24.3 MINIMUM HOURS OF PARTICIPATION

Each adult and emancipicated minor who receive WV WORKS benefits must meet a work requirement at a minimum rate of participation. The work requirement does not necessarily mean that the participant must be employed. Work, however, is the focus of
WV WORKS. The activities that meet the work requirement are listed in Section 24.5.

A. REQUIRED PARTICIPATION

Federal TANF reports require information about 2-parent families to be reported to determine the State's participation rate.

For federal TANF purposes, all AG's with 2 parents or 2 non-parent caretakers included, whether married to each other or not, are 2-parent families. With that starting point, those families with 2 parents/non-parent caretakers that meet certain requirements could then be exempt from meeting the 2-parent family requirements.

The definitions below are used only for the Worker to determine the required level of participation, based on the family's circumstances, and should not be used for any other purpose.

S A 2-Parent Family, for these purposes only, meets all of the following criteria:

- There are 2 parents living together and included in the same WV WORKS payment; and
- Both parents are age 20 or over; and
- Both parents have at least one eligible child in common living in the home; and
- Neither parent is incapacitated or disabled according to item D below; and
- Neither parent is providing care for a severely disabled child.

– A 1-Parent Family, for these purposes only, is a family that does not meet all of the 6 criteria above, regardless of the number of parents or other adults included in the payment.

One-parent families include, but are not limited to, the following situations:

- Families with only 1 parent included in the WV WORKS check;
- Families with 2 parents included in the check when one or both parents is incapacitated or disabled according to item D below;

- Families with 1 parent and 1 stepparent included in the check when they have no common child;
- Families with 1 or 2 non-parent caretaker relatives included in the WV WORKS payment;
- Families with 2 parents included in the check when one or both parents is under age 20;
- Families with 2 parents included in the check when a parent provides care for a severely disabled child.

The minimum requirements for each group are found below.

1. One-Parent Families

The minimum hours of participation increase over time as follows:

Federal FY 97-98	20 hours/week (average)
Federal FY 99	25 hours/week (average)
Federal FY 2000 and later	30 hours/week (average)

The federal fiscal year begins on October 1st of the preceding year, i.e., FY 2000 begins 10/01/99.

There are 2 special considerations that do not apply to families with 2 parents included in the AG even though the families work requirement is that of a 1-parent family in setting work requirements for a family with parent. Details of these considerations are below.

a. Parent Of A Child Under Age 6

A single parent with a child under age 6 meets the work participation requirement by participating an average of 20 hours/week. The parent may be required to participate more than 20 hours, or may volunteer to participate more than 20 hours, but no sanction may be imposed as long as the average 20 hours/week level is met.

b. Parents Under Age 20

A parent who is under age 20 and who does not have a high school diploma or the equivalent, meets the family's work requirement as long as he:

- Maintains satisfactory attendance at a secondary school, or the equivalent, during the month; or

- Participates in education that is directly related to employment for at least the minimum average number of hours per week identified above in item 1.

2. Two-Parent Families

The minimum hours of participation for 2-Parent Families depend upon the receipt of federally funded child care.

When the family does not receive federally funded child care, the minimum number of hours of participation is 35 hours/week. The participation requirement may be met by one or both parents. There is no requirement that each parent participate equally.

When the family receives federally funded child care, the minimum number of hours of participation is 55 hours/week. The participation requirement may be met by one or both parents. There is no requirement that each parent participate equally.

The activities that may be used to meet the work requirement are found in Section 24.5.

B. ABSENCES

With the exception of inclement weather, Workers must determine whether absences are excused or unexcused. Participation is calculated on the actual hours of attendance or participation each month and converted to a weekly average. The following guidelines are used to determine actual hours of

attendance/participation for planned school breaks, inclement weather or individual absences.

When excused absences are used in the total number of hours of participation, according to the instructions below, the Worker includes the excused absences on WP screen WPSC and records on CMIC how the total was computed.

1. Planned School Breaks

When calculating hours of participation certain rules must be followed. The specific activity determines when school breaks can be used as hours of participation.

- High School, Junior High or Middle School: When the student expects to return after the summer break, the normal hours of attendance are treated as participation hours for the summer. Breaks during the school year are also included, such as Thanksgiving, Christmas, Spring break, school holidays, etc.

- ABE: Only planned school breaks which occur during the regular school year are counted as participation hours. These include Thanksgiving, Christmas, Spring Break and other scheduled school holidays. Summer breaks are not counted.

- Vocational/Skills Training and Proprietary Schools: Only planned breaks which occur during the regular school year are counted as participation hours. Summer breaks are not counted.

2. Inclement Weather

When inclement weather results in school closings or imposition of a state of emergency that prevents travel, the client is considered to have participated.

Contact the OFS Policy Unit for approval when a closure of more than one day is anticipated or occurs.

3. Individual Absences

This policy establishes the guidelines for the treatment of hours missed in a participation under WV WORKS. All missed time whether excused or unexcused, must be made up within the month in which it is missed. When it is impossible to make up time missed, the Worker must decide if the absence is excused

or unexcused.

Excused absences of up to three days/month may be counted as hours worked in the month. The hours worked include the excused hours when participation did not actually occur. An excused absence includes illness or other good cause which prevented participation. It is the responsibility of the Worker to determine if the absence is excused or unexcused. Close contact must be maintained with the employer/contractor to ensure that the determination is made timely. A determination of good cause may only be made by the WV WORKS staff.

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

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

4. Holidays

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

5. Paid Vacation

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

C. PARTICIPANT DOCUMENTATION

Written documentation of participation is required, when possible. The Worker may, in very unusual circumstances accept the information from the employer verbally, as long as he records on CMIC the same information found most on time sheets.

Some employers/sponsors/contractors have their own time sheets. These are normally acceptable, as long as they provide the necessary information and are signed by the employer or his representative.

The Participant Time Sheet (WT-12) may be used to document participation and satisfactory progress for work requirement activities. When used, it is given to providers to report attendance and satisfactory progress on a monthly basis. It may also be given to the client for self-declaration of his participation when no other source is available.

In addition, this form may also be used by participants to report days of actual participation for documentation of support service needs.

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

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

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

1. Establishing Disability Without A Physician's Statement

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

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

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

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

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

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

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

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

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

- The individual has one of the following conditions:

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

    - Amputation of leg at hip

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

    - Total deafness, not correctable by surgery or hearing aid

    - Statutory blindness, unless due to cataracts or detached retina

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

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

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

- Muscular dystrophy with irreversible wasting of the muscles with a significant effect on the ability to use the arms and/or legs.
- Impaired renal function due to chronic renal disease, documented by persistent adverse objective findings, resulting in severely reduced function which may require dialysis or kidney treatment.

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

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

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

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

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

- Recipients of benefits from the following Medicaid coverage groups:

  - SSI-Related Medicaid

  - HCB Waiver

  - MR/DD Waiver

2. Establishing Disability With A Physician's Statement

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

a. Definition Of Physician's Statement

The term physician's statement means a medical report from a licensed medical professional, including but not limited to: Physicians, Surgeons, Doctors of Osteopathy, Chiropractors, licensed or certified Psychologist, Nurse Practitioners, etc.

b. Content Of The Physician's Statement

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

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

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

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

c. Making The Determination

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

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

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

3. Establishing Incapacity

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