1.2 to assure compliance with this procedure.

E. CLIENT RESPONSIBILITY

The client's responsibility is to provide information about his circumstances so the Worker is able to make a correct decision about his eligibility. When the client is not able to provide the required verification, the Worker must assist him. The client must be instructed that his failure to fulfill his obligation may result in one or more of the following actions:

- Denial of the application

- Closure of the active AG

- Removal of the individual from the AG

- Repayment of benefits

- Reduction in benefits

The action taken by the Worker depends on the specific requirement. These actions are found with the specific policy or in this Chapter under the program-specific information.

Prior to taking any of the actions described above, the Worker must determine whether or not the client is able to cooperate. If he is able, but has not complied, the appropriate action described above is taken. If not, the Worker must assist the client in obtaining the required information.

F. APPLICANT RECEIVES BENEFITS FROM ANOTHER STATE

When an applicant states that he is or has been receiving SNAP benefits, cash assistance and/or Medicaid from another state and presents a letter which shows the last date for which he received benefits, contact with the other state is usually necessary only to inquire about repayment of benefits in that state, if the issue is not addressed in the letter. However, if cash assistance is involved, a contact is also necessary to determine the amount and the number of months received. The Worker must obtain the following information by telephone from the other state. The American Public Human Services Association (APHSA) Directory contains current telephone numbers. This information may also be found on state web sites on the internet.

- Date on which the client last received or will receive his last benefits

- Effective date of the termination of benefits

  NOTE: The effective date of benefit closure in West Virginia is the month for which the client last received benefits. This may not be true in other states.

- The individuals included in the benefit

- Whether or not any of the client's last benefits were returned to the agency

- For WV WORKS cases: the Worker must determine how many months the client received TANF payments in the other state.

  NOTE: States had until July, 1997 to convert from AFDC/U to a TANF-funded program. Therefore, for benefits received prior to 7/97, the Worker must also determine how many months of the cash assistance payments were funded under TANF. Appendix C contains information about when other states converted to TANF funding.

  NOTE: Counting months for which benefits were prorated toward the 3-month limit, is an option for each state. If the client’s previous state of residence includes a month of prorated benefits, the Worker asks only for the number of whole months of receipt. Therefore, regardless of the option chosen by the other state, the Worker must not count a prorated month.

- Whether or not the client owes a repayment to any Program

Each Program has specific requirements related to receipt of benefits from other states. Refer to Date of Application under each Program section below.

G. CONTINUATION OF THE CASE NUMBER AND TRANSFER OF A CLOSED CASE

Prior to data system entry for disposition of another application, the Worker must determine if there is an existing case number for the client.

When an existing case number is found in another county, the Worker must request immediate data system transfer to the client's new county of residence. The case record must be mailed to the new county of residence within 10 working days. The request may be accomplished by memorandum, electronic mail release or by telephone.

H. WHEN APPLICATION IS MADE OR RECEIVED IN THE INCORRECT COUNTY OFFICE

1. Applications Made In Person Or By Mail

The following procedures are used when an applicant mails or makes his application in the office of a county in which he does not reside.

- When a mail-in application is received in the incorrect county office, it must be mailed to the correct county office the same day it is received. In addition, the correct county office must be notified the same day by electronic mail that the form is being mailed.

- If the client visits the incorrect office to apply, the application must be accepted and an intake interview completed. The Worker must complete a system transfer to the correct county office on the date the application is made. The correct county office must be notified by electronic mail that the case is being transferred. The client must be informed of additional requirements he may have to complete in the correct county.

- If the client telephones the incorrect office, the Worker must give him the address and telephone number of the appropriate office. If he requests an application be mailed to him and does not choose to contact the appropriate office to have this done, one is mailed to him from the contact office, along with instructions to return it to the address of the correct county office. The Worker must notify the other office, by electronic mail, so the county may add the client's name to the application register. If the client, after explanation of

the available Programs, wants to apply for SNAP benefits, the contact county screens for Expedited Service eligibility, explains this to the client and notifies the correct county office that this was done. Expedited benefits are issued by the county of residence.

- within prescribed time limits, based on the date of application established by the contact office.

