2.1 INTRODUCTION

Case maintenance is used to describe all activities which are required, between AG approval and the first redetermination and between redeterminations, to ensure that only eligible clients receive benefits and that the benefit amount is correct.

The process requires that specific changes in the client's circumstances be reported to the Department. The primary source of such information is expected to be the client, but information from all sources is considered. The Worker is then required to take all necessary action to update the client's case record and data system case, when appropriate. When any case maintenance activity results in AG closure or a change in the benefit level, the Worker must notify the client. Some changes, such as an address change, require client notification even when the benefit is not affected. See Chapter 6.

A. GENERAL SOURCES OF INFORMATION

The need for case maintenance originates from many sources. The following general list of sources applies to all programs and coverage groups. More specific information about these sources and others is found in the Program-specific sections which follow.

- The client

- An individual acting for the client. The client may ask someone to act on his behalf. When an individual, other than the client, reports information about the client, no action is taken based on such information, until it is confirmed by the client. The Worker must initiate contact with the client, when required by the Program.

  EXCEPTION: In the following circumstances, action is taken without client confirmation:

  - The client is a child, and the information is reported by a parent, or by another individual, who applied for the child.

  - The individual is the appointed legal representative for the client. This includes, but is not limited to, a conservator, Power-of-Attorney (POA), Authorized Representative or committee.

  - The information is provided by the client's spouse, who is living with him, or would be living with him, if he were not institutionalized.

  - The client is unable to act for himself because of mental or physical illness, and there is no reason to doubt the motives or competency of the individual who supplies the information.

- For the Supplemental Nutrition Assistance Program (SNAP), the client's Authorized Representative(s) or Authorized Cardholder(s).

The case recording must state the source of information, whether or not the client confirmed the information, or the reason confirmation was not obtained.

- Complaints about the client. Individuals in the community and other DHHR employees may report information to the Department which has a bearing on the client's eligibility. The report may be in the form of a complaint about the client or a claim that he is receiving benefits fraudulently. If the reported information would have no effect on eligibility for the specific Program, this must be explained to the individual providing the information, without confirming that the client receives such benefits or revealing any case information. The nature of the complaint must be recorded in the case record, but not the name of the complainant.

  If the reported information would have a bearing on eligibility or the benefit level, if true, the Worker must contact the client to confirm it, keeping in mind the AG's reporting requirements. Verification may be requested, if appropriate. The Worker must not take action, or indicate he is taking action, until the complaint is substantiated. Regardless of the outcome, the nature of the complaint, but not the complainant's name, and the resolution must be recorded. When the complaint involves allegations of fraud, the Worker must determine if there is reason to believe the client committed fraud. If so, and the amount is $500 or more, the Worker must make a referral to IFM. See Chapter 20.

  EXAMPLE: A woman calls to report her neighbor's oldest son moved out of the home and she has purchased a new vehicle. After reviewing the case, the Worker finds that the AG is receiving SNAP benefits only and is not required to report changes except when the AG's income exceeds the 130% FPL. The Worker thanks the caller for her information and explains that countable assets and reporting requirements differ among Programs. The information is noted in case comments and explored at the next scheduled redetermination.

- Information from other offices or bureaus within DHHR.

- Data system matches and case maintenance functions. Each Program has specific reports and other case maintenance functions. See Program-specific information.

- Federal Data Hub is used for Medicaid Groups.

B. PROCEDURES FOR COUNTY TRANSFERS AND AG CLOSURES

The following information provides procedural instructions for case actions common to all programs.

1. County Transfers

When a recipient moves to another county, data system action is taken immediately to change the address and transfer the case. The local office in the client's new location must be notified electronically of the case name, case number, new address, effective date of the transfer and any other pertinent information the new county of residence needs before receipt of the case record, such as a redetermination due or overdue or a domestic violence situation, etc.

The Worker forwards the case record and any separate file which contains information about a domestic violence situation to the new local office, within 10 days. A memorandum is attached to the case record. In addition to case name and case number, the memorandum must include the new address, type of benefit and/or services being received and the date the case is due for redetermination. If the client is in a nursing facility, this is indicated. A copy of this memorandum is retained in the closed files of the originating office. If the case is active with the Division of Children and Adult Services or BCSE, the Worker must notify the other units of the transfer electronically or by DHS-1.