2. Applications Submitted By Use Of inROADS

When an applicant submits his application by inROADS to a county in which he does not reside the Worker must transfer the RFA to the proper dashboard.

3. Applications Made In Person Or By Mail Initiated From The SSA's Low Income Subsidy (LIS)/Medicare Premium Assistance (MPA) Data Exchange

The SSA exchanges LIS data files with the Department to process the LIS applicant's request for MPA. The client files are considered applications for MPA. eRAPIDS issues the DFA-QSQ-1 to these potential recipients of MPA. If the MPA applicant has had no case in eRAPIDS in the last 30 days, eRAPIDS designates a sending county based on the applicant's address in the LIS file. When the designated county is not the county of the client's residence, but the DFA-QSQ-1 is returned to the sending/incorrect county, that county is responsible for processing the DFA-QSQ-1 and responding to all applicant inquiries related to the application until an eligibility decision is determined. When application processing is complete, the case is transferred to the correct county, the DFA-QSQ-1 is forwarded, and the receiving county is notified electronically of the transfer.

NOTE: Differences in the processing of the DFA-QSQ-1 applications initiated from the SSA's LIS/MPA data exchange are found in Section 1.15.

I. GENERAL REQUIREMENTS FOR THE INTAKE INTERVIEW

Regardless of the Program or coverage group for which the client applies, the Worker is responsible for the following when an interview is conducted:

- Screening the client for all DFA benefits and explaining that he may be eligible for more than one benefit. The client must be given the opportunity to apply for any Programs in which he expresses an interest, even if the Worker is able to pre-determine his ineligibility.

  NOTE: Certain programs, CDCS, I/DD, AD, and TBI Waiver, require a medical and/or other determination by a community agency or government division other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

- Reviewing the DFA-2 or other application form to make certain that the client understood each question and answered to the best of his ability. If the client is unable to complete the form himself, and there is no one else to help him, the Worker must complete the form based on information provided by the client.

- Explaining the applicant's responsibility to provide complete and accurate information and the penalties for failure to do so.

- Discussing all statements on the DFA-RR-1 with the client to be sure he understands each one and marks each appropriately.

- Explaining fully the benefits of the Program(s) for which the client applies. This includes: when benefits are received, how received, description of the benefit, how to use the benefit, as well as any other pertinent information related to receipt and use of the benefit.

- Explaining how eligibility for the Program(s) is determined and, if applicable, how the amount of the benefit is computed.

- Explaining the applicant's reporting requirements.

- Providing the applicant with a list of verifications needed to determine eligibility, using form DFA-6 or the eRAPIDS verification checklist. He must also be told the penalty for failure to provide the verifications and what he must do if he finds he cannot obtain it by the deadline.

- Explaining other resources within the agency from which the client may benefit.

- Explain to the client that he is authorized to receive information and referral services about TANF and other programs offered by the Department.

- Finding resources to meet the client's emergency needs by referral to a community resource or by an application for Emergency Assistance.
- Ensuring that information about available community resources addressing domestic violence issues is made available to all persons who could benefit from it.

- Referring all clients who request assistance in dealing with domestic violence to a local domestic violence agency, so that an interview may be conducted the same day. When this is not possible, referring the client to the Division of Children and Adult Services.

- Providing each Medicaid applicant with a copy of the Department's Notice of Privacy Practices (NOPP). This includes clients who are completing a redetermination of Medicaid eligibility. In addition, the Worker must answer any questions the client may have about the document or about HIPAA or must refer the client to another source of information, such as the Regional or State-level DHHR HIPAA Privacy Officer. When no in-office Intake Interview is conducted, the Worker must mail the NOPP with a notice about how to obtain more information. This must be done at each mail-in or online Medicaid application and redetermination.

J. HOME VISITS

Home visits may be conducted for any Program during any phase of the eligibility determination process when the Worker or Supervisor believes a home visit is advisable. The client may also request one due to illness or inability to travel, when he has no one to act on his behalf.

NOTE: Home visits for SNAP AG's may only be made on a case-by-case basis and not because an AG fits an error prone or other profile.

The client may refuse entry to the Department's representative without losing eligibility, as long as he provides the information which prompted the home visit within a reasonable amount of time, to be mutually agreed upon by the client and the Worker.

Eligibility is not affected for any Program by the client's failure to be home for a home visit, unless:

- At least two attempts have been made; and

- At least the second visit was scheduled; and

- The client has not contacted the county office to make other arrangements.

The DFA-HV-1 may be left at the client's home, after the first attempt, to advise the client of a return visit. If the DFA-HV-1 is used for this purpose, a copy must be retained by the Worker.

NOTE: For the SNAP Program, home visits must be scheduled. For all other Programs, the visit may be scheduled or unscheduled, at the Worker or Supervisor's discretion. If a home visit is made for another Program, and information is obtained which affects SNAP eligibility or benefit level, it is acted upon whether or not the home visit was scheduled.

K. MAIL-IN, inROADS AND APPLICATIONS INITIATED FROM THE SSA's LIS/MPA DATA EXCHANGE AND REDETERMINATIONS

1. Applications Submitted By Mail

The Department responds to requests for applications to be mailed to potential applicants and accepts applications submitted by mail. Some Programs and coverage groups still require a face-to-face interview. This may be accomplished by the client's visiting the office, by his appointment of an authorized representative to apply on his behalf or by the Worker's making a home visit. Whether or not a face-to-face interview is required is found in Program-specific sections of this Chapter, along with any information which is specific to a particular Program or coverage group. The following is a general description of the mail-in application process.

NOTE: The same basic process applies when the client or his representative picks up and/or drops off an application for the client, without a contact with the Worker, and when the client requests in writing that an application form be mailed to him. The following description does not indicate which form is mailed, because the form depends upon the benefit for which the client wishes to apply. The appropriate forms are shown with each Program and coverage group found in the Program-specific sections which follow.

- If an individual telephones a DHHR county office to request an application be mailed to him, the Worker will inform him of the following:

  - If he wishes, a Worker will complete the application for him in a face-to-face interview, either in the office or in his home; and

  - The mail-in application procedure will result in a delay in processing his application due to a delay in receipt of the form through the mail, and a possible face-to-face or telephone interview, if required.

  - If he wishes, he may complete the inROADS application process, if applicable.

- If the individual still prefers to make an application by mail, an application form is mailed to him on the date of his telephone call. If the client requested the application by letter, an application form is mailed to him on the day the letter is received in the county office.

If the individual expresses an interest in Medicare Premium Assistance (MPA) when he applies for the Low Income Subsidy at the SSA, an application is mailed to him when the LIS/MPA data exchange containing his file is received by eRAPIDS.

When the application form is returned which contains at least the applicant's name, address and signature, an application is considered filed. The policy and procedures concerning the formal disposition of the application are applicable.

- The date of application is the date the application form which contains the applicant's name, address and signature is returned to the county office. The forms must be date-stamped when received.

  NOTE: The date of application for a DFA-QSQ-1 submitted in person or by mail, that was initiated from the SSA's LIS/MPA data exchange is the LIS application date.

- The application is logged on the DFA-15, Application Register, or other method developed by the local office, and assigned to a Worker for processing and completion.

2. Applications Submitted By inROADS

Applications for benefits which include, but are not limited to, Medicaid for Children and Pregnant Women, WV CHIP and SNAP benefits, may be submitted online by using West Virginia inROADS. The following outlines some special procedures associated with the process.

Individuals submitting applications using inROADS must electronically sign the application. The Request for Assistance (RFA) date and application date are the same.

See eRAPIDS User and Desk Guides for additional information about the inROADS Administration System.

3. Applications Submitted By inROADS From A Community Partner

Some inROADS applications are submitted with the assistance of a Community Partner. This is an agency or organization that assists

individuals and families in applying for benefits which include, but are not limited to Medicaid,WV CHIP, SNAP benefits, QMB, SLIMB, QI-1, SCA and LIEAP. An example of a Community Partner is the Primary Care Association.

Community Partners who enter into an agreement with DHHR are permitted to verify the identity and citizenship of the applicant and submit the application with an electronic signature. The Community Partner may choose to submit any verification to the local office on behalf of the applicant.

See eRAPIDS User and Desk Guides for additional information about the inROADS Administration System.