2. AG Closures

When a client's circumstances change so that he becomes ineligible, the AG is closed. In some situations, the AG is automatically closed by the data system. However, most AG closures are completed by the Worker. AG closures usually involve failure to continue to meet an eligibility requirement. These are addressed in the Program-specific items which follow. The closures described below are related to general requirements, common to all Programs.

a. Automatic Closures

AG's are automatically closed by the data system under the following circumstances:

- A SNAP or WV WORKS AG redetermination is not completed by the deadline date in the month the AG is due for redetermination.

- Phase II of TM ends.

- Extended Medicaid coverage ends.

- Medically Needy non-spenddown AG's, not redetermined in the 6th month of eligibility.

- Medically Needy spenddown AG's at the end of the POC.

b. Closure Due to Loss of Contact

Loss of contact occurs when the client moves and does not notify the Department. The Worker may become aware of this when a support services payment, medical card or other correspondence is returned. The Federal Data Hub may also indicate a client's updated address.

The Worker must first check the address in RAPIDS. If it is incorrect due to a data entry error, the Worker must correct it and release the benefit(s) to the correct address. For SSI Medicaid recipients, the Worker must check SOLQ.

If the address is correct and/or the Postal Service indicated a new address on the returned correspondence, the Worker sends an DFA-6 to the client's new address. If the DFA-6 is returned as undeliverable, or, if the client does not report his new address by the date indicated on the form, the AG is closed, after proper notice. If the Postal Service indicates no new address on the returned correspondence, the AG is closed, after proper notice.

NOTE: This does not apply to Medicaid for Continuously Eligible Medicaid (CME) AG's. The AG remains open until the next redetermination.

For SNAP AG's, see the specific reporting requirement in Section 2.2,B. SNAP AG's are not required to report a change of address and information from the Postal Service is not considered verified upon receipt. The Worker must only act on this information if it affects other programs of assistance in RAPIDS.

c. Closure Because Client Moves to Another State

When the client moves to another state and his address is known, the Worker must complete the appropriate notification letter for AG closure and send it to the client. For SNAP AG's, see Section 2.2,B for the appropriate action. In addition, for those who receive or previously received WV WORKS benefits, the Worker must include the following statement on the form: "If you want to apply for benefits in (new state), please take this letter with you to show that your West Virginia benefits have been stopped.

You have received _____ months of TANF benefits from West Virginia toward the 60-month lifetime limit. In addition, you received _____ months from the State of ____________________ . This is a total of _____ months received."

d. Closure at Client's Request

The Worker must close the AG when the client requests that such action be taken. The Worker should encourage the client to state the reason he is making the request, but acts on the AG closure even if he does not. Advance notice is required.

e. Medicaid Certificate of Coverage

For any individual in any Medicaid coverage group whose Medicaid benefits stopped on or after July 1, 1996, the Worker must, upon request, complete form DFA-HIP-1, Certificate of Medicaid Coverage.

All individuals in the same AG with the same period of coverage may be included on the same certificate. A separate certificate must be issued for individuals who have different dates of coverage, or when all individuals do not have 18 months of coverage.

C. WV WORKS AND MEDICAID PROCEDURES FOR ADDING NEWBORN CHILDREN

Each CSM is responsible for assigning one person in each of the counties under his supervision to seek out information about newborn children. This individual is responsible for ensuring that information about newborn children is added to the WV WORKS or Medicaid AG and that the information is entered into RAPIDS within 5 work days of the date information is obtained. This individual is also expected to work with medical providers to develop mutually agreeable

procedures for obtaining the necessary information as quickly as possible. The CSM must also have a back-up designee when the contact person is unavailable.

RAPIDS issues the following alerts for expected births:

- 169 - Pregnancy Due This Month
- 110 - Pregnancy Past Due

See Sections 2.4,D,3 and 2.17,D,3.

This process is required only for WV WORKS and Medicaid AG's. See Section 2.2,B for instances in which you must add a newborn child(ren) to a SNAP AG.

D. VOTER REGISTRATION PROCEDURES

A voter registration application and declination form must be provided at any point a client reports a change of address. See Section 1.2,A,4 and Chapter 1, Appendices F, G and H.