4. Applications Submitted from the SSA's Low Income Subsidy (LIS)/Medicare Premium Assistance (MPA) Data Exchange

Applications for benefits include MPA only. The following, outlines special procedures associated with the Medicaid Improvements for Patient and Providers Act (MIPPA) process.

a. LIS/MPA Data Exchange with RAPIDS

When an individual applies for LIS prescription drug assistance at the SSA and expresses an interest in MPA, he is considered to have made an application for QMB/SLIMB/QI-1 on that date. LIS files are sent daily, Monday through Friday with the exception of federal holidays, to RAPIDS through data exchange. The Worker receives a DXRL alert when a client's file is received and can access the LIS application information on the DX screens.

b. eRAPIDS' Response to the LIS Data Exchange

When a LIS file is received, eRAPIDS determines if the applicant is a MPA recipient, a recipient of other DFA program benefits, or is unknown to the data system and responds accordingly.

- When the LIS/MPA applicant is a current MPA recipient, no action is taken by RAPIDS nor required by the Worker.

  EXCEPTION: When the LIS application date is prior to the beginning date of coverage in the active MPA AG, backdated eligibility must be considered and provided if applicable. See Section 1.15.

  EXAMPLE: Mr. Jacobs applies for the LIS at the SSA on October 29, 2010 and expresses an interest in MPA. This is his LIS/MPA application date. He visits his local office on November 1, completes a DFA-QSQ-1 and is approved for QI-1 with backdated coverage to August 2010. The LIS/MPA data exchange is transmitted November 2, 2010. The Worker checks her DXRL data exchange alerts and finds Mr. Jacob's LIS application date is October 2010. She takes corrective action and backdates Mr. Jacobs' beginning date of coverage to July 2010, if otherwise eligible.

  - When the LIS/MPA applicant is a recipient of other programs, or known to the data system, eRAPIDS issues a DFA-QSQ-1. No action is required by the Worker.

  - When the LIS/MPA applicant is unknown to the data system, RAPIDS issues a DFA-QSQ-1. No action is required by the Worker.

The DFA-QSQ-1 is issued to the address in eRAPIDS if there has been an active AG in the last 30 days. Otherwise, the DFA-QSQ-1 is issued to the LIS file address.

If there are differences in the addresses, DX displays a discrepancy indicator.

NOTE: The next business day after eRAPIDS receives SSA's LIS data, the data system issues a DFA-QSQ-1. If the DFA-QSQ-1 is not returned within 31 days from the date RAPIDS received the LIS file, eRAPIDS sends a denial notice. No action is required by the Worker.

If the DFA-QSQ-1 is returned, it is processed in accordance with Section 1.15.

NOTE: See Section 1.2 regarding when the DFA-QSQ-1 is returned to a county other than where the client resides.

See eRAPIDS User and Desk Guides for additional information about the MIPPA application process.

5. Applications for Insurance Affordability Programs Coordinated with Marketplace

a. Applications Received From the Marketplace

Beginning October 1, 2013 individuals interested in applying for Insurance Affordability Programs due to the Affordable Healthcare Act may apply at the Department or the Marketplace. The Marketplace determines eligibility for MAGI Medicaid groups and WV CHIP only, in real time without delay when possible. Non-financial and financial information about the applicant is matched with the federal data hub.

If the individual is over income for MAGI Medicaid or WV CHIP, the Marketplace evaluates him for the insurance affordability programs.

If the individual is eligible for MAGI Medicaid or WV CHIP, the Marketplace shares the decision with the Department. Medicaid or WV CHIP is issued by eRAPIDS. A system evaluation for other Department programs does not occur at the Marketplace. See Section 1.24,G.

b. Applications Received by the Department

Individuals interested in applying for MAGI Medicaid or WV CHIP with coverage beginning October 1, 2013 due to the Affordable Healthcare Act may apply at the Marketplace or at the Department. The Worker determines eligibility for MAGI Medicaid and WV CHIP groups. Non-financial and financial information about the applicant is matched by the federal data hub in real time.

If the individual is over income for MAGI Medicaid coverage groups or WV CHIP, eRAPIDS shares the individual's file with the Marketplace. The Marketplace evaluates the individual for insurance affordability programs. The Department does not determine eligibility for the Marketplace's benefits but may refer individuals to an in-person assistor or Navigator for assistance.

When an individual is ineligible for MAGI Medicaid or WV CHIP due to income, and he attests to disability, he may be eligible for an SSI-Related, M-WIN or other Medicaid Group. During this time he

may receive Marketplace benefits. If approved for other non-MAGI Medicaid coverage, the Marketplace is electronically notified. See Section 1.24,G.

6. Redeterminations Submitted by Mail

Recipients of some Medicaid coverage groups, WV CHIP and other Programs receive an instruction letter and redetermination form which is submitted by mail, along with appropriate verifications. The client must complete, sign and mail or bring the form and other required information to his local DHHR office or the Customer Service Reporting Center as directed by the letter. See below for redeterminations submitted by inROADS. The client may always request a face-to-face interview. See Program Sections for specific information about the redetermination process.

7. Redeterminations Submitted by inROADS

Recipients of some Medicaid coverage groups, WV CHIP and other Programs receive an instruction letter and redetermination form. The client may choose to return the completed form and information by mail or complete the redetermination online by use of inROADS. The recipient receives certain information in the letter which must be entered online to use the inROADS redetermination process. See program sections for specific information about the redetermination process.

No signature page is required and the redetermination is considered electronically signed when the recipient uses this process and enters information from the letter and other identifying information requested.

The online process is available for use through the end of the month the redetermination is due. Redeterminations submitted in inROADS are processed by use of eRAPIDS Inbox screen or the Worker's dashboard.

The client may also submit an application for another benefit(s) at the time of the inROADS redetermination.

8. Presumptive Eligibility

Individuals receiving services at a qualified hospital, or other entity identified in the West Virginia Medicaid State Plan - Comprehensive Behavioral Health Centers, Free Clinics and Federally Qualified Health Centers, may apply for Medicaid with the assistance of an Authorized Employee (AE). Qualified entities may elect to provide Presumptive Eligibility (PE) determinations to individuals who are without any other form of health coverage. Presumptive financial eligibility is not permitted for any other program and is unrelated to Presumptive Medical decisions for the Medical Review Team (MRT). Eligibility is established on date of determination. Back-dating does not apply to this provision.

Categories Eligible for PE:

- Children under age 19
- Pregnant Women
- Parents/Caretaker Relatives
- Adult Group
- Former WV Foster Children
- Breast and Cervical Cancer Women Receiving Current Treatment

a. Duties of the AE

The AE makes a PE decision based on preliminary information provided by either the individual seeking treatment or someone with the patient who would reasonably be expected to know about the individual. They can attest to the individual's US Citizenship or satisfactory immigration status. The AE is prohibited from requiring any other verification prior to approval. Additional information gathered includes name, household size, income limit, sex, address, and prior approval for PE in the last 12 months. Using the same inROADS portal as Community Partners, the AE sends the information electronically to the data system and issues a medical card with a PE Medical ID. The PE determination is not subject to fair hearing rights and advance notice is not required.

The presumptive eligibility period begins on the date of the PE determination and concludes on the last day of the following month. Eligibility may not be backdated.

PE eligibility ends:

- The date the eligibility determination is completed based on the submission of a full application.

- The last day of the month following the month of the PE approval without submission of a full application.

EXAMPLES: Eligibility for PE is determined on June 15th. A full Medicaid eligibility is determined August 3 based on an application dated July 30. PE coverage ends August 3.

PE is determined June 15th. Eligibility would expire July 31 if an application was not filed.

If a patient is determined PE on June 15, applies for Medicaid and is denied on July 10, PE ends July 10.

NOTE: PE is limited to once every twelve months, starting with the effective date of the initial presumptive eligibility period, with the exception of pregnant women, who are eligible once per pregnancy.

The AE must assist the applicant or his representative in completing full Healthcare application and forward the application to the Department. The full Healthcare application can be submitted online, by mail, fax, telephone, or in person.

If the patient or the authorized representative (AR) is unable or unwilling to complete the full application at the time of service, the AE will tell the patient or AR of the different options they have to complete the full application. If the patient indicates that they would like to complete their application via the telephone, the worker must have them contact the call center at 1-877-716-1212. The worker should explain that they must call this number because they will be required to give a recorded telephonic signature.

b. DHHR Worker Responsibilities

Upon receipt of a completed application, the DHHR worker begins processing the application which includes the PE Medicaid Identification Number. This process combines the two applications together, and closes the PE period upon approval or denial of the Medicaid application. The Worker must establish whether the client was eligible at the time of the PE determination, as well as ongoing. Medicaid eligibility begins on the first day of the month of the PE determination. Retroactive back-dating is allowed with the full Medicaid application, if the client is eligible.

The DHHR Worker or qualified entity must take the BMS approved PE training and receive certification prior to becoming an Authorized Employee that will be permitted to take application for Presumptive Eligibility. The qualified entities at which the DHHR Worker is placed will have made agreement to accept responsibility for all decisions and outcomes of the DHHR AE. The DHHR Worker that is at the hospital will follow the same procedures for taking Presumptive Eligibility applications as any other PE Worker.

c. Other PE Specifications

(1) Qualified Entity

To be qualified to make presumptive eligibility determinations, a hospital or other entity must:

- Be a qualified entity identified in the WV Medicaid State Plan as eligible to conduct PE;
- Be enrolled in WV Medicaid as a provider;
- Elect to participate in the PE program by:
  - Submitting a PE application attesting to their qualifications to participate in the PE program, and
  - Agree to all the terms and conditions related to the use of the presumptive eligibility determination portion of the WVinROADS on-line system.
- Assign an employee to serve as the Presumptive Eligibility Administrative Point of Contact;

- Assist applicants with the completion of the full Medicaid application;
- Follow state and federal privacy and security requirements;
- Follow state requirements for data submission.

(2) Authorized Employee (AE)

For all authorized employees, DHHR workers and other third party contractors, the following conditions must be met:

- Before a hospital employee, DHHR worker or other third party contractor can be authorized to perform presumptive eligibility determinations he or she must satisfactorily complete the training course provided by BMS.
- A certificate of course completion must be kept in the AE worker file at the qualified entity and must be made available to BMS within five (5) days of request. A file must be kept on third party vendors and DHHR workers who are assigned to do presumptive eligibility determinations.
- Access to WVinROADS may not be granted by the Presumptive Eligibility Administrator or the Administrative Point of Contact until all training is completed and a certificate is presented by the employee.
- All authorized presumptive eligibility employees must complete and submit a User Agreement with WVinROADS prior to conducting presumptive eligibility determinations.
- When an AE leaves the employment of the hospital, their contract ends or is no longer assigned to determine presumptive eligibility on behalf of the hospital the Presumptive Eligibility Administrative Point of Contact must immediately remove his/her access to the WVinROADS system.

9. Applications Submitted Through inROADS From the West Virginia Division of Corrections (DOC) or Regional Jail Authority (RJA)

The West Virginia Division of Corrections (DOC) or Regional Jail Authority (RJA) will provide the Bureau for Medical Services (BMS) a list of incarcerated individuals that have been admitted as an inpatient in a medical institution for at least 24 hours. Hospitals will also provide a list to BMS of incarcerated individuals who have been admitted for services for reconciliation against the DOC and RJA list.

If the individual is a current Medicaid recipient, BMS will code MMIS with the appropriate incarceration status. This will place a restriction on payment of Medicaid services while the recipient is an inmate, or incarcerated. BMS will also notify the Customer Service Reporting Center (CSRC) if the recipient is not coded as incarcerated, so the living arrangement code in the case can be updated

If the individual is not a current Medicaid recipient, BMS will notify DOC or RJA to assist the individual with submitting a Healthcare Application via inROADS.

The inROADS applications will be forwarded to the Customer Service Reporting Center (CSRC) for processing. If Medicaid eligible, the incarcerated individual living arrangement code will inform BMS/MMIS of the recipients' incarcerated status. The CSRC notifies BMS by email that the application has been processed.

L. CLIENT NOTIFICATION, WRITTEN AND VERBAL

The client must be notified in writing of the final decision on his application and the reason for it. Notification must be provided for each Program for which the client applied, but notification for more than one Program may be included on one form letter.

NOTE: There is specific, court-ordered client notification policy which must be followed. There are also specific forms which must be used and detailed procedures to follow. See Chapter 6.

During the intake interview or during some other client contact prior to written client notification, the Worker may know whether or not the client is eligible and, if so, the amount of the benefit. The Worker may tell the client the status of his application and/or benefit level, if he so chooses. However, even if the client has been told his status and/or benefit level, he must still receive the information in writing.

Under some circumstances, the data system automatically generates notification to the client. See the eRAPIDS User Guide.

M. COMPLETION OF THE APPLICATION PROCESS

The application process is completed when all of the following have occurred:

- Action is taken as follows:

  - To approve the application when all eligibility requirements are met; or

  - To deny the application when at least one eligibility requirement is not met or the client has failed to establish eligibility.

    - The client is notified of the action taken.

  EXCEPTION: When eRAPIDS determines a LIS/MPA applicant is a current MPA recipient, no notice is sent.

    - The client receives his initial benefit, if eligible.

N. COMMUNICATION WITH SOCIAL SECURITY ADMINISTRATION (SSA)

Each CSM is responsible for appointing a contact person to communicate with a contact person in the local SSA Office. This contact person does not interpret

policy, but works out communication problems and any problems dealing with the completion and forwarding of forms, including those involved in the joint application process for SNAP benefits. The Department's contact works directly with the contact from SSA.

Any matters that cannot be worked out between the local office and the SSA contact person are referred to a DFA Policy Unit and to the SSA District Office by the appropriate staff.

NOTE: The Worker must not contact the SSA regarding LIS files received through data exchange. Different eligibility criteria are used by the SSA and the Department. The Worker may issue a eRAPIDS verification checklist or a DFA-6 if information in the LIS file and the Department's records differ and must be reconciled.

O. DOMESTIC VIOLENCE ASSISTANCE

Information about community resources that address the issue of domestic violence must be readily available in each waiting room of each county office. The information must be written and must be available for the client to take with him discreetly, without having to ask for it. In addition, the Worker must provide such information when it is requested and must offer it to any person who, in the Worker's judgment, could benefit. When possible, this must be accomplished during the office interview. In order to insure the safety of the individual to whom information about domestic violence is given, it is suggested that the domestic violence information be part of a packet which contains a variety of information. If, during the interview, the Worker observes language or other behavior which is threatening and discussion of such matters could pose a possible threat to the person who is judged to be in need of information the Worker must avoid direct discussion with the client. In those instances, a referral to the local domestic violence program, other available community resource or to Social Services is in order so that a contact can be made without the threat of additional harm to the client.

Each CSM is responsible for coordinating efforts between DFA staff, Division of Children and Adult Services, and available community resources. The CSM is also responsible for making sure that up-to-date information about domestic violence services is available at all times.

See Section 4.1 regarding allowances in the verification process for MAGI Medicaid and WV CHIP when the applicant attests to being a victim of domestic violence.

P. DETERMINING RACE AND ETHNICITY FOR FEDERAL REPORTING

It is the Worker's responsibility to determine the client's appropriate race and ethnic category and correctly enter the information in eRAPIDS.

1. Race

When a client identifies himself as being of a single race or a combination of races, the appropriate race is entered in eRAPIDS. The following are the races with which he may identify.

- Asian Indian
- Black or African American
- American Indian or Alaska Native
- White
- Native Hawaiian or other Pacific Islander
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Guamanian or Chamorro
- Samoan
- Other Asian

2. Ethnicity

The client must be placed in an ethnic category, regardless of the race with which he identifies.

- Hispanic or Latino
- None of the above

If Hispanic or Latino

- Mexican
- Mexican American
- Chicano/a
- Puerto Rican
- Cuban
- Other

EXAMPLE: The client identifies his race as Black, with some Hispanic ancestry. His ethnicity is entered as “Hispanic or Latino.”

EXAMPLE: The client identifies his race as White, with no Hispanic background. His ethnicity is entered as “None of the above.”

When the client refuses to identify his race and/or ethnicity, the Worker must use his best judgment when entering the information in eRAPIDS